

# Affordable Care Act Individual Provisions

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### The Individual Shared Responsibility Provision

**Facts about the Individual Shared Responsibility Provision**  
[Publication 5156](#) – Facts about the Individual Shared Responsibility Provision

Under the Affordable Care Act, the Federal government, State governments, insurers, employers, and individuals share the responsibility for health insurance coverage beginning in 2014. Many people already have qualifying health insurance coverage (called minimum essential coverage) and do not need to do anything more than maintain that coverage.

The individual shared responsibility provision requires you and each member of your family to either:

- Have minimum essential coverage, or
- Have an exemption from the responsibility to have minimum essential coverage, or
- Make a shared responsibility payment when you file your 2014 federal income tax return in 2015.

You will report minimum essential coverage, report exemptions, or make any individual shared responsibility payment when you file your 2014 federal income tax return in 2015.

#### **Minimum Essential Coverage**

If you and your family need to acquire minimum essential coverage, you may have several options. They include:

- Health insurance coverage provided by your employer,
- Health insurance purchased through the Health Insurance Marketplace in the area where you live, where you may qualify for financial assistance,
- Coverage provided under a government-sponsored program for which you are eligible (including Medicare, Medicaid, and health care programs for veterans),
- Health insurance purchased directly from an insurance company, and
- Other health insurance coverage that is recognized by the Department of Health & Human Services as minimum essential coverage.

U.S. citizens who are residents of a foreign country for an entire year, and residents of U.S. territories, are deemed to have minimum essential coverage. [See questions 11 and 12 of our Questions and Answers](#) for more information.

For purposes of the individual shared responsibility payment, you are considered to have minimum essential coverage for the entire month as long as you have minimum essential coverage for at least one day during that month. For example, if you start a new job on June 26 and are covered under your employer's health coverage starting on that day, you're treated as having coverage for the entire month of June. Similarly, if you're eligible for an exemption for any one day of a month, you're treated as exempt for the entire month.

For more information about minimum essential coverage, check this [minimum essential coverage chart](#) and [see questions 14-20 of our Questions and Answers](#).

You can learn more at [HealthCare.gov](#) about which health insurance options are available to you, how to purchase health insurance coverage, and how to get financial assistance with the cost of insurance. If you purchase health insurance through the Marketplace and you meet certain requirements, you may be eligible for a premium tax credit to help pay your premiums. Learn more about the [premium tax credit](#). The deadline for the initial open enrollment period is March 31, 2014. You may also qualify for a special enrollment period (e.g., you move to a different state). See [HealthCare.gov](#) to learn about special enrollment periods.

## Exemptions

You may be exempt from the requirement to maintain minimum essential coverage and thus will not have to make a shared responsibility payment when you file your 2014 federal income tax return in 2015, if you meet certain criteria.

You may be exempt if you:

- Have no affordable coverage options because the minimum amount you must pay for the annual premiums is more than eight percent of your household income,
- Have a gap in coverage for less than three consecutive months, or
- Qualify for an exemption for one of several other reasons, including having a hardship that prevents you from obtaining coverage, or belonging to a group explicitly exempt from the requirement.

Because of the Affordable Care Act, more Americans have access to coverage that is affordable. However, if there is no coverage available to you and your family that costs less than eight percent of your household income, you can [qualify for an exemption](#).

An exemption applies to individuals who purchase their insurance through the Marketplace during the initial enrollment period for 2014, which runs through March 31, 2014. This hardship exemption will apply from January 1, 2014, until the start of your health care coverage, which if you enroll between March 16 and March 31 would generally be May 1. ([See this HHS Question and Answer](#) for more information.) Another hardship exemption may apply if you have been notified that your health insurance policy will not be renewed and you consider the other plans available to you unaffordable. ([See this HHS guidance](#) and [Questions and Answers](#) for more information.)

How you get an exemption depends upon the type of exemption for which you are eligible. You can obtain some exemptions [only from the Marketplace](#), others only from the IRS, and yet others from either the Marketplace or the IRS.

Learn more about exemptions in this [chart](#) and in questions 21-24 of our [Questions and Answers](#). Also, see [Healthcare.gov](#) for more information on hardship exemptions.

## Reporting Coverage or Exemptions

The individual shared responsibility provision goes into effect in 2014. You won't need to report minimum essential coverage or exemptions or make any individual shared responsibility payment until you file your 2014 federal income tax return in 2015. Information will be made available later about how to report your coverage or exemption (or make a payment) on your 2014 income tax return.

## **Making a Payment**

If you or any of your dependents don't have minimum essential coverage and don't have an exemption, you will need to make an individual shared responsibility payment on your tax return. It is important to remember that choosing to make the individual shared responsibility payment instead of purchasing minimum essential coverage means you will also have to pay the entire cost of all your medical care. You won't be protected from the kind of very high medical bills that can sometimes lead to bankruptcy.

If you must make an individual shared responsibility payment, the annual payment amount is the greater of a percentage of your household income or a flat dollar amount, but is capped at the national average premium for a bronze level health plan available through the Marketplace. You will owe 1/12th of the annual payment for each month you or your dependent(s) don't have either coverage or an exemption.

For 2014, the annual payment amount is:

- The greater of:
  - 1 percent of your household income that is above the tax return filing threshold for your filing status, or
  - Your family's flat dollar amount, which is \$95 per adult and \$47.50 per child, limited to a family maximum of \$285,
- But capped at the cost of the national average premium for a bronze level health plan available through the Marketplace in 2014.

Check out these [basic examples of the payment calculation](#) and the federal tax filing requirement thresholds. For more detailed examples, see the individual shared responsibility provision [final regulations](#).

The percentages and flat dollar amounts increase over the first three years. In 2015, the income percentage increases to 2 percent of household income and the flat dollar amount increases to \$325 per adult (\$162.50 per child under 18). In 2016, these figures increase to 2.5 percent of household income and \$695 per adult (\$347.50 per child under 18). After 2016, these figures increase with inflation.

Information will be made available later about how you will account for the payment on your 2014 federal income tax return filed in 2015.

## **More Information**

More detailed information about the individual shared responsibility provision is available in our [Questions and Answers](#). The Department of the Treasury and the IRS have issued the following legal guidance related to the individual shared responsibility provision, including detailed examples of the payment calculation:

- [Final regulations](#) on the individual shared responsibility provision.
- [Notice 2013-42](#), which provides transition relief from the individual shared responsibility provision for employees and their families who are eligible to enroll in employer-sponsored health plans with a plan year other than a calendar year if the plan year begins in 2013 and ends in 2014.
- Proposed regulations on minimum essential coverage and other rules regarding the shared responsibility provision.
- [Notice 2014-10](#), which provides transition relief for individuals enrolled in coverage under certain limited-benefit Medicaid and TRICARE programs that are not minimum essential coverage.

Additional information on exemptions and minimum essential coverage is available in [final regulations](#) issued by the Department of Health & Human Services.

## Individual Shared Responsibility Provision - Minimum Essential Coverage

The [individual shared responsibility provision](#) requires you and each member of your family to have basic health insurance coverage (also known as minimum essential coverage), qualify for an exemption from the responsibility to have minimum essential coverage, or make an individual shared responsibility payment when you file your federal income tax return.

The chart shows some types of coverage that qualify as minimum essential coverage and some that do not.

Coverage Type	Qualifies As Minimum Essential Coverage	Doesn't Qualify As Minimum Essential Coverage
<p><b>Employer-sponsored coverage:</b></p> <ul style="list-style-type: none"> <li>• Employee coverage (including self-insured plans)</li> <li>• COBRA coverage</li> <li>• Retiree coverage</li> </ul>	✓	
<p><b>Individual health coverage:</b></p> <ul style="list-style-type: none"> <li>• Health insurance you purchase from an insurance company directly</li> <li>• Health insurance you purchase through the Health Insurance Marketplace</li> <li>• Health insurance provided through a student health plan</li> <li>• Health coverage provided through a student health plan that is self-funded by a university (only for a</li> </ul>	✓	

plan year beginning on or before December 31, 2014, unless recognized as minimum essential coverage by HHS)

**Coverage under government-sponsored programs:**

- Medicare Part A coverage
- Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP)
- Most types of TRICARE coverage under chapter 55, title 10 of the United States Code
- Comprehensive health care programs offered by the Department of Veterans Affairs
- State high-risk health insurance pools (only for a plan year beginning on or before December 31, 2014, unless recognized as minimum essential coverage by HHS)
- Health coverage provided to Peace Corps volunteers
- Department of Defense Non-appropriated Fund Health Benefits Program
- Refugee Medical Assistance



**Certain coverage that may provide limited benefits:**

- Coverage consisting solely of excepted benefits, such as:
  - Stand-alone dental and vision insurance
  - Accident or disability income insurance
  - Workers' compensation insurance
- Medicaid providing only family planning services\*
- Medicaid providing only tuberculosis-related services\*
- Medicaid providing only coverage limited to treatment of emergency medical conditions\*
- Pregnancy-related Medicaid coverage\*
- Medicaid coverage for the medically needy\*
- Section 1115 Medicaid demonstration projects\*
- Space available TRICARE coverage provided under chapter 55 of title 10 of the United States Code for individuals who are not eligible for TRICARE coverage for health services from private sector providers\*
- Line of duty TRICARE coverage provided under chapter 55 of title 10 of the United States Code\*
- [AmeriCorps](#) coverage for those serving in programs receiving AmeriCorps State and National grants



- After Corps coverage purchased by returning members of the Peace Corps  
 \*In Notice [2014-10](#), the IRS announced relief from the individual shared responsibility payment for months in 2014 in which individuals are covered under one of these programs. Information will be made available later about how to claim an exemption for one of these programs on your income tax return.

## Individual Shared Responsibility Provision - Exemptions

The [individual shared responsibility provision](#) requires you and each member of your family to have basic health insurance coverage (also known as [minimum essential coverage](#)), qualify for an exemption, or make an individual shared responsibility payment when you file your federal income tax return.

How you get the exemption depends upon the type of exemption for which you are eligible. You can obtain some exemptions only from the Marketplace in the area where you live, others only from the IRS, and yet others from either the Marketplace or the IRS.

This chart shows the types of exemptions available and whether they must be granted by the Marketplace, claimed on an income tax return filed with the IRS, or either may be granted by the Marketplace or claimed on a tax return. For additional information about how to get exemptions that may be granted by the Marketplace, visit [HealthCare.gov/exemptions](http://HealthCare.gov/exemptions).

Information will be made available later about how to report health insurance coverage and claim exemptions on your income tax return.

Exemptions	May only be granted by Marketplace	May be granted by Marketplace or claimed on tax return	May only be claimed on tax return
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### Coverage is considered unaffordable -

The amount you would have paid for employer-sponsored coverage or a bronze level health plan (depending on your circumstances) is more than eight percent of your actual household income for the year as computed on your tax return. Also see the second hardship listed below, which provides a prospective exemption granted by the Marketplace if the amount you would have paid for coverage is more than



eight percent of your projected household income for the year.

**Short coverage gap** - You went without coverage for less than three consecutive months during the year. For more information, see question 22 of our [questions and answers](#).



**Household income below the return filing threshold** - Your household income is below the minimum threshold for filing a tax return. [Learn more about household income](#).



**Certain noncitizens** - You are neither a [U.S. citizen](#), a [U.S. national](#), nor an alien lawfully present in the U.S.



**Members of a health care sharing ministry** - You are a member of a health care sharing ministry, which is an organization described in section 501(c)(3) whose members share a common set of ethical or religious beliefs and have shared medical expenses in accordance with those beliefs continuously since at least December 31, 1999.



**Members of Federally-recognized Indian Tribes** - You are a member of a [federally-recognized Indian tribe](#).



**Incarceration** - You are in a jail, prison, or similar penal institution or correctional facility after the disposition of charges.



**Members of certain religious sects** - You are a member of a religious sect in existence since December 31, 1950, that is recognized by the Social Security Administration (SSA) as conscientiously opposed to accepting any insurance benefits, including Medicare and Social Security.



## Hardships:

- Your gross income is below the filing threshold. To find out if you are required to file, use our [Interactive Tax Assistant](#). 
- Two or more family members' aggregate cost of self-only employer-sponsored coverage exceeds 8 percent of household income, as does the cost of any available employer-sponsored coverage for the entire family. 
- You purchased insurance through the Marketplace during the initial enrollment period but have a coverage gap at the beginning of 2014. See this [HHS Question and Answer](#). 
- You are experiencing circumstances that prevent you from obtaining coverage under a qualified health plan. Learn more about the [criteria for this exemption](#). 
- You do not have access to affordable coverage based on your projected household income. 
- You are ineligible for Medicaid solely because the State does not participate in the Medicaid expansion under the Affordable Care Act. 
- You are an American Indian, Alaska Native, or a spouse or descendant who is eligible for services through an Indian health care provider. [Learn more](#). 

- You have been notified that your health insurance policy will not be renewed and you consider the other plans available unaffordable. See [HHS guidance](#) and [HHS Questions and Answers](#) for more information.

## The fee you pay if you don't have health coverage

If you don't have health coverage in 2014, you may have to pay a fee. You also have to pay for all of your health care.

The fee is sometimes called the "penalty," "fine," "individual responsibility payment," or "individual mandate."

**Important.** Marketplace [Open Enrollment](#) ended March 31. You can now buy a Marketplace health plan **only** if you qualify for a [special enrollment period](#). You can apply for Medicaid and CHIP any time.

Find out if you qualify for a [Special Enrollment Period or Medicaid and CHIP](#). Open Enrollment for 2015 coverage starts November 15, 2014.

## The fee in 2014 and beyond

The penalty in 2014 is calculated one of 2 ways. If you or your dependents don't have insurance that qualifies as [minimum essential coverage](#) you'll pay whichever of these amounts is higher:

- **1% of your yearly household income.** (Only the amount of income above the tax filing threshold, \$10,150 for an individual, is used to calculate the penalty.) The maximum penalty is the national average premium for a bronze plan.
- **\$95 per person for the year (\$47.50 per child under 18).** The maximum penalty per family using this method is \$285.

The way the penalty is calculated, a single adult with household income below \$19,650 would pay the \$95 flat rate. A single adult with household income above \$19,650 would pay an amount based on the 1% rate. (If income is below \$10,150, no penalty is owed.) The penalty increases every year. In 2015 it's 2% of income or \$325 per person. In 2016 and later years it's 2.5% of income or \$695 per person. After that it's adjusted for inflation.

If you're uninsured for just part of the year, 1/12 of the yearly penalty applies to each month you're uninsured. If you're uninsured for less than 3 months, you don't have to make a payment.

You'll pay the fee on your 2014 federal income tax return. Most people will file this return in 2015.

Learn more about the [individual shared responsibility payment from the Internal Revenue Service](#).

## When the uninsured need care

When someone without health coverage gets urgent — often expensive — medical care but doesn't pay the bill, everyone else ends up paying the price.

That's why the health care law requires all people who can afford it to take responsibility for their own health insurance by getting coverage or paying a fee.

## If you pay the fee, you're not covered

It's important to remember that even if you pay the penalty you still don't have any health insurance coverage. You are still responsible for 100% of the cost of your medical care.

## Minimum essential coverage

To avoid the penalty you need insurance that qualifies as [minimum essential coverage](#). If you're covered by any of the following, you're considered covered and don't have to pay a penalty:

- Any Marketplace plan, or any individual insurance plan you already have
- Any employer plan (including [COBRA](#)), with or without "[grandfathered](#)" status. This includes retiree plans
- [Medicare](#)
- [Medicaid](#)
- [The Children's Health Insurance Program \(CHIP\)](#)
- TRICARE (for current service members and military retirees, their families, and survivors)
- Veterans health care programs (including the Veterans Health Care Program, VA Civilian Health and Medical Program (CHAMPVA), and Spina Bifida Health Care Benefits Program)
- Peace Corps Volunteer plans
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014

Other plans may also qualify. Ask your health coverage provider.

## Health plans that don't qualify as coverage

Health plans that don't meet minimum essential coverage don't qualify as coverage in 2014. If you have only these types of coverage, you may have to pay the fee. Examples include:

- Coverage only for vision care or dental care
- Workers' compensation
- Coverage only for a specific disease or condition
- Plans that offer only discounts on medical services

## Exemptions from the fee

Some people with limited incomes and other situations can get exemptions from the fee. Learn about [exemptions from paying the fee](#).

# Exemptions from the fee for not having health coverage

Most people must have health coverage or pay a fee (the “individual shared responsibility payment”). You can get an exemption in certain cases.

## The individual shared responsibility payment

If you can afford health insurance but choose not to buy it, you must pay a fee known as the [individual shared responsibility payment](#).

The fee in 2014 is 1% of your yearly income or \$95 per person for the year, whichever is higher. The fee increases every year. In 2016 it's 2.5% of income or \$695 per person, whichever is higher.

If you're paying under the \$95 per person method, in 2014 the payment for uninsured children is \$47.50 per child. The most a family would have to pay under this method in 2014 is \$285.

You make the payment when you file your 2014 taxes, which are due in April 2015.

## Exemptions from the payment

Under certain circumstances, you won't have to make the individual responsibility payment. This is called an “exemption.”

You may qualify for an exemption if:

- You're uninsured for less than 3 months of the year
- The lowest-priced coverage available to you would cost more than 8% of your household income

- You don't have to file a tax return because your income is too low (Learn about the [filing limit](#).)
- You're a member of a [federally recognized tribe](#) or eligible for services through an Indian Health Services provider
- You're a member of a recognized health care sharing ministry
- You're a member of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- You're incarcerated (either detained or jailed), and not being held pending disposition of charges
- You're not [lawfully present](#) in the U.S.

## Hardship exemptions

If you have any of the circumstances below that affect your ability to purchase health insurance coverage, you may qualify for a “hardship” exemption:

1. You were homeless.
2. You were evicted in the past 6 months or were facing eviction or foreclosure.
3. You received a shut-off notice from a utility company.
4. You recently experienced domestic violence.
5. You recently experienced the death of a close family member.
6. You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
7. You filed for bankruptcy in the last 6 months.
8. You had medical expenses you couldn't pay in the last 24 months which resulted in substantial debt.
9. You experienced unexpected increases in necessary expenses due to caring for an ill, disabled, or aging family member.

10. You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, you do not have to pay the penalty for the child.
11. As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace.
12. You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act.
13. [Your individual insurance plan was cancelled](#) and you believe other Marketplace plans are unaffordable.
14. You experienced another hardship in obtaining health insurance.

## How to apply for an exemption

**If you're applying for an exemption based on: coverage being unaffordable; membership in a health care sharing ministry; membership in a federally-recognized tribe; or being incarcerated:**

You have 2 options:

1. You can claim these exemptions when you fill out your 2014 federal tax return, which is due in April 2015
2. You can apply for the exemptions using the right form below. [See instructions to help you fill out an exemption application.](#)
  - [Form to apply for exemption based on coverage being unaffordable \(if you live in a state using Healthcare.gov\)](#)
  - [Form to apply for exemption based on coverage being unaffordable \(if you live in a state using its own health exchange\)](#)
  - [Form to apply for exemption based on membership in a health care sharing ministry](#)

- [Form to apply for exemption for American Indians and Alaska Natives and others who are eligible for services from an Indian health care provider](#)
- [Form to apply for exemption based on being incarcerated](#)

**Note:** If you get an exemption because coverage is unaffordable based on your expected income, you may also qualify to buy [catastrophic coverage through the Marketplace](#). This may be more affordable than your other options.

**If you're applying for an exemption based on: membership in a recognized religious sect whose members object to insurance; eligibility for services through an Indian health care provider; or one of the hardships described above:**

- You fill out an exemption application using the right form below. [See instructions to help you fill out an exemption application.](#)
  - [Form to apply for exemption based on membership in a recognized religious sect whose members object to insurance](#)
  - [Form to apply for exemption based eligibility for services through an Indian health care provider](#)
  - [Form to apply for exemption based on a hardship](#)

**If your income will be low enough that you will not be required to file taxes:**

- You don't need to apply for an exemption. This is true even if you file a return in order to get a refund of money withheld from your paycheck. You won't have to make the shared responsibility payment.

**If you have a gap in coverage of less than 3 months, or you're not lawfully present in the U.S.:**

- You don't need to apply for an exemption. This will be handled when you file your federal tax return.

## What happens after I apply for an exemption?

After you submit your application, The Marketplace will review it and determine your eligibility. The time it takes to receive a response will depend on how complicated your request is, how complete your application is, and whether you need to submit supporting documentation after you apply. If additional information is needed, it could take longer. To speed the process up, you should submit any required documentation with your application.

The Marketplace will mail you a notice of the exemption eligibility result. If you are granted an exemption, the Marketplace notice will show your unique exemption certificate number (ECN). You will use your ECN when you complete your taxes for the 2014 tax year beginning in January 2015 to avoid paying the shared responsibility payment.

The notice will also give you access to view catastrophic plan information in case you need or wish to purchase it. You can contact the issuer of the catastrophic coverage to enroll using your ECN. Note: if you are granted a hardship exemption, you are not required to purchase catastrophic coverage.

## How long will a hardship exemption last?

Hardship exemptions are usually provided for the month before the hardship, the months of the hardship, and the month after the hardship. However, the Marketplace may provide the exemption for additional months after the hardship, including up to a full calendar year.

- For a hardship exemption based on affordability, the exemption will be granted for the remaining months in the coverage year.
- For individuals ineligible for Medicaid solely based on a state's decision not to expand coverage, the hardship exemption will be granted for the entire calendar year.
- For individuals eligible for Indian Health Services, the hardship exemption will be granted on a continuing basis. It may be kept for future years without having to submit another application as long as there are no changes to your membership in a tribe or eligibility for services from an Indian health care provider.

## Individual Shared Responsibility Provision – Calculating the Payment

The [individual shared responsibility provision](#) requires you and each member of your family to either have [basic health insurance coverage \(also known as minimum essential coverage\)](#), [qualify for an exemption](#), or make an individual shared responsibility payment when you file your federal income tax return. It is important to remember that choosing to make the individual shared responsibility payment instead of purchasing minimum essential coverage means you will also have to pay the entire cost of all your medical care. You won't be protected from the kind of very high medical bills that can sometimes lead to bankruptcy.

If you must make an individual shared responsibility payment with your return, the annual payment amount is the greater of a percentage of your household income or a flat dollar amount, but is capped at the national average premium for a bronze level health plan available through the Marketplace. You will owe 1/12th of the annual payment for each month you or your dependent(s) don't have either coverage or an exemption.

For 2014, the annual payment amount is:

- The greater of:
  - 1 percent of your household income that is above the tax return filing threshold for your filing status, or
  - Your family's flat dollar amount, which is \$95 per adult and \$47.50 per child, limited to a family maximum of \$285,
- But capped at the cost of the national average premium for a bronze level health plan available through the Marketplace in 2014.

Calculating your payment requires you to know your household income and your tax return filing threshold.

- **Household income** is the adjusted gross income from your tax return plus any excludible foreign earned income and tax-exempt interest you receive during the taxable year. Household income also includes the incomes of all of your dependents who are required to file tax returns.
- **Tax return filing threshold** is the amount of gross income an individual of your age and with your filing status (e.g., single, married filing jointly, head of household) must make to be required to file a tax return.

### 2014 Federal Tax Filing Requirement Thresholds

Filing Status	Age	Must File a Return If Gross Income Exceeds
Single	Under 65	\$10,150
	65 or older	\$11,700
Head of Household	Under 65	\$13,050
	65 or older	\$14,600

<b>Married Filing Jointly</b>	Under 65 (both spouses)	\$20,300
	65 or older (one spouse)	\$21,500
	65 or older (both spouses)	\$22,700
<b>Married Filing Separately</b>	Any age	\$3,950
<b>Qualifying Widow(er) with Dependent Children</b>	Under 65	\$16,350
	65 or older	\$17,550

### Examples

In the examples below, we assume that the payment amounts do not exceed the national average premium for bronze level coverage for the individuals involved. These examples are used only to represent the mechanics of calculating the payment and are not estimates of current or future health insurance premium costs. For information on the cost of bronze level plans, visit [HealthCare.gov](http://HealthCare.gov).

#### Example 1: Single individual with \$40,000 income

Jim, an unmarried individual with no dependents, does not have minimum essential coverage for any month during 2014 and does not qualify for an exemption. For 2014, Jim's household income is \$40,000 and his filing threshold is \$10,150.

- **To determine his payment using the income formula**, subtract \$10,150 (filing threshold) from \$40,000 (2014 household income). The result is \$29,850. One percent of \$29,850 equals \$298.50.
- Jim's **flat dollar amount** is \$95.

Because \$298.50 is greater than \$95 (and is less than the national average premium for bronze level coverage for 2014), Jim's shared responsibility payment for 2014 is \$298.50, or \$24.87 for each month he is uninsured (1/12 of \$298.50 equals \$24.87).

Jim will make his shared responsibility payment for the months he was uninsured when he files his 2014 income tax return, which is due in April 2015.

#### Example 2: Married couple with 2 children, \$70,000 income

Eduardo and Julia are married and have two children under 18. They do not have minimum essential coverage for any family member for any month during 2014 and no one in the family qualifies for an exemption. For 2014, their household income is \$70,000 and their filing threshold is \$20,300.

- **To determine their payment using the income formula**, subtract \$20,300 (filing threshold) from \$70,000 (2014 household income). The result is \$49,700. One percent of \$49,700 equals \$497.

- Eduardo and Julia's **flat dollar amount** is \$285, or \$95 per adult and \$47.50 per child. The total of \$285 is the flat dollar amount in 2014.

Because \$497 is greater than \$285 (and is less than the national average premium for bronze level coverage for 2014), Eduardo and Julia's shared responsibility payment is \$497 for 2014, or \$41.41 per month for each month the family is uninsured (1/12 of \$497 equals \$41.41).

## Questions and Answers on the Individual Shared Responsibility Provision

### Basic Information

#### 1. What is the individual shared responsibility provision?

Under the Affordable Care Act, the federal government, state governments, insurers, employers and individuals are given shared responsibility to reform and improve the availability, quality and affordability of health insurance coverage in the United States. Starting in 2014, the [individual shared responsibility provision](#) calls for each individual to have minimum essential health coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.

#### 2. Who is subject to the individual shared responsibility provision?

The provision applies to individuals of all ages, including children. The adult or married couple who can claim a child or another individual as a dependent for federal income tax purposes is responsible for making the payment if the dependent does not have coverage or an exemption.

#### 3. When does the individual shared responsibility provision go into effect?

The provision goes into effect on Jan. 1, 2014. It applies to each month in the calendar year.

#### 4. Is transition relief available in certain circumstances?

Yes. [Notice 2013-42](#), published on June 26, 2013, provides transition relief from the shared responsibility payment for individuals who are eligible to enroll in eligible employer-sponsored health plans with a plan year other than a calendar year (non-calendar year plans) if the plan year begins in 2013 and ends in 2014 (2013-2014 plan year). The transition relief applies to an employee, or an individual having a relationship to the employee. The transition relief begins in January 2014 and continues through the month in which the 2013-2014 plan year ends.

In addition, [Notice 2014-10](#), published on Jan. 23, 2014, provides transition relief for individuals covered under certain limited-benefit government-sponsored programs. Coverage under these programs is not minimum essential coverage unless it is designated as such by the Department of Health and Human Services. Under Notice 2014-10, individuals who have coverage under these government-sponsored programs will not be held liable for the shared responsibility payment for months in 2014 when they

have that coverage. The specific government-sponsored programs are optional family planning coverage of family services under title XIX of the Social Security Act, optional coverage of tuberculosis-related services under title XIX of the Social Security Act, coverage of pregnancy-related services under title XIX of the Social Security Act, coverage limited to treatment of emergency medical conditions (in accordance with section 1611(b)(12)(A) of title 8 of the United States Code) under title XIX of the Social Security Act, coverage for medically needy individuals under title XIX of the Social Security Act, coverage authorized under section 1115(a)(2) of the Social Security Act, limited-benefit TRICARE coverage of space available care provided under chapter 55 of title 10 of the United States Code and limited-benefit TRICARE coverage of line of duty care under chapter 55 of title 10 of the United States Code.

#### **5. What counts as minimum essential coverage?**

Minimum essential coverage includes the following:

- Employer-sponsored coverage, including self-insured plans, COBRA coverage and retiree coverage
- Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace
- Medicare Part A coverage and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration
- Most types of TRICARE coverage under chapter 55 of title 10 of the United States Code
- Coverage provided to Peace Corps volunteers
- Coverage under the Non-appropriated Fund Health Benefit Program
- Refugee Medical Assistance supported by the Administration for Children and Families
- Self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these programs may apply to HHS to be recognized as minimum essential coverage)
- State high risk pools for plan or policy years that begin on or before Dec. 31, 2014 (for later plan or policy years, sponsors of these program may apply to HHS to be recognized as minimum essential coverage)
- Other coverage recognized by the Secretary of HHS as minimum essential coverage

Minimum essential coverage does not include coverage providing only limited benefits, such as the following:

- Coverage consisting solely of excepted benefits, such as:
  - Stand-alone vision care or dental care
  - Workers' compensation
  - Accident or disability policies
- Medicaid providing only family planning services
- Medicaid providing only tuberculosis-related services
- Medicaid providing only coverage limited to treatment of emergency medical conditions
- Pregnancy-related Medicaid coverage\*
- Medicaid coverage for the medically needy\*
- Section 1115 Medicaid demonstration projects\*

- Space available TRICARE coverage provided under chapter 55 of title 10 of the United States Code for individuals who are not eligible for TRICARE coverage for health care services from private sector providers\*
- Line of duty TRICARE coverage provided under chapter 55 of title 10 of the United States Code\*

\* These categories of coverage are generally not minimum essential coverage. However, to the extent that certain programs within these categories provide comprehensive coverage, the Secretary of HHS may recognize these programs as minimum essential coverage in the future. The IRS in [Notice 2014-10](#) announced relief from the shared responsibility payment for months in 2014 in which individuals are covered under any of these programs to the extent that they are not minimum essential coverage. Information will be made available later about how the income tax return will take account of coverage under one of these programs.

## 6. What are the statutory [exemptions](#) from the requirement to obtain minimum essential coverage?

1. **Religious conscience.** You are a member of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits. The Social Security Administration administers the process for recognizing these sects according to the criteria in the law.
2. **Health care sharing ministry.** You are a member of a health care sharing ministry.
3. **Indian tribes.** You are (1) a member of a [federally recognized Indian tribe](#) or (2) an individual eligible for services through an Indian care provider.
4. **Income below the income tax return filing requirement.** Your income is below the [minimum threshold for filing a tax return](#). The requirement to file a federal tax return depends on your filing status, age and types and amounts of income. To find out if you are required to file a federal tax return, use the IRS [Interactive Tax Assistant](#) (ITA).
5. **Short coverage gap.** You went without coverage for less than three consecutive months during the year. For more information, see question 22.
6. **Hardship.** You have suffered a [hardship](#) that makes you unable to obtain coverage, as defined in final regulations issued by the Department of Health and Human Services. See question 21 for more information on claiming hardship exemptions..
7. **Affordability.** You can't afford coverage because the minimum amount you must pay for the premiums is more than eight percent of your household income.
8. **Incarceration.** You are in a jail, prison, or similar penal institution or correctional facility after the disposition of charges against you.
9. **Not lawfully present.** You are not a [U.S. citizen](#), a [U.S. national](#) or an alien lawfully present in the U.S.

## 7. What do I need to do if I want to be sure I have minimum essential coverage or an exemption for 2014?

The vast majority of coverage that people have today counts as [minimum essential coverage](#). For those who do not have coverage, who anticipate discontinuing the coverage they have currently, or who want to explore whether more affordable options are available, the Health Insurance Marketplace is open in every state and the District of Columbia. The Marketplace helps individuals compare available coverage options, assess

their eligibility for financial assistance and find minimum essential coverage that fits their budget.

For those seeking an [exemption from the individual responsibility provision](#), the Marketplace is able to provide certificates of exemption for many of the exemption categories. HHS has issued [final regulations](#) on how the Health Insurance Marketplace grants these exemptions. Individuals will also be able to claim certain exemptions for 2014 when they file their federal income tax returns in 2015. Individuals who are not required to file a federal income tax return because their gross income falls below the [return filing threshold](#) do not need to take any further action to secure an exemption. See question 21 for further information on how to claim an exemption.

For more information about the Marketplace, visit the [Health Insurance Marketplace website](#). For more information about financial assistance, see our [Questions and Answers](#) on the premium tax credit.

### **8. Is more detailed information available about the individual shared responsibility provision?**

Yes. The Treasury Department and the IRS have issued [final regulations](#) on the new individual shared responsibility provision, and the IRS has created an [individual shared responsibility page](#). In addition, the Treasury Department and the IRS have issued [proposed regulations](#), which provide guidance on additional issues that were identified in the preamble to the final regulations. Additional information on exemptions and minimum essential coverage is available in [final regulations](#) issued by the Department of Health and Human Services and in a Shared Responsibility Provision Question and Answer issued by the [Centers for Medicare & Medicaid Services](#).

### **Who is affected?**

### **9. Are children subject to the individual shared responsibility provision?**

Yes. Each child must have minimum essential coverage or qualify for an exemption for each month in the calendar year. Otherwise, the adult or married couple who can claim the child as a dependent for federal income tax purposes will generally owe a shared responsibility payment for the child..

### **10. Are senior citizens subject to the individual shared responsibility provision?**

Yes. Senior citizens must have minimum essential coverage or qualify for an exemption for each month in a calendar year. Both Medicare Part A and Medicare Part C (also known as Medicare Advantage) qualify as minimum essential coverage.

### **11. Are all individuals living in the United States subject to the individual shared responsibility provision?**

All U.S. citizens living in the United States are subject to the individual shared responsibility provision as are all permanent residents and all foreign nationals who are in the United States long enough during a calendar year to qualify as resident aliens for tax

purposes. Foreign nationals who live in the United States for a short enough period that they do not become resident aliens for federal income tax purposes are not subject to the individual shared responsibility payment even though they may have to file a U.S. income tax return. The IRS has more information available on [when a foreign national becomes a resident alien](#) for federal income tax purposes.

## **12. Are US citizens living abroad subject to the individual shared responsibility provision?**

Yes. However, U.S. citizens who are not physically present in the United States for at least 330 full days within a 12-month period are treated as having minimum essential coverage for that 12-month period. In addition, U.S. citizens who are bona fide residents of a foreign country (or countries) for an entire taxable year are treated as having minimum essential coverage for that year. In general, these are individuals who qualify for a foreign earned income exclusion under section 911 of the Internal Revenue Code. Individuals may qualify for this rule even if they cannot use the exclusion for all of their foreign earned income because, for example, they are employees of the United States. Individuals that qualify for this rule need take no further action to comply with the individual shared responsibility provision during the months when they qualify. See [Publication 54](#), Tax Guide for U.S. Citizens and Resident Aliens Abroad, for further information on the foreign earned income exclusion.

U.S. citizens who meet neither the physical presence nor residency requirements will need to maintain [minimum essential coverage](#), qualify for an [exemption](#) or make a [shared responsibility payment for each month of the year](#). For this purpose, minimum essential coverage includes a group health plan provided by an overseas employer. One exemption that may be particularly relevant to U.S. citizens living abroad for a small part of a year is the exemption for a short coverage gap. This exemption provides that no shared responsibility payment will be due for a once-per-year gap in coverage that lasts less than three months.

## **13. Are residents of the territories subject to the individual shared responsibility provision?**

All bona fide residents of the United States territories are treated by law as having minimum essential coverage. They are not required to take any action to comply with the individual shared responsibility provision.

## **Minimum Essential Coverage**

### **14. If I receive my coverage from my spouse's employer, will I have minimum essential coverage?**

Yes. Employer-sponsored coverage is generally [minimum essential coverage](#). (See question 5 for information on specialized types of coverage that are not minimum essential coverage.) If an employee enrolls in employer-sponsored coverage that provides minimum value for himself and his family, the employee and all of the covered family members have minimum essential coverage.

**15. Do my spouse and dependent children have to be covered under the same policy or plan that covers me?**

No. You, your spouse and your dependent children do not have to be covered under the same policy or plan. However, you, your spouse and each dependent child for whom you may claim a personal exemption on your federal income tax return must have minimum essential coverage or qualify for an exemption, or you will owe a shared responsibility payment when you file a return.

**16. My employer tells me that our company’s health plan is “grandfathered.” Does my employer’s plan provide minimum essential coverage?**

Yes. Grandfathered group health plans provide minimum essential coverage.

**17. I am a retiree, and I am too young to be eligible for Medicare. I receive my health coverage through a retiree plan made available by my former employer. Is the retiree plan minimum essential coverage?**

Yes. Retiree health plans are generally minimum essential coverage.

**18. I work for a local government that provides me with health coverage. Is my coverage minimum essential coverage?**

Yes. Employer-sponsored coverage is minimum essential coverage regardless of whether the employer is a governmental, nonprofit or for-profit entity.

**19. Do I have to be covered for an entire calendar month to avoid the shared responsibility payment liability for not having minimum essential coverage for that month?**

No. You will be treated as having minimum essential coverage for a month as long as you have coverage for at least one day during that month.

**20. If I change health coverage during the year and end up with a gap when I am not covered, will I owe a payment?**

Individuals are treated as having minimum essential coverage for a calendar month if they have coverage for at least one day during that month. Additionally, as long as the gap in coverage is less than three months, you may qualify for an exemption and not owe a payment. See question 22 for more information on the exemption for a short coverage gap.

## **Exemptions**

**21. If I think I qualify for an exemption, how do I obtain it?**

It depends upon the [exemption](#) for which you qualify.

- The religious conscience exemption and most hardship exemptions are available only by going to the Health Insurance Marketplace and applying for an exemption certificate. Information on obtaining these exemptions is available in [final rules](#) issued by the Department of Health and Human Services.

- The exemptions for members of federally recognized Indian tribes, members of health care sharing ministries and individuals who are incarcerated are available either by going to a Marketplace or Exchange and applying for an exemption certificate or by claiming the exemption as part of filing a federal income tax return.
- The exemptions for lack of affordable coverage, a short coverage gap, certain hardships, household income below the filing threshold and individuals who are not lawfully present in the United States may be claimed only as part of filing a federal income tax return.

## **22. What qualifies as a short coverage gap?**

In general, a gap in coverage that lasts less than three months qualifies as a short coverage gap. If an individual has more than one short coverage gap during a year, the short coverage gap exemption only applies to the first gap.

## **23. If my income is so low that I am not required to file a federal income tax return, do I need to do anything special to claim an exemption from the individual shared responsibility provision?**

No. If you are not required to file a federal income tax return for a year because your gross income is below your return filing threshold, you are automatically exempt from the shared responsibility provision for that year and do not need to take any further action to secure an exemption. If you are not required to file a tax return for a year but file one anyway, you will be able to claim the exemption on your tax return.

## **24. If I am exempt from the shared responsibility payment, can I still be eligible for the premium tax credit?**

In many cases, yes, but it depends upon the exemption. If you are exempt because you are incarcerated or because you are not lawfully present in the United States, you are not eligible to enroll in a qualified health plan through the Marketplace and therefore cannot claim a premium tax credit. However, individuals with other types of exemptions may obtain coverage through the Marketplace and claim a premium tax credit if they otherwise qualify for the credit.

## **Reporting Coverage or Exemptions or Making Payments**

### **25. Will I have to do something on my federal income tax return to show that I had coverage or an exemption?**

The [individual shared responsibility provision](#) goes into effect in 2014. You will not have to account for coverage or [exemptions](#) or to make any [payments](#) until you file your 2014 federal income tax return in 2015. Information will be made available later about how the income tax return will take account of coverage and exemptions. Insurers will be required to provide everyone that they cover each year with information that will help them demonstrate they had coverage beginning with the 2015 tax year.

### **26. What happens if I do not have minimum essential coverage or an exemption, and I cannot afford to make the shared responsibility payment when filing my tax return?**

The IRS routinely works with taxpayers who owe amounts they cannot afford to pay. The law prohibits the IRS from using liens or levies to collect any [individual shared responsibility payment](#). However, if you owe a shared responsibility payment, the IRS may offset that liability against any tax refund that may be due to you.

## The Premium Tax Credit

**Publication 5120:** Your Credit, Your Choice – Get it Now or Get it Later [English](#) | [Spanish](#)

**Publication 5121:** Need help paying for health insurance premiums? [English](#) | [Spanish](#)

**Publication 5152:** Report changes to the Marketplace as they happen [English](#)

### Basic Information

Starting in 2014, if you get your health insurance coverage through the Health Insurance Marketplace, you may be eligible for the premium tax credit. This tax credit can help make purchasing health insurance coverage more affordable for people with moderate incomes. The 2014 Open Enrollment Period has ended. However, under certain circumstances eligible individuals may qualify for a [Special Enrollment Period](#) and can buy a private health plan through the Marketplace. Visit [Healthcare.gov](#) for details of who is eligible for a Special Enrollment Period.

The Department of Health and Human Services administers the requirements for the Marketplace and the health plans they offer. For more information about your coverage options, financial assistance and the Marketplace, visit [HealthCare.gov](#).

### Eligibility

In general, you may be eligible for the credit if you meet all of the following:

- buy health insurance through the Marketplace;
- are ineligible for coverage through an employer or government plan;
- are within certain income limits;
- do not file a Married Filing Separately tax return (unless you meet the criteria in [Notice 2014-23](#), which allows certain victims of domestic abuse to claim the premium tax credit using the Married Filing Separately filing status for the 2014 calendar year); and
- cannot be claimed as a dependent by another person.

### Filing Status

If you file your tax return using the filing status Single, Married Filing Jointly, Head of Household ([including married individuals who qualify to use the Head of Household status](#)) or Qualifying Widow/Widower, you may be eligible for the premium tax credit if you meet the other criteria. If you are married and you file your tax return using the filing status Married Filing Separately, you will not be eligible for the premium tax credit unless you meet the criteria in [Notice 2014-23](#), which allows certain victims of domestic abuse to claim the premium tax credit using the Married Filing Separately filing status for the 2014 calendar year.

### Getting the Credit

To qualify for the credit, you must get insurance through the Marketplace.

If you are eligible for the credit, you can choose to:

- Get It Now: have some or all of the estimated credit paid in advance directly to your insurance company to lower what you pay out-of-pocket for your monthly premiums; or
- Get It Later: wait to get all of the credit when you file your tax return.

During enrollment through the Marketplace, using information you provide about your projected income and family composition for the year, the Marketplace will estimate the amount of the premium tax credit you will be able to claim on your tax return.

You will then decide whether you want to have all, some or none of your estimated credit paid in advance directly to your insurance company.

### **Change in Circumstances**

Report income and family size changes to the Marketplace throughout the year. Reporting changes will help make sure you get the proper type and amount of financial assistance and will help you avoid getting too much or too little in advance. Receiving too much or too little in advance can affect your refund or balance due when you file your tax return.

For example, if you do not report income or family size changes to the Marketplace when they happen, the advance payments may not match your actual qualified credit amount on your federal tax return. This might result in a smaller refund or a balance due.

### **Claiming the Credit on Your Federal Tax Return**

For any tax year, if you receive advance credit payments in any amount or if you plan to claim the premium tax credit, you must file a federal income tax return for that year.

**If you choose to get it now:** When you file your tax return, you will subtract the total advance payments you received during the year from the amount of the premium tax credit calculated on your tax return. If the premium tax credit computed on the return is more than the advance payments made on your behalf during the year, the difference will increase your refund or lower the amount of tax you owe. If the advance credit payments are more than the premium tax credit, the difference will increase the amount you owe and result in either a smaller refund or a balance due.

**If you choose to get it later:** You will claim the full amount of the premium tax credit when you file your tax return. This will either increase your refund or lower your balance due.

### **More Information**

More detailed information about the credit is available in our [Questions and Answers](#). The Department of the Treasury and the IRS issued the following legal guidance related to the premium tax credit:

- [Final regulations](#) on the rules for individuals who enroll in qualified health plans through Marketplaces and claim the premium tax credit.
- [Final regulations](#) on the premium tax credit affordability test for related individuals.
- [Proposed regulations](#) on determining minimum value of eligible employer-sponsored plans and other rules regarding the premium tax credit.
- [Notice 2013-41](#) on determining whether or when individuals are considered eligible for coverage under certain Medicaid, Medicare, CHIP, TRICARE, student health or state high risk pool programs.

An electronic flyer (Publication 5120 [English](#) | [Spanish](#) ) and trifold (Publication 5121 [English](#) | [Spanish](#) ) entitled Facts about the Premium Tax Credit are available for public use and distribution.

### Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby).

## Questions and Answers on the Premium Tax Credit

### Facts about the Premium Tax Credit

Publication 5120 –Your Credit, Your Choice – Get it Now or Get it  
Later [English](#) | [Spanish](#)

Publication 5121 –Need help paying for health insurance premiums? [English](#) | [Spanish](#)

Publication 5152 –Report changes to the Marketplace as they happen [English](#)

### The Basics

#### 1. What is the premium tax credit?

The premium tax credit is an advanceable, refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the [Health Insurance Marketplace](#), also known as the Exchange, beginning in 2014. You can choose to have the credit paid in advance to your insurance company to lower what you pay for your monthly premiums, or you can claim all of the credit when you file your tax return for the year. If you choose to have the credit paid in advance, you will reconcile the amount paid in advance with the actual credit you compute when you file your tax return.

#### 2. What is the Health Insurance Marketplace?

The Health Insurance Marketplace, also known as the Exchange, is the place where you will find information about private health insurance options, purchase health insurance, and obtain help with premiums and out-of-pocket costs if you are eligible. Open enrollment to purchase health insurance for 2014 through the Marketplace begins Oct. 1, 2013, and continues through March 31, 2014. The Department of Health and Human Services (HHS) administers the requirements for the Marketplace and the health plans offered. Learn more about the Marketplace at [HealthCare.gov](#).

#### 3. How do I get the premium tax credit?

When you apply for coverage in the Marketplace, the Marketplace will estimate the amount of the premium tax credit that you may be able to claim for the tax year, using information you provide about your family composition and projected household income. Based upon that estimate, you can decide if you want to have all, some, or none of your estimated credit paid in advance directly to your insurance company to be applied to your monthly premiums. If you choose to have all or some of your credit paid in advance, you will be required to reconcile on your income tax return the amount of advance payments that the government sent on your behalf with the premium tax credit that you may claim

based on your actual household income and family size.

If you do not opt for advance credit payments, you may claim the credit when you file your tax return for the year, which will either lower the amount of taxes owed on that return or increase your refund.

#### **4. What happens if my income or family size changes during the year?**

The actual premium tax credit for the year will differ from the advance credit amount estimated by the Marketplace if your family size and household income as estimated at the time of enrollment are different from the family size and household income you report on your return. The more your family size or household income differs from the Marketplace estimates used to compute your advance credit payments, the more significant the difference will be between your advance credit payments and your actual credit. If your actual allowable credit on your return is less than your advance credit payments, the difference, subject to certain caps, will be subtracted from your refund or added to your balance due. If your actual allowable credit is more than your advance credit payments, the difference will be added to your refund or subtracted from your balance due.

Notifying the Marketplace about changes in circumstances will allow the Marketplace to update the information used to determine your expected amount of the premium tax credit and adjust your advance payment amount. This adjustment will decrease the likelihood of a significant difference between your advance credit payments and your actual premium tax credit. Changes in circumstances that can affect the amount of your actual premium tax credit include:

- Increases or decreases in your household income.
- Marriage.
- Divorce.
- Birth or adoption of a child.
- Other changes to your household composition.
- Gaining or losing eligibility for government sponsored or employer sponsored health care coverage.

### **Eligibility**

#### **5. Who is eligible for the premium tax credit?**

You are eligible for the premium tax credit if you meet all of the following requirements:

- Purchase coverage through the Marketplace.
- Have household income that falls within a certain range (see question 6).
- Are not able to get affordable coverage through an eligible employer plan that provides minimum value (see questions 8 and 9).
- Are not eligible for coverage through a government program, like Medicaid, Medicare, CHIP or TRICARE.
- Do not file a Married Filing Separately tax return (unless you meet the criteria in [Notice 2014-23](#), which allows certain victims of domestic abuse to claim the premium tax credit using the Married Filing Separately filing status for the 2014 calendar year).

- Cannot be claimed as a dependent by another person.

## **6. What are the income limits?**

In general, individuals and families whose household income for the year is between 100 percent and 400 percent of the federal poverty line for their family size may be eligible for the premium tax credit. An individual who meets these income requirements must also meet the other eligibility criteria described in question 5. Thus, if you have household income between 100 percent and 400 percent of the federal poverty line, but are eligible for coverage through your state's Medicaid program (for example, because your state provides Medicaid to individuals with household income up to 133 percent of the federal poverty line), you are not eligible for the premium tax credit.

For 2013, for residents of one of the 48 contiguous states or Washington, D.C., the following illustrates when household income would be between 100 percent and 400 percent of the federal poverty line:

- \$11,490 (100%) up to \$45,960 (400%) for one individual.
- \$15,510 (100%) up to \$62,040 (400%) for a family of two.
- \$23,550 (100%) up to \$94,200 (400%) for a family of four.

Note: The federal poverty guidelines — sometimes referred to as the “federal poverty line” or FPL — state an income amount considered poverty level for the year, adjusted for family size. HHS determines the federal poverty guideline amounts annually. The government adjusts the income limits annually for inflation. The Federal Register publishes a chart reflecting these amounts at the beginning of each calendar year. You can also find this information on the [HHS website](#). HHS provides three federal poverty guidelines: one for residents of the 48 contiguous states and D.C., one for Alaska residents and one for Hawaii residents. For purposes of the premium tax credit, eligibility for a certain year is based on the most recently published set of poverty guidelines at the time of the first day of the annual open enrollment period. As a result, the tax credit for 2014 will be based on the 2013 guidelines. The tax credit for 2015 will be based on the 2014 guidelines. Use of the 2014 federal poverty guidelines (FPL) for the 2015 premium tax credit eligibility determinations will begin on the first day of the [open enrollment period for 2015 coverage](#), which is November 15, 2014.

## **7. What is household income?**

For purposes of the premium tax credit, your household income is your modified adjusted gross income plus that of every other individual in your family for whom you can properly claim a personal exemption deduction and who is required to file a federal income tax return. Modified adjusted gross income is the adjusted gross income on your federal income tax return plus any excluded foreign income, nontaxable Social Security benefits (including tier 1 railroad retirement benefits), and tax-exempt interest received or accrued during the taxable year. It does not include Supplemental Security Income (SSI).

## **8. How do I know if the insurance offered by my employer is affordable?**

An employer-sponsored plan is affordable if the portion of the annual premium you must pay for self-only coverage does not exceed 9.5 percent of your household income. (See question 7 for what is included in household income.) The affordability test applies only to the portion of the annual premiums for self-only coverage and does not include any additional cost for family coverage. If the employer offers multiple health coverage

options, the affordability test applies to the lowest-cost option available to you that also satisfies the minimum value requirement. If your employer offers any wellness programs, the affordability test is based on the premium you would pay if you received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

**9. How do I know if the insurance offered by my employer provides minimum value?**

An employer-sponsored plan provides minimum value if the plan covers at least 60 percent of the expected total allowed costs for covered services. Beginning in 2014, your employer will provide you with a document called a Summary of Benefits and Coverage. That document will give you information about the benefits and coverage under your employer-sponsored plan, including whether the plan provides minimum value. Also, under the Fair Labor Standards Act, most employers will provide employees with a notice about their options in the Marketplace and their potential eligibility for a premium tax credit. This one-time notice will include information about whether the employer has a plan that provides minimum value.

**10. Am I eligible for the premium tax credit if I enroll in coverage through an employer?**

If you enroll in an employer-sponsored plan, including retiree coverage, you are not eligible for the premium tax credit even if the plan is unaffordable or fails to provide minimum value.

**Reporting and Claiming**

**11. Will I have to file a federal income tax return to get the premium tax credit?**

For any tax year, if you receive advance credit payments in any amount or if you plan to claim the premium tax credit, you must file a federal income tax return for that year. If you receive any advance credit payments, you will use your return to reconcile the difference between the advance credit payments made on your behalf and the actual amount of the credit that you may claim. This filing requirement applies whether or not you would otherwise be required to file a return. If you are married and you file your tax return using the filing status Married Filing Separately, you will not be eligible for the premium tax credit unless you meet the criteria in [Notice 2014-23](#), which allows certain victims of domestic abuse to claim the premium tax credit using the Married Filing Separately filing status for the 2014 calendar year.

**12. If I get insurance through the Marketplace, how will I know what to report on my federal tax return?**

The Marketplace will send you an information statement showing the amount of your premiums and advance credit payments by January 31 of the year following the year of coverage. For example, you will receive the 2014 information statement by Jan. 31, 2015, and can use this information to compute your premium tax credit on your 2014 tax return and to reconcile the advance credit payments made on your behalf with the amount of the actual premium tax credit.

**13. How is the amount of the premium tax credit determined?**

The law bases the size of your premium tax credit on a sliding scale. Those who have a lower income get a larger credit to help cover the cost of their insurance. In other words, the higher your income, the lower the amount of your credit.

Additionally, the premium tax credit is a refundable tax credit. This means that if the amount of the credit is more than the amount of your tax liability, you will receive the difference as a refund. If you owe no tax, you can get the full amount of the credit as a refund. However, if you receive advance payments of the credit, you will reconcile the advance payments with the amount of the actual premium tax credit that you calculate on your tax return. If your actual allowable credit on your return is less than your advance credit payments, the difference, subject to certain caps, will be subtracted from your refund or added to your balance due. If your actual allowable credit is more than your advance credit payments, the difference will be added to your refund or subtracted from your balance due. (See question 4 for information on changes in circumstances.)

## Other Individual & Family Resources

### Affordable Care Act Tax Provisions Questions and Answers

Questions and answers have been prepared for each of the provisions listed below. The IRS will update this page as additional information or new guidance becomes available.

#### Individuals and Families



[Additional Medicare Tax](#)

[Adoption Credit](#)

[Health Flexible Spending Arrangements \(FSA\)](#)

[Individual Shared Responsibility](#)

[Itemized Deduction for Medical Expenses, Changes](#)

[Net Investment Income Tax](#)

[Premium Tax Credit](#)

## Employers



[Employer Health Care Arrangements](#)

[Employer Shared Responsibility](#)

[Health Flexible Spending Arrangements \(FSA\)](#)

[Reporting Value of Employer-provided Health coverage on Form W-2](#)

[Small Business Health Care Tax Credit](#)

## 2 Affordable Care Act Tax Provisions for Employers

The Affordable Care Act, or health care law, contains benefits and responsibilities for employers. The size and structure of your workforce – small, large, or part of a group – helps determine what applies to you. However, if you have no employees, the following information does not apply to you.



### Small Employers

**Small employers, generally those with fewer than 50 full-time employees, may be eligible for credits and other benefits.**

> [More...](#)



### Large Employers

**A large employer has 50 or more full-time employees or equivalents.**

> [More...](#)

### How do I know if I am a small or large employer? Why does it matter?

An employer's size is determined by the number of its employees. Employer benefits, opportunities and requirements are dependent upon the employer's size and the applicable rules. Generally, an employer with 50 or more full-time employees or equivalents will be considered a large employer.

#### Employers with:

- Fewer than 25 full-time equivalent employees may be eligible for a [Small Business Health Care Tax Credit](#) to help cover the cost of providing coverage.
- Generally 50 or fewer employees may be eligible to buy coverage through the Small Business Health Options Program (SHOP). Learn more at [HealthCare.gov](#)
- 50 or more full-time equivalent employees will need to file an annual return reporting whether and what health insurance they offered employees. In addition, they are subject to the [Employer Shared Responsibility provisions](#).

Certain affiliated employers with common ownership or part of a controlled group must aggregate their employees to determine their workforce size. Proposed [regulations](#) (pdf) and [FAQs](#) provide more information about determining the size of your workforce.



## Small Employers

Small employers, generally those with fewer than 50 full-time employees, may be eligible for credits and other benefits.

## Overview of the Shop Marketplace

The Small Business Health Options Program (SHOP) Marketplace helps businesses provide health coverage to their employees.

For 2014, the SHOP Marketplace is open to employers with 50 or fewer full-time-equivalent employees (FTEs). If you have fewer than 25 employees, you may qualify for tax credits if you buy insurance through SHOP. [Learn more about more about SHOP eligibility rules.](#)

If you're [self-employed](#) with no employees, you can get coverage through the individual market [Health Insurance Marketplace](#), but not through SHOP.

## Benefits of the SHOP Marketplace

- You control the coverage you offer and how much you pay toward employee premiums.
- You can choose from [4 levels of coverage](#) to find a plan that meets the needs of your business and employees.
- You can start coverage any time. Enroll by the 15th of the month and coverage can begin on the 1st of the following month. [Learn more about buying coverage outside of Open Enrollment through the SHOP Marketplace.](#)
- If you buy SHOP coverage and have fewer than 25 employees, you may qualify for a [small business health care tax credit](#) worth up to 50% of your premium costs. You can still deduct from your taxes the rest of your premium costs not covered by the tax credit. **Beginning in 2014 the tax credit is available only for plans purchased through SHOP.**

Use the [Small Business Health Care Tax Credit Estimator](#) to find out if you qualify and how much you may save.

## How to know if you qualify for the SHOP Marketplace

- In 2014, SHOP is open to employers with 50 or fewer full-time equivalent (FTE) employees. Use our [FTE Calculator](#) to find out if you qualify to use SHOP.
- In order to use SHOP, you must offer coverage to all of your **full-time** employees – generally those working 30 or more hours per week on average.
- In many states, at least 70% of your full-time employees must enroll in your SHOP plan. (Employers who apply for SHOP coverage between November 15 and December 15 each year can enroll without meeting this requirement.)
- There is a SHOP Marketplace in each state. You must have an office or employee work site within the SHOP's service area to use that particular SHOP.

Get [more details on SHOP eligibility rules](#).

## Preview plans and prices now

You can [browse health and dental plan information](#) right now. You'll see available plans and sample prices based on the number and ages of your employees.

## Apply for SHOP coverage

To enroll in a SHOP plan, you'll use an agent, broker, or insurance company. You'll also fill out a SHOP eligibility application.

[Choose your state](#) and we'll help you get started.

## Questions?

[Learn how to get help for the SHOP Marketplace](#).

Have questions about the SHOP Marketplace for businesses with 50 or fewer employees? Call 1-800-706-7893 (TTY: 711). Hours: Monday through Friday, 9 a.m. to 7 p.m. EST. Agents and brokers may also use this number.

## What You Need to Know about the Small Business Health Care Tax Credit

### How will the credit make a difference for you?

For tax years 2010 through 2013, the maximum credit is 35 percent of premiums paid for small business employers and 25 percent of premiums paid for small tax-exempt employers such as charities.

For tax years beginning in 2014 or later, there are changes to the credit:

- The maximum credit increases to 50 percent of premiums paid for small business employers and 35 percent of premiums paid for small tax-exempt employers.
- To be eligible for the credit, a small employer must pay premiums on behalf of employees enrolled in a qualified health plan offered through a Small Business Health Options Program (SHOP) Marketplace or qualify for an exception to this requirement.
- The credit is available to eligible employers for two consecutive taxable years.

Here's what this means for you. If you pay \$50,000 a year toward employees' health care premiums — and if you qualify for a 15 percent credit, you save... \$7,500. If you save \$7,500 a year from tax year 2010 through 2013, that's total savings of \$30,000. If, in 2014, you qualify for a slightly larger credit, say 20 percent, your savings go from \$7,500 a year to \$10,000 a year.

Even if you are a small business employer who did not owe tax during the year, you can carry the credit back or forward to other tax years. Also, since the amount of the health insurance premium payments is more than the total credit, eligible small businesses can still claim a business expense deduction for the premiums in excess of the credit. That's both a credit and a deduction for employee premium payments.

There is good news for small tax-exempt employers too. The credit is refundable, so even if you have no taxable income, you may be eligible to receive the credit as a refund so long as it does not exceed your income tax withholding and Medicare tax liability. Refund payments issued to small tax-exempt employers claiming the refundable portion of credit are subject to sequestration. For more information on sequestration, click [here](#).

And finally, if you can benefit from the credit this year but forgot to claim it on your tax return, there's still time to file an amended return. Refund limitations may apply. Generally, a claim for refund must be filed within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires the later, or if no return was filed by the taxpayer, within 2 years from the time the tax was paid.

[Click here](#) if you want more examples of how the credit applies in different circumstances.  
Small Business Health Care Tax Credit Scenarios

**Example 1: Auto Repair Shop with 10 Employees Gets \$24,500 Credit for 2010**

Main Street Mechanic:

- Employees: 10
- Wages: \$250,000 total, or \$25,000 per worker
- Employee Health Care Costs: \$70,000

2010 Tax Credit: \$24,500 (35% credit)

2014 Tax Credit: \$35,000 (50% credit)

**Example 2: Restaurant with 40 Part-Time Employees Gets \$28,000 Credit for 2010**

Downtown Diner:

- Employees: 40 half-time employees (the equivalent of 20 full-time workers)
- Wages: \$500,000 total, or \$25,000 per full-time equivalent worker
- Employee Health Care Costs: \$240,000

2010 Tax Credit: \$28,000 (35% credit with phase-out)

2014 Tax Credit: \$40,000 (50% credit with phase-out)

### **Example 3: Foster Care Non-Profit with 9 Employees Gets \$18,000 Credit for 2010**

First Street Family Services.org:

- Employees: 9
- Wages: \$198,000 total, or \$22,000 per worker
- Employee Health Care Costs: \$72,000

2010 Tax Credit: \$18,000 (25% credit)

2014 Tax Credit: \$25,200 (35% credit)

### **Can you claim the credit?**

Now that you know how the credit can make a difference for your business, let's determine if you can claim it.

To be eligible, you must cover at least 50 percent of the cost of employee-only (not family or dependent) health care coverage for each of your employees. You must also have fewer than 25 full-time equivalent employees (FTEs). Those employees must have average wages of less than \$50,000 (as adjusted for inflation beginning in 2014) per year. **Remember, you will have to purchase insurance through the SHOP Marketplace (or qualify for an exception to this requirement) to be eligible for the credit for tax years 2014 and beyond.** Participating in the direct enrollment process, such as the one adopted by federally-facilitated [SHOP Marketplaces](#), counts as SHOP Marketplace participation for 2014 only.

Let us break it down for you even more.

You are probably wondering: what IS an FTE. Basically, two half-time employees count as one FTE. That means 20 half-time employees are equivalent to 10 FTEs, which makes the number of FTEs 10, not 20.

Now let's talk about average annual wages. Say you pay total wages of \$200,000 and have 10 FTEs. To figure average annual wages you divide \$200,000 by 10 — the number of FTEs — and the result is your average annual wage. The average annual wage would be \$20,000.

Also, the amount of the credit you receive works on a sliding scale. The smaller the business or charity, the bigger the credit. So if you have more than 10 FTEs or if the average wage is more than \$25,000 (as adjusted for inflation beginning in 2014), the amount of the credit you receive will be less.

### **How do you claim the credit?**

You must use [Form 8941](#), Credit for Small Employer Health Insurance Premiums, to calculate the credit. For detailed information on filling out this form, see the [Instructions](#) for Form 8941.

If you are a small business, include the amount as part of the general business credit on your income tax return.

If you are a tax-exempt organization, include the amount on line 44f of the [Form 990-T](#), Exempt Organization Business Income Tax Return. You must file the Form 990-T in order to claim the credit, even if you don't ordinarily do so.

Don't forget... if you are a small business employer, you may be able to carry the credit back or forward. And if you are a tax-exempt employer, you may be eligible for a refundable credit.



**A large employer has 50 or more full-time employees or equivalents.**

[> More...](#)

### **2014 Reporting Requirements Delayed until 2015**

Transition Relief for 2014 under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions)

NOT-129718-13

#### **Notice 2013-45**

##### **I. PURPOSE AND OVERVIEW**

This notice provides transition relief for 2014 from

(1) The information reporting requirements applicable to insurers, self-insuring employers, and certain other providers of minimum essential coverage under § 6055 of the Internal Revenue Code (Code) (§ 6055 Information Reporting),

(2) The information reporting requirements applicable to applicable large employers under § 6056 (§ 6056 Information Reporting), and (3) the employer shared responsibility provisions under § 4980H (Employer Shared Responsibility Provisions). This transition relief will provide additional time for input from employers and other reporting entities in an effort to simplify information reporting consistent with effective implementation of the law. This transition relief also is intended to provide employers, insurers, and other providers of minimum essential coverage time to adapt their health coverage and reporting systems.

Both the information reporting and the Employer Shared Responsibility Provisions will be fully effective for 2015. In preparation for that, once the information reporting rules have been issued, employers and other reporting entities are encouraged to voluntarily comply with the information reporting provisions for 2014. This transition relief through 2014 for

the information reporting and Employer Shared Responsibility Provisions has no effect on the effective date or application of other Affordable Care Act provisions.

## Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act

On Feb. 10, 2014, the IRS and Treasury issued [final regulations](#) on the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code. The following questions and answers provide helpful information about the guidance:

- [Basics of the Employer Shared Responsibility Provisions](#): Questions 1-3
- [Which Employers are Subject to the Employer Shared Responsibility Provisions](#): Questions 4-14
- [Identification of Full-Time Employees](#): Questions 15-17
- [Liability for the Employer Shared Responsibility Payment](#): Questions 18-23
- [Calculation of the Employer Shared Responsibility Payment](#): Questions 24-26
- [Making an Employer Shared Responsibility Payment](#): Questions 27-28
- [Transition Relief](#): Questions 29-39
- [Basics for Small Employers](#): Questions 40-42
- [Related Provisions](#): Questions 43-47
- [Additional Information](#): Questions 48-56

### [Basics of the Employer Shared Responsibility Provisions](#)

#### **1. What are the Employer Shared Responsibility provisions?**

For 2015 and after, employers employing at least a certain number of employees (generally 50 full-time employees or a combination of full-time and part-time employees that is equivalent to 50 full-time employees) will be subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (added to the Code by the Affordable Care Act). As defined by the statute, a full-time employee is an individual employed on average at least 30 hours of service per week. An employer that meets the 50 full-time employee threshold is referred to as an applicable large employer.

Under the Employer Shared Responsibility provisions, if these employers do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees (and their dependents), the employer may be subject to an Employer Shared Responsibility payment if at least one of its full-time employees receives a premium tax credit for purchasing individual coverage on one of the new Affordable Insurance Exchanges, also called a Health Insurance Marketplace (Marketplace).

#### **2. When do the Employer Shared Responsibility provisions go into effect?**

The Employer Shared Responsibility provisions generally are not effective until Jan. 1, 2015, meaning that no Employer Shared Responsibility payments will be assessed for 2014. See [Notice 2013-45](#). Employers will use information about the number of employees they employ and their hours of service during 2014 to determine whether they employ enough employees to be an applicable large employer for 2015. See question 4

for more information on determining whether an employer is an applicable large employer and questions 29 through 39 for more information about transition relief for 2015.

**3. Is more detailed information available about the Employer Shared Responsibility provisions?**

Yes. Treasury and the IRS have issued [final regulations](#) on the Employer Shared Responsibility provisions. Treasury and the IRS also have issued [proposed regulations](#) on the related Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered under Employer-Sponsored Plans.

[Back to top](#)

**Which Employers Are Subject to the Employer Shared Responsibility Provisions?**

**4. I understand that the Employer Shared Responsibility provisions apply only to employers employing at least a certain number of employees. How many employees must an employer have to be subject to the Employer Shared Responsibility provisions?**

To be subject to the Employer Shared Responsibility provisions for a calendar year, an employer must have employed during the previous calendar year at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50. For example, an employer that employs 40 full-time employees (that is, employees employed 30 or more hours per week on average) and 20 employees employed 15 hours per week on average has the equivalent of 50 full-time employees, and would be an applicable large employer.

Seasonal workers are taken into account in determining the number of full-time employees. However, if an employer's workforce exceeds 50 full-time employees (including full-time equivalents) for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days were seasonal workers, the employer is not considered an applicable large employer. Seasonal workers are workers who perform labor or services on a seasonal basis as defined by the Secretary of Labor, and retail workers employed exclusively during holiday seasons. For this purpose, employers may apply a reasonable, good faith interpretation of the term "seasonal worker."

Employers will determine each year, based on their current number of employees, whether they will be considered an applicable large employer for the next year. For example, if an employer has at least 50 full-time employees (including full-time equivalents) for 2014, it will be considered an applicable large employer for 2015. Note that because employers will be performing this calculation for the first time to determine their status for 2015, there is a transition rule intended to make this first calculation easier. See question 31 for a discussion of this transition rule for 2015 determination of applicable large employer status.

Employers average their number of employees across the months in the year to see whether they will be an applicable large employer for the next year. This averaging can take account of fluctuations that many employers may experience in their work force

across the year. The final regulations provide additional information about how to determine the average number of employees for a year, including information about how to take account of salaried employees who may not clock their hours.

**5. How does an employer that was not in existence throughout the preceding calendar year determine if it employs enough employees to be subject to the Employer Shared Responsibility provisions?**

An employer that was not in existence on any business day in the prior calendar year is considered an applicable large employer in the current year if the employer is reasonably expected to employ an average of at least 50 full-time employees (including full-time equivalents) on business days during the current calendar year and it actually employs an average of at least 50 full-time employees (including full-time equivalents) on business days during the calendar year. In contrast, for the next year (the year after the first year the employer was in existence), the employer will determine its status as an applicable large employer using the rules that generally apply (that is, based on the number of full-time employees and full-time equivalents that the employer employed in the preceding year).

**6. If two or more companies have a common owner or are otherwise related, are they combined for purposes of determining whether they employ enough employees to be subject to the Employer Shared Responsibility provisions?**

Yes, section 4980H includes a longstanding provision that also applies for other tax and employee benefit purposes, under which companies that have a common owner or are otherwise related generally are combined and treated as a single employer, and so would be combined for purposes of determining whether or not they collectively employ at least 50 full-time employees (including full-time equivalents). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions, even those companies that individually do not employ enough employees to meet the threshold. (Note that these rules for combining related employers do not apply for purposes of determining whether a particular company owes an Employer Shared Responsibility payment or the amount of any payment. That is determined separately for each related company).

**7. Do the Employer Shared Responsibility provisions apply only to large employers that are for-profit businesses or to other large employers as well?**

All employers that are applicable large employers are subject to the Employer Shared Responsibility provisions, including for-profit, non-profit, and government entity employers.

**8. Do the Employer Shared Responsibility provisions apply to government entities?**

Yes. There is no exclusion from the Employer Shared Responsibility provisions for government entities. All employers that are applicable large employers are subject to the Employer Shared Responsibility provisions, including federal, state, local, and Indian tribal government employers.

**9. Do the Employer Shared Responsibility provisions apply to employers in states where a Federally-facilitated Exchange (Marketplace) has been established on behalf of the state?**

Yes. An applicable large employer is subject to an Employer Shared Responsibility payment if at least one of its full-time employees receives a premium tax credit. A premium tax credit is only available to eligible individuals who obtain coverage through a Marketplace, which includes a State Based Exchange, regional Exchange, subsidiary Exchange, or the Federally-facilitated Exchange established on behalf of a state.

**10. Do the Employer Shared Responsibility provisions apply to employers with full-time employees who are eligible for health coverage through another source, such as Medicare, Medicaid, or a spouse's employer?**

Yes. For purposes of determining whether an employer is an applicable large employer, all employees are counted (subject to a limited exception for certain seasonal workers), regardless of whether the employees are eligible for health coverage from another source, such as Medicare, Medicaid, or a spouse's employer. Thus, an applicable large employer with full-time employees who are eligible for health coverage through another source, such as Medicare, Medicaid, or a spouse's employer, will be subject to the Employer Shared Responsibility provisions regardless of whether those employees are eligible for coverage from another source. But, employees who are eligible for Medicare or Medicaid are not eligible for a premium tax credit. If no full-time employee receives a premium tax credit (for example, because all of an employer's full-time employees are eligible for Medicare or Medicaid), the employer will not be subject to an Employer Shared Responsibility payment.

However, as described in question 18 below, if an applicable large employer does not offer coverage to its full-time employees (and their dependents) or offers coverage to fewer than 95% of its full-time employees (and their dependents) and a full-time employee receives a premium tax credit, the employer will be liable for an Employer Shared Responsibility payment, which will be calculated based on the employer's number of full-time employees. For this purpose, the number of full-time employees includes full-time employees who are eligible for coverage from another source. See questions 33 through 37 for transition relief for 2015.

**11. Do the Employer Shared Responsibility provisions apply to employers with full-time employees who are exempt from the Individual Shared Responsibility provision, such as members of a Health Care Sharing Ministry or members of a Federally-recognized Indian tribe?**

Yes. For purposes of determining whether an employer is an applicable large employer, all employees are counted (subject to a limited exception for certain seasonal workers), regardless of whether they are exempt from the Individual Shared Responsibility provision. Thus, an applicable large employer with full-time employees who are exempt from the Individual Shared Responsibility provision will be subject to the Employer Shared Responsibility provision. Employees who are exempt from the Individual Shared Responsibility provision may be eligible for a premium tax credit. If no full-time employee receives a premium tax credit, the employer will not be subject to an Employer Shared Responsibility payment. However, if an applicable large employer does not offer coverage to its full-time employees (and their dependents) and a full-time employee receives a premium tax credit, the employer will be liable for an Employer Shared Responsibility payment which will be calculated based on the employer's number of full-time employees. See questions 10 and 18.

**12. Which employers are not subject to the Employer Shared Responsibility provisions?**

For a calendar year, employers who employ fewer than 50 full-time employees (including full-time equivalents) in the prior calendar year are not subject to the Employer Shared Responsibility provisions. See question 4 for a limited exception for employers with certain seasonal workers, and questions 34 through 36 for 2015 transition relief for employers with fewer than 100 full-time employees (including full-time equivalents).

**13. Are companies with employees working outside the United States subject to the Employer Shared Responsibility provisions?**

For purposes of determining whether an employer is an applicable large employer, an employer generally takes into account only work performed in the United States. For example, if a foreign employer has a large workforce worldwide, but fewer than 50 full-time employees (including full-time equivalents) in the United States, the foreign employer generally would not be subject to the Employer Shared Responsibility provisions.

**14. Are companies that employ U.S. citizens working abroad subject to the Employer Shared Responsibility provisions?**

A company that employs U.S. citizens working abroad generally would be subject to the Employer Shared Responsibility provisions only if the company had at least 50 full-time employees (including full-time equivalents), determined by taking into account work performed in the United States. Thus, employees working only abroad, whether or not U.S. citizens, generally will not be taken into account for purposes of determining whether an employer is applicable large employer or for purposes of determining whether the employer owes an Employer Shared Responsibility payment or the amount of any such payment.

[Back to top](#)

## **Identification of Full-Time Employees**

### **15. How does an employer identify its full-time employees for purposes of the Employer Shared Responsibility provisions?**

An employer's number of full-time employees matters both for purposes of whether the Employer Shared Responsibility provisions apply to an employer and whether an Employer Shared Responsibility payment is owed by an employer (and the amount of that payment). An employer identifies its full-time employees based on each employee's hours of service. For purposes of the Employer Shared Responsibility provisions, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week. Under the final regulations, for purposes of determining full-time employee status, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week.

The final regulations provide two measurement methods for determining whether an employee has sufficient hours of service to be a full-time employee. One method is the monthly measurement method under which an employer determines each employee's status as a full-time employee by counting the employee's hours of service for each month. The other method is the look-back measurement method under which an employer may determine the status of an employee as a full-time employee during a future period (referred to as the stability period), based upon the hours of service of the employee in a prior period (referred to as the measurement period). The look-back measurement method for identifying full-time employees is available only for purposes of determining and computing liability for an Employer Shared Responsibility payment, and not for purposes of determining if the employer is an applicable large employer. The final regulations describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees, and employees of educational organizations.

These methods prescribe minimum standards for the identification of full-time employee status. Employers always may make additional employees eligible for coverage, or otherwise offer coverage more expansively than required.

### **16. For purposes of the Employer Shared Responsibility provisions, what is an hour of service?**

Generally, an hour of service means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Under the final regulations, an hour of service does not include any hour of service performed as a bona fide volunteer, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or to the extent the

compensation for services performed constitutes income from sources without the United States.

In addition, until further guidance is issued, a religious order is permitted, for purposes of determining if an employee is a full-time employee for the Employer Shared Responsibility provisions, to not count as an hour of service any work performed by an individual who is subject to a vow of poverty as a member of that order when the work is in the performance of tasks usually required (and to the extent usually required) of an active member of the order.

**17. Are there special rules for hours of service that are particularly challenging to identify or track or for whom the final regulations' general rules for determining hours of service may present special difficulties?**

Treasury and the IRS continue to consider additional rules for the determination of hours of service for certain categories of employees whose hours of service are particularly challenging to identify or track or for whom the general rules for determining hours of service may present special difficulties (including adjunct faculty, commissioned salespeople and airline employees) and certain categories of work hours associated with some positions of employment, including layover hours (for example for airline employees) and on-call hours. For this purpose, until further guidance is issued, employers are required to use a reasonable method of crediting hours of service that is consistent with section 4980H. The preamble to the final regulations includes examples of methods of crediting these hours that are reasonable and that are not reasonable, including a method that is considered reasonable for crediting hours of service for adjunct faculty members.

[Back to top](#)

**Liability for the Employer Shared Responsibility Payment**

**18. Under what circumstances will an employer owe an Employer Shared Responsibility payment?**

For 2015 and after, an applicable large employer will be liable for an Employer Shared Responsibility payment only if:

(a) The employer does not offer health coverage or offers coverage to fewer than 95% of its full-time employees and the dependents of those employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on a Marketplace;

OR

(b) The employer offers health coverage to all or at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on a Marketplace, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee (see question 19, below) or did not provide minimum value (see question 20, below).

But see question 33 for transition relief with respect to offers of coverage to dependents for 2015, questions 34 through 36 for 2015 transition relief for certain employers with fewer than 100 full-time employees (including full-time equivalents), and question 37 for 2015 transition relief for all other employers with respect to the percentage of full-time employees to whom coverage must be offered to avoid the payment described in paragraph (a) above.

**19. How does an employer know whether the coverage it offers is affordable?**

If an employee's share of the premium for employer-provided coverage would cost the employee more than 9.5% of that employee's annual household income, the coverage is not considered affordable for that employee. Because employers generally will not know their employees' household incomes, employers can take advantage of one or more of the three affordability safe harbors set forth in the final regulations that are based on information the employer will have available, such as the employee's Form W-2 wages or the employee's rate of pay. If an employer meets the requirements of any of these safe harbors, the offer of coverage will be deemed affordable for purposes of the Employer Shared Responsibility provisions regardless of whether it was affordable to the employee for purposes of the premium tax credit.

The three affordability safe harbors are (1) the Form W-2 wages safe harbor, (2) the rate of pay safe harbor, and (3) the federal poverty line safe harbor. These safe harbors are all optional. An employer may use one or more of the safe harbors only if the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that provides minimum value for the self-only coverage offered to the employee. An employer may choose to use one or more of the safe harbors for all of its employees or for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category. If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost self-only option available to the employee that also meets the minimum value requirement (see question 20, below.)

The Form W-2 wages safe harbor generally is based on the amount of wages paid to the employee that are reported in Box 1 of that employee's Form W-2. The rate of pay safe harbor generally is based on the employee's rate of pay at the beginning of the coverage period, with adjustments permitted, for an hourly employee, if the rate of pay is decreased (but not if the rate of pay is increased). The federal poverty line safe harbor generally treats coverage as affordable if the employee contribution for the year does not exceed 9.5% of the federal poverty line for a single individual for the applicable calendar year. The [final regulations](#) provide additional information on these affordability safe harbors.

**20. How does an employer know whether the coverage it offers provides minimum value?**

A plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan. The Department of Health and Human Services (HHS) and the IRS have produced a [minimum value calculator](#). By entering certain information about the plan, such as deductibles and co-pays, into the calculator employers can get a determination as to whether the plan provides minimum

value. Additionally, on May 3, 2013, Treasury and the IRS issued [proposed regulations](#) regarding the other methods available to determine minimum value.

**21. If an employer offers health coverage that is affordable and that provides minimum value to its full-time employees and offers health coverage to the dependents of those employees, will it be subject to an Employer Shared Responsibility payment if some of its employees purchase health insurance through a Marketplace or if some of its employees enroll in Medicare or Medicaid?**

No. An applicable large employer will not be subject to an Employer Shared Responsibility payment solely because one, some, or all of its employees purchase health insurance coverage through a Marketplace or enroll in Medicare or Medicaid. An employer will not be liable for an Employer Shared Responsibility payment unless at least one full-time employee receives a premium tax credit. In general, an employee will not be eligible for a premium tax credit if the employer has offered that employee health coverage that is affordable (see question 19) and that provides minimum value (see question 20), even if that employee rejects the offer of coverage and instead enrolls in coverage through a Marketplace or enrolls in Medicare or Medicaid. If no full-time employee receives a premium tax credit, the employer will not be subject to an Employer Shared Responsibility payment.

**22. If an employer offers health coverage that is affordable and that provides minimum value to its full-time employees and offers health coverage to the dependents of those employees, will it be subject to an Employer Shared Responsibility payment if an employee's spouse purchases health insurance through a Marketplace, or if a spouse enrolls in Medicare or Medicaid?**

No. To avoid a potential Employer Shared Responsibility payment an applicable large employer must offer health coverage that is affordable and provides minimum value to its full-time employees and must offer health coverage to the dependents of those employees (see questions 18, 19 and 20). For this purpose, a spouse is not a dependent. An applicable large employer will not be subject to an Employer Shared Responsibility payment solely because it does not offer health coverage to an employee's spouse or if the spouse purchases health insurance coverage through a Marketplace or enrolls in Medicare or Medicaid. An employer will not be liable for an Employer Shared Responsibility payment unless a full-time employee receives a premium tax credit. If no full-time employee receives a premium tax credit, the employer will not be subject to an Employer Shared Responsibility payment. Thus, even if an employee's spouse receives a premium tax credit, the employer will not be subject to an Employer Shared Responsibility payment.

If an applicable large employer offers health coverage that is affordable and that provides minimum value to a full-time employee's spouse, the spouse will not be eligible for the premium tax credit. For more information about eligibility for the premium tax credit, see our [final regulations](#) and [questions and answers](#).

**23. If an employer offers health coverage that is affordable and that provides minimum value to its full-time employees and offers health coverage to the dependents of those employees, will it be subject to an Employer Shared Responsibility payment if some of its employees purchase health insurance coverage for their dependents through a Marketplace or if some of its employees enroll their dependents in Medicare or Medicaid?**

No. An applicable large employer will not be subject to an Employer Shared Responsibility payment solely because one, some or all of its employees purchase health insurance coverage for their dependents through a Marketplace or enroll their dependents in Medicare or Medicaid. An employer will not be liable for an Employer Shared Responsibility payment unless a full-time employee receives a premium tax credit. If no full-time employee receives a premium tax credit, the employer will not be subject to an Employer Shared Responsibility payment.

If an employer offers health coverage that is affordable (see question 19) and that provides minimum value (see question 20) to the dependents of its full-time employees, those dependents will not be eligible for a premium tax credit. For more information about eligibility for a premium tax credit, see our [final regulations](#) and [questions and answers](#).

[Back to top](#)

### **Calculation of the Employer Shared Responsibility Payment**

**24. If an employer that does not offer coverage or that offers coverage to fewer than 95% of its full-time employees (and their dependents) owes an Employer Shared Responsibility payment, how is the amount of the payment calculated?**

If an applicable large employer does not offer coverage or offers coverage to fewer than 95% of its full-time employees (and their dependents), it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the year (minus up to 30) multiplied by \$2,000, as long as at least one full-time employee receives the premium tax credit. (Note that for purposes of this calculation, a full-time employee does not include a full-time equivalent). Also, see question 33 for transition relief for offers of coverage to dependents for 2015.

For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered. The amount of the payment for the month equals the number of full-time employees the employer employed for the month (minus up to 30) multiplied by 1/12 of \$2,000. If the employer is related to other employers (see question 6 above), then the 30-employee exclusion is allocated among all the related employers in proportion to each employer's number of full-time employees. See questions 38 and 39 for information about 2015 transition relief for calculating the payment.

**25. If an employer offers coverage to at least 95% of its full-time employees (and their dependents), but, nevertheless, owes the Employer Shared Responsibility payment, how is the amount of the payment calculated?**

For an employer that offers coverage to at least 95% of its full-time employees (and their dependents), but has one or more full-time employees who receive a premium tax credit, the payment is computed separately for each month. See question 33 for transition relief with respect to offers of coverage to dependents for 2015. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of \$3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month

(minus up to 30) multiplied by 1/12 of \$2,000. (The cap ensures that the payment for an employer that offers coverage can never exceed the payment that employer would owe if it did not offer coverage (See question 24)). See questions 38 and 39 for information about 2015 transition relief for calculating the payment.

**26. Will the amount of the Employer Shared Responsibility payment be increased over time?**

Yes. The Employer Shared Responsibility provisions provide an inflation adjustment mechanism beginning in years after 2014. The transition relief announced in Notice 2013-45 that section 4980H will not be applied for 2014 does not affect the statutory inflation adjustment mechanism beginning in years after 2014.

[Back to top](#)

**Making an Employer Shared Responsibility Payment**

**27. How will an employer know that it owes an Employer Shared Responsibility payment?**

The IRS will adopt procedures that ensure employers receive certification that one or more employees have received a premium tax credit. The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after the due date for employees to file individual tax returns for that year claiming premium tax credits and after the due date for applicable large employers to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).

**28. How will an employer make an Employer Shared Responsibility payment?**

If it is determined that an employer is liable for an Employer Shared Responsibility payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the Employer Shared Responsibility payment on any tax return that they file.

As explained in question 2, no Employer Shared Responsibility payments will be assessed for 2014.

[Back to top](#)

## **Transition Relief**

### **29. Is there transition relief from the Employer Shared Responsibility provisions for 2014?**

Yes. Notice 2013-45, issued on July 9, 2013, provides as transition relief that no Employer Shared Responsibility payment applies for 2014. The Employer Shared Responsibility provisions are effective for 2015 (see question 2). See questions 30 through 39 for additional information about 2015 transition relief.

### **30. I understand that the Employer Shared Responsibility provisions do not go into effect until 2015. However, the health plan that I offer to my employees runs on a non-calendar year plan year that starts in 2014 and will run into 2015. Do I need to make sure my plan complies with the Employer Shared Responsibility provisions in 2014 when the next non-calendar year plan year starts?**

The preamble to the final regulations provides three pieces of transition relief addressing non-calendar year plans — (1) pre-2015 eligibility transition relief, (2) significant percentage transition relief (all employees) and (3) significant percentage transition relief (full-time employees). The first piece of relief generally addresses employees that are already eligible to participate in the non-calendar year plan. Specifically the pre-2015 eligibility transition relief provides that for any employees (whenever hired) who are eligible for coverage on the first day of the 2015 plan year under the eligibility terms of the plan as of Feb. 9, 2014, (whether or not they take the coverage) and who are offered affordable coverage that provides minimum value effective no later than the first day of the 2015 plan year, the employer will not be subject to a potential Employer Shared Responsibility payment until the first day of the 2015 plan year. The remaining two pieces of relief generally address employees that have not been eligible to participate in the non-calendar year plan. They provide that if the employer meets certain requirements generally related to the portion of the employer's employees already eligible for or participating in the non-calendar year plan, the relief may be extended to those employees that have not been eligible to participate. The preamble to the final regulations provides additional information on the rules for determining whether an employer is eligible for this relief. All of this transition relief applies for the period before the first day of the first non-calendar year plan year beginning in 2015 (the 2015 plan year) but only for employers that maintained non-calendar year plans as of Dec. 27, 2012, and only if the plan year was not modified after Dec. 27, 2012, to begin at a later calendar date. See question 36 on 2015 transition relief.

### **31. Is transition relief available to assist employers that are close to the 50 full-time employee threshold in determining if they are an applicable large employer for 2015?**

Yes. Rather than being required to use the full twelve months of 2014 to measure whether it has 50 full-time employees (or equivalents), an employer may measure during any consecutive six-month period (as chosen by the employer) during 2014. For example, an employer could use a period of at least six months through August 2014 to determine its applicable large employer status and, if it is an applicable large employer, the period from September through December 2014 to make any needed adjustments to its plan (or to establish a plan). See question 36 on 2015 transition relief.

**32. For 2015, will employees who receive offers of coverage effective as of the first day of the first pay period beginning on or after the first day of the year be treated as having been offered coverage for January 2015?**

Yes. Generally, if an employer fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not offered coverage during the entire month. Solely for purposes of January 2015, if an employer offers coverage to a full-time employee no later than the first day of the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for January 2015.

**33. Do employers have additional time to expand their 2015 health plans to add dependent coverage?**

The transition relief in the preamble to the final regulation generally extends the transition relief that had been provided for plan years that begin in 2014 (2014 plan years) to plan years that begin in 2015 (2015 plan years). Under this transition relief, an employer that takes steps during its 2014 plan year toward offering dependent coverage will not be subject to an Employer Shared Responsibility payment solely on account of a failure to offer coverage to dependents for that plan year.

This extended transition relief applies to employers for the 2015 plan year for plans under which (1) dependent coverage is not offered, (2) dependent coverage that does not constitute minimum essential coverage is offered, or (3) dependent coverage is offered for some, but not all, dependents.

The transition relief is not available to the extent the employer had offered dependent coverage during either the plan year that begins in 2013 (2013 plan year), or the 2014 plan year and subsequently dropped that offer of coverage. The transition relief, as extended, applies only for dependents who were without an offer of coverage from the employer in both the 2013 and 2014 plan years and if the employer takes steps during the 2014 or 2015 plan year (or both) to extend coverage under the plan to dependents not offered coverage during the 2013 or 2014 plan year (or both). See question 36 on 2015 transition relief.

**34. Is additional transition relief available for employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents)?**

Yes. For employers with fewer than 100 full-time employees (including full-time equivalents) in 2014, that meet the conditions described below, no Employer Shared Responsibility payment under section 4980H(a) or (b) will apply for any calendar month during 2015. For employers with non-calendar-year health plans, this applies to any calendar month during the 2015 plan year, including months during the 2015 plan year that fall in 2016.

In order to be eligible for the relief, an employer must certify that it meets the following conditions:

- (1) **Limited Workforce Size.** The employer must employ on average at least 50 full-time employees (including full-time equivalents) but fewer than 100 full-time employees (including full-time equivalents) on business days during 2014. (Employers with fewer than 50 full-time employees (including full-time equivalents) on business days during

the previous year are not subject to the Employer Shared Responsibility provisions.) The number of full-time employees (including full-time equivalents) is determined in accordance with the otherwise applicable rules in the final regulations for determining status as an applicable large employer.

(2) **Maintenance of Workforce and Aggregate Hours of Service.** During the period beginning on Feb. 9, 2014 and ending on Dec. 31, 2014, the employer may not reduce the size of its workforce or the overall hours of service of its employees in order to qualify for the transition relief. However, an employer that reduces workforce size or overall hours of service for bona fide business reasons is still eligible for the relief.

(3) **Maintenance of Previously Offered Health Coverage.** During the period beginning on Feb. 9, 2014 and ending on Dec. 31, 2015 (or, for employers with non-calendar-year plans, ending on the last day of the 2015 plan year) the employer does not eliminate or materially reduce the health coverage, if any, it offered as of Feb. 9, 2014. An employer will not be treated as eliminating or materially reducing health coverage if (i) it continues to offer each employee who is eligible for coverage an employer contribution toward the cost of employee-only coverage that either (A) is at least 95 percent of the dollar amount of the contribution toward such coverage that the employer was offering on Feb. 9, 2014, or (B) is at least the same percentage of the cost of coverage that the employer was offering to contribute toward coverage on Feb. 9, 2014; (ii) in the event of a change in benefits under the employee-only coverage offered, that coverage provides minimum value after the change; and (iii) it does not alter the terms of its group health plans to narrow or reduce the class or classes of employees (or the employees' dependents) to whom coverage under those plans was offered on Feb. 9, 2014.

**35. Is the transition relief for employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents) available to newly formed employers? If so, how does a new employer know whether it qualifies for the relief?**

Yes, the relief is available to new employers (that is, employers that are not in existence on any business day in 2014).

For new employers that would be applicable large employers under the general rules in the final regulations, the special transition relief applies if the employer certifies that it (i) reasonably expects to employ and actually employs fewer than 100 full-time employees (including full-time equivalents) on business days during 2015; and (ii) reasonably expects to meet and actually meets the standards relating to maintenance of workforce and aggregate hours of service and of previously offered health coverage, as measured from the date the employer is first in existence.

**36. How does the transition relief for employers with fewer than 100 full-time employees coordinate with other transition relief available under the final regulations?**

For periods on or after Jan. 1, 2016 (or, if applicable, for any period after the last day of the 2015 plan year) the transition relief for 2015 generally is not available. An employer may, however, use the shorter period in 2014 permitted for determining applicable large employer status for 2015 in determining applicable large employer status and full-time employee count for 2015 (but not for any subsequent year). See questions 30 through 33.

**37. Under what circumstances will an employer that is not eligible for the relief described in question 34 owe an Employer Shared Responsibility payment for 2015?**

For 2015 (and for employers with non-calendar-year plans, any calendar months during the 2015 plan year that fall in 2016), an employer that (a) had at least 100 full-time employees (including full-time equivalents) in 2014, or (b) had at least 50 but fewer than 100 full-time employees (including full-time equivalents) but does not qualify for the relief described in question 34, will be liable for an Employer Shared Responsibility payment only if:

- The employer does not offer health coverage or offers coverage to fewer than 70% of its full-time employees and (unless the employer qualifies for the 2015 dependent coverage transition relief described in question 33) the dependents of those employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on a Marketplace.

OR

- The employer offers health coverage to at least 70% of its full-time employees and (unless the employer qualifies for the 2015 dependent coverage transition relief described in question 33) the dependents of those employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on a Marketplace, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable (see question 19) to the employee or did not provide minimum value (see question 20).

After 2015, 95% should be substituted for 70% in the bullets above (see question 18).

**38. For 2015, if an employer with at least 100 full-time employees (including full-time equivalents) that does not offer coverage or that offers coverage to fewer than 70% of its full-time employees (and their dependents) owes an Employer Shared Responsibility payment, how is the amount of the payment calculated?**

For any calendar month in 2015 or any calendar month in 2016 that falls within an employer's non-calendar 2015 plan year, if an applicable large employer with at least 100 full-time employees (including full-time equivalents) does not offer coverage to at least 70% of its full-time employees (and their dependents), it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the month (minus 80) multiplied by 1/12 of \$2,000, provided that at least one full-time employee receives a premium tax credit for that month. See questions 24 and 25.

**39. For 2015, if an employer with at least 100 full-time employees (including full-time equivalents) offers coverage to at least 70% of its full-time employees, and, nevertheless, owes an Employer Shared Responsibility payment, how is the amount of the payment calculated?**

For an employer with at least 100 full-time employees (including full-time equivalents) that offers coverage to at least 70% of its full-time employees in 2015, but has one or more full-time employees who receive a premium tax credit, the payment is computed separately for each month. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of \$3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month (minus up to 80) multiplied by 1/12 of \$2,000. See questions 24 and 25.

[Back to top](#)

## **Basics for Small Employers**

### **40. I am a small employer with 30 employees. How do the Employer Shared Responsibility provisions (Code section 4980H) affect me?**

They don't. Employers that employ fewer than 50 full-time employees (including full-time equivalents) in their businesses are not subject to the Employer Shared Responsibility provisions. The vast majority of businesses fall below this threshold.

In addition, the preamble to the final regulations for the Employer Shared Responsibility provisions provides transition relief for 2015. Employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents) in 2014 that meet conditions described in the preamble to the final regulations will not be subject to any Employer Shared Responsibility payments for 2015 (or for the 2015 plan year in the case of an employer with a non-calendar-year health plan).

### **41. If I hire additional employees, including some part-time employees, how do I determine if I have become large enough to be subject to the Employer Shared Responsibility provisions?**

An employer determines if it is subject to these provisions for a current year by counting how many full-time employees and full-time equivalents it employed during the prior calendar year.

First, for each month of the prior year, the employer counts its employees working an average of 30 or more hours per week as full-time employees and, if it has employees working less than that, adds the number of full-time equivalents (determined by simply adding up the hours that are worked by these less-than-full-time employees for the month, but no more than 120 hours per employee, and then dividing by 120).

Second, the resulting totals for each month in the prior year are added together and then divided by 12 to get an average for the prior year. If the result is less than 50, the employer is not subject to these rules for the current year and need not take any other action.

(If the result is 50 or more but some of the employees are seasonal workers, certain adjustments may still bring the average down to less than 50.)

Two transition rules apply in 2015 that are particularly relevant for small employers close to the 50 full-time employee (including full-time equivalents) threshold. First, employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents) in 2014 that meet conditions described in the preamble to the final regulations will not be subject to any Employer Shared Responsibility payments for 2015 (or for the 2015 plan year in the case of an employer with a non-calendar-year health plan). These employers determine if they have 100 or more employees in the same manner as described above. And, second, rather than being required to use the full twelve months of 2014 to measure if it has 100 full-time employees (including full-time equivalents), an employer may measure during any consecutive six-month period (as chosen by the employer) during 2014. For example, an employer could use a period of at least six months through

August 2014 to determine its applicable large employer status and, if it is an applicable large employer, the period from September through December 2014 to make any needed adjustments to its plan (or to establish a plan). See question 36 on 2015 transition relief.

**42. What if I buy or start another business that has another group of employees, but my new business is in an entity that is separate from my existing business?**

In that case, section 4980H provides for common ownership and control “aggregation” rules that may apply. These are similar to rules that have applied to 401(k) and other retirement plans for years. Under these rules, the employees of businesses that are under common control are added together to determine if an employer employs the equivalent of at least 50 (or 100 under the 2015 transition rule noted above) full-time employees (including full-time equivalents).

For example, if an individual owns 80% or more of two businesses that are separate legal entities, the total number of full-time employees of that employer is based on the full-time employees (including full-time equivalents) in both businesses combined together. If the employees in the combined businesses add up to fewer than 50 full-time employees (including full-time equivalents) in a year, the Employer Shared Responsibility provisions will not apply to those businesses for the following year.

[Back to top](#)

**Related Provisions**

**43. When can an employee receive a premium tax credit?**

The [premium tax credit](#) generally is available to help pay for coverage for employees who

- have household income between 100% and 400% of the federal poverty line and enroll in coverage through a Marketplace,
- are not eligible for coverage through a government-sponsored program like Medicaid or CHIP, and
- are not eligible for coverage offered by an employer or are eligible only for employer coverage that is unaffordable or that does not provide minimum value.

**44. If an employer does not employ enough employees to be subject to the Employer Shared Responsibility provisions, does that affect the employees’ eligibility for a premium tax credit?**

No. The rules for how eligibility for employer-sponsored insurance affects eligibility for the premium tax credit are the same, regardless of whether the employer is subject to the Employer Shared Responsibility provisions.

**45. Where can employers get more information about the information reporting requirements on health coverage for employers and for insurers?**

Treasury and the IRS have issued proposed regulations on information reporting on health coverage for employers and information reporting on health coverage for providers of minimum essential coverage.

**46. Where can employees get more information about the Marketplace?**

The Department of Health and Human Services administers the requirements for the Marketplace and the health plans offered in the Marketplace. For more information about your coverage options, financial assistance, and the Marketplace, visit [HealthCare.gov](http://HealthCare.gov).

**47. My spouse and I own a small business and are the only employees. Previously I bought coverage in the small group market in my state to cover me, my spouse, and our dependents and received the Self-Employment Health Insurance Tax Deduction. For 2014, I purchased coverage in the individual market in my state to cover me, my spouse, and our dependents. How does that affect my eligibility for the Self-Employment Health Insurance Tax Deduction?**

If you are self-employed and purchase health insurance coverage for yourself and your family, you will still be eligible for the self-employment health insurance tax deduction. You may claim the deduction regardless of whether you purchase coverage in the individual market or the small group market. However, if you purchase coverage in the individual Marketplace and claim the premium tax credit on your tax return, the amount of the premium reimbursed by the credit may not also be deductible. Specific rules on how the premium tax credit is coordinated with the self-employment health insurance deduction will be issued in the near future.

[Back to top](#)

### **Additional Information**

**48. What are the consequences for an employer covered by the Employer Shared Responsibility provisions if the employer offers health insurance coverage to all full-time employees but does not offer dependent coverage? Would a payment be owed by the employer? If so, beginning in what year? Does the answer depend on whether a dependent gets health insurance coverage in the Marketplace?**

Under the Employer Shared Responsibility provisions, an applicable large employer may have to make an Employer Shared Responsibility payment if the employer does not offer health coverage to the dependents of its full-time employees (as well as to those employees themselves) and at least one of its full-time employees receives a premium tax credit for purchasing individual coverage on the Marketplace. However, under transition relief provided in the preamble to the final regulations under the Employer Shared Responsibility provisions, an employer that takes steps during its 2014 and 2015 plan years toward offering dependent coverage will not be subject to an Employer Shared Responsibility payment solely on account of a failure to offer coverage to dependents for that plan year. This transition relief applies to employers for plans under which (1) dependent coverage is not offered, (2) dependent coverage that does not constitute minimum essential coverage is offered, or (3) dependent coverage is offered for some, but not all, dependents. The transition relief is not available to the extent the employer had offered dependent coverage during either the plan year that begins in 2013 (2013 plan year), or the 2014 plan year and subsequently dropped that offer of coverage. The transition relief applies for the 2015 plan year only for dependents who were without an offer of coverage from the employer in both the 2013 and 2014 plan years and if the employer takes steps during the 2014 or 2015 plan year (or both) to extend coverage

under the plan to dependents not offered coverage during the 2013 or 2014 plan year (or both).

For 2015 and in later years, an employer may be liable for an Employer Shared Responsibility payment only if one or more of its full-time employees enrolls in coverage through a Marketplace and receives a premium tax credit. Whether or not one or more of its full-time employees' dependents enrolls in a Marketplace and receives a premium tax credit does not affect an employer's liability.

**49. Although my company offers all its full-time employees and dependents health insurance coverage, one of my employees' dependents enrolled for coverage in the Marketplace and received a premium tax credit – does my company have to make an Employer Shared Responsibility Payment?**

An applicable large employer will not be subject to an Employer Shared Responsibility payment solely because one, some, or all of the dependents of its full-time employees receive health insurance coverage through a Marketplace and receive a premium tax credit. An employer will potentially be liable for an Employer Shared Responsibility payment only if a full-time employee enrolls in coverage through a Marketplace and receives a premium tax credit. If no full-time employee receives a premium tax credit, the employer will not be subject to an Employer Shared Responsibility payment.

If an employer offers health coverage to its full-time employees and their dependents and that coverage is affordable and provides minimum value with respect to the full-time employees, those dependents will not be eligible for a premium tax credit.

**50. I own a business with fewer than 50 full-time (including full-time equivalent) employees. I offer insurance that is generally affordable and minimum value. However, for one employee it's unaffordable and he goes to the Marketplace for insurance and gets advance payments of the premium tax credit—do I have an employer shared responsibility payment?**

No. Employers that employ fewer than 50 full-time employees (including full-time equivalents) in their businesses for the prior year are not subject to the Employer Shared Responsibility provisions. The vast majority of businesses fall below this threshold.

In addition, for employers with fewer than 100 full-time employees, the preamble to the final regulations for the Employer Shared Responsibility provisions provides transition relief for 2015. Employers with at least 50 but fewer than 100 full-time employees (including full-time equivalents) in 2014 that meet conditions described in the preamble to the final regulations will not be subject to any Employer Shared Responsibility payments for 2015 (or for the 2015 plan year in the case of an employer with a non-calendar-year health plan).

**51. I own a business that is subject to the Employer Shared Responsibility rules. Who certifies that my employer plan meets the minimum value requirements?**

Beginning in 2016 (for calendar year 2015) all applicable large employers must report to the IRS and provide statements to all full-time employees certain information regarding coverage offered to full-time employees, including whether the coverage offered met the minimum value requirements. A plan provides minimum value if it covers at least 60

percent of the total allowed cost of benefits that are expected to be incurred under the plan. On May 3, 2013, Treasury and the IRS issued [proposed regulations](#) regarding the methods available to determine minimum value. One such method is a [minimum value calculator](#) produced by the Department of Health and Human Services (HHS) in coordination with the IRS. By entering certain information about the plan, such as deductibles and co-pays, into the calculator, an employer (or an insurance company, third-party administrator, or other entity) can get a determination as to whether the plan provides minimum value.

**52. I own a business that is subject to the Employer Shared Responsibility provisions; however, all of my employees obtain other health insurance coverage. Do I still need to offer insurance to them to avoid an Employer Shared Responsibility payment?**

Yes. An applicable large employer must generally offer coverage to its full-time employees (and their dependents) even if the employee is eligible for coverage from another source, to avoid a potential Employer Shared Responsibility payment. An applicable large employer may be subject to an Employer Shared Responsibility payment if the employer does not offer health coverage to its full-time employees (and their dependents) and at least one of its full-time employees receives a premium tax credit for purchasing individual coverage on the Marketplace. If an applicable large employer does not offer coverage to its full-time employees (and their dependents) or offers coverage to fewer than 95% of its full-time employees (70% in 2015 as a transition) (and their dependents), and at least one full-time employee receives a premium tax credit, the employer will be liable for an Employer Shared Responsibility payment, which will be calculated based on the employer's number of full-time employees. For this purpose, all full-time employees are counted, including those who are eligible for coverage from another source. (See Q&A 48, above, for a 2015 transition rule under which an employer that takes steps during its 2014 and 2015 plan years toward offering dependent coverage may not be subject to an Employer Shared Responsibility payment solely on account of a failure to offer coverage to dependents.)

An employer may owe an Employer Shared Responsibility payment only if one or more full-time employees receive a premium tax credit. Individuals (including employees) who are eligible for Medicare or Medicaid are generally not eligible for a premium tax credit. Thus, if all of an employer's full-time employees are eligible for Medicare or Medicaid, the employer will not be subject to an Employer Shared Responsibility payment. However, if even one full-time employee receives a premium tax credit, the employer may be subject to an Employer Shared Responsibility payment.

**53. How do I determine if my business is part of a controlled group under the Employer Shared Responsibility rules? Are there any resources or tools to help me make this determination?**

Section 4980H includes a provision that has long applied for other tax and employee benefit purposes, under which companies that have a common owner or are otherwise related generally are combined and treated as a single employer, and so would be combined for purposes of determining whether or not they collectively employ at least 50 full-time employees (including full-time equivalents). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions, even those companies that individually do not employ enough employees to

meet the threshold. (Note that these rules for combining related employers do not apply for purposes of determining whether a particular company owes an Employer Shared Responsibility payment or the amount of any payment. That is determined separately for each related company. For example, if a particular company does not have a full-time employee who receives a premium tax credit, then that particular company will not owe an Employer Shared Responsibility Payment, even if a full-time employee of a related company receives a premium tax credit.)

**54. What is the impact under the Employer Shared Responsibility provisions if some of my employees are seasonal “employees” and some are seasonal “workers”? Is a seasonal employee the same as a seasonal worker under these rules?**

The terms “seasonal worker” and “seasonal employee” are both used in the Employer Shared Responsibility provisions but in two different contexts.

The term “seasonal worker” is relevant for determining whether an employer is an applicable large employer subject to the Employer Shared Responsibility provisions.

To be an applicable large employer, an employer must have employed, during the previous calendar year, at least 50 full-time employees (including full-time equivalent employees). However, if an employer’s workforce exceeds 50 full-time employees (including full-time equivalent employees) for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days were seasonal workers, the employer is not considered an applicable large employer. Seasonal workers are workers who perform labor or services on a seasonal basis, as defined by the Secretary of Labor, and include retail workers employed exclusively during holiday seasons. For this purpose, employers may apply a reasonable, good faith interpretation of the term “seasonal worker.”

The term “seasonal employee” is relevant for determining an employee’s status as a full-time employee under the look-back measurement method. For purposes of the Employer Shared Responsibility provisions, an employee is a full-time employee for a calendar month if he or she averages at least 30 hours of service per week (or 130 hours of service per month). The final regulations under the Employer Shared Responsibility provisions provide two methods for determining full-time employee status, one of which is the look-back measurement method. Under the look-back measurement method an employer may determine an employee’s status as a full-time employee during a period (referred to as the stability period), based upon the hours of service of the employee in a prior period (referred to as the measurement period). The look-back measurement method includes special rules that apply to new employees who are seasonal employees. For this purpose, a seasonal employee means an employee who is hired into a position for which the customary annual employment is six months or less and for which the period of employment begins each calendar year in approximately the same part of the year, such as summer or winter. Note that the look-back measurement method is not available for purposes of determining whether the employer is an applicable large employer.

**55. I own a small business. How do I count the hours of my interns (both paid and unpaid) to determine whether or not my business is an applicable large employer subject to the Employer Shared Responsibility provisions?**

To be subject to the Employer Shared Responsibility provisions for a calendar year, an employer must be an applicable large employer. To be an applicable large employer, an employer must have employed, during the previous calendar year, at least 50 full-time employees or a combination of full-time employees and part-time employees (referred to as full-time equivalent employees) that equals at least 50. Both to determine its number of full-time employees and to determine its number of full-time equivalent employees, an employer must determine the hours of service of each of its employees.

Under the final regulations for the Employer Shared Responsibility provisions, generally, an hour of service means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

For purposes of determining hours of service, interns are treated like all other employees. Therefore, under the general rule, an employee, including an intern, who receives no payment from an employer (for example, an unpaid intern) will not have any hours of service.

An employee, including an intern, who is paid, or entitled to payment, for the performance of duties (or for a period of time during which no duties are performed) will have hours of service. However, under the final regulations, an hour of service does not include any hour of service performed as a bona fide volunteer (as defined in the regulations) for a government entity or tax-exempt entity, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof), or to the extent the compensation for services performed constitutes income from sources without the United States.

**56. I own a business that is subject to the Employer Shared Responsibility provisions. How do I measure a particular employee's average hours worked if that employee works both for my company and another unrelated company? What if the employee works for two different subsidiaries under a parent corporation that forms a controlled group of companies?**

Under the Employer Shared Responsibility provisions, common ownership and control "aggregation" rules apply for purposes of identifying the employer in computing an employee's hours of service. These are similar to rules that have applied to retirement plans for years. Under these rules, employers under common control are treated as a single employer so that an employee's hours of service for all the different employers are added together. In other words, an employee's hours of service for one member of a controlled group is treated as an hour of service for another member of the controlled group, for whom the individual is also an employee.

However, if an employee is employed by two employers that are not under common control and therefore are not treated as a single employer for purposes of the Employer Shared Responsibility provisions, an employee's hours of service for one of the employers are not treated as hours of service for the other employer.

[Back to top](#)

## Affordable Care Act Tax Provisions Questions and Answers

Questions and answers have been prepared for each of the provisions listed below. The IRS will update this page as additional information or new guidance becomes available.

### Individuals and Families



[Additional Medicare Tax](#)  
[Adoption Credit](#)  
[Health Flexible Spending Arrangements \(FSA\)](#)  
[Individual Shared Responsibility](#)  
[Itemized Deduction for Medical Expenses, Changes](#)  
[Net Investment Income Tax](#)  
[Premium Tax Credit](#)

### Employers



[Employer Health Care Arrangements](#)  
[Employer Shared Responsibility](#)  
[Health Flexible Spending Arrangements \(FSA\)](#)  
[Reporting Value of Employer-provided Health coverage on Form W-2](#)  
[Small Business Health Care Tax Credit](#)

### Other Entities and Organizations



[Disclosure or Use of Information by Tax Return Preparers](#)  
[Disclosure of Certain Taxpayer Information to Verify Eligibility for Health Care Affordability Programs](#)  
[Medical Device Excise Tax](#)

## 3 Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements

Notice 2013-54

## I. PURPOSE AND OVERVIEW

This notice provides guidance on the application of certain provisions of the Affordable Care Act<sup>1</sup> to the following types of arrangements: (1) health reimbursement arrangements (HRAs), including HRAs integrated with a group health plan; (2) group health plans under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy, such as a reimbursement arrangement described in Revenue Ruling 61-146, 1961-2 CB 25, or arrangements under which the employer uses its funds to directly pay the premium for an individual health insurance policy covering the employee (collectively, an employer payment plan); and (3) certain health flexible spending arrangements (health FSAs). This notice also provides guidance on section 125(f)(3) of the Internal Revenue Code (Code) and on employee assistance programs or EAPs.

The Departments of the Treasury (Treasury Department), Health and Human Services (HHS), and Labor (DOL) (collectively, the Departments) are continuing to work together to develop coordinated regulations and other administrative guidance to assist stakeholders with implementation of the Affordable Care Act. The guidance in this notice is being issued in substantially identical form by DOL, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this notice.

## II. BACKGROUND

### A. Health Reimbursement Arrangements

An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Code § 213(d)) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. IRS Notice 2002-45, 2002-02 CB 93; Revenue Ruling 2002-41, 2002-2 CB 75. This reimbursement is excludable from the employee's income. Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years. HRAs generally are considered to be group health plans within the meaning of Code § 9832(a), § 733(a) of the Employee Retirement Income Security Act of 1974 (ERISA), and § 2791(a) of the Public Health Service Act (PHS Act) and are subject to the rules applicable to group health plans.

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<sup>1</sup> The "Affordable Care Act" refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148) (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), and as further amended by the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (enacted April 15, 2011, Pub. L. No. 112-10).

## **B. Employer Payment Plans**

Revenue Ruling 61-146 holds that if an employer reimburses an employee's substantiated premiums for non-employer sponsored hospital and medical insurance, the payments are excluded from the employee's gross income under Code § 106. This exclusion also applies if the employer pays the premiums directly to the insurance company. An employer payment plan, as the term is used in this notice, does not include an employer-sponsored arrangement under which an employee may choose either cash or an after-tax amount to be applied toward health coverage. Individual employers may establish payroll practices of forwarding post-tax employee wages to a health insurance issuer at the direction of an employee without establishing a group health plan, if the standards of the DOL's regulation at 29 C.F.R. §2510.3-1(j) are met.

## **C. Health Flexible Spending Arrangements (Health FSAs)**

In general, a health FSA is a benefit designed to reimburse employees for medical care expenses (as defined in Code § 213(d), other than premiums) incurred by the employee, or the employee's spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.125-5); Code §§ 105(b) and 106(f). Contributions to a health FSA offered through a cafeteria plan satisfying the requirements of Code § 125 (a Code § 125 plan) do not result in gross income to the employee. Code § 125(a). While employees electing coverage under a health FSA typically also elect to enter into a salary reduction agreement, employers may provide additional health FSA benefits in excess of the salary reduction amount. See Employee Benefits—Cafeteria Plans, 72 Fed. Reg. 43938, 43955-43957 (August 6, 2007) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §§1.125-1(r), 1.125-5(b)). For plan years beginning after December 31, 2012, the amount of the salary reduction is limited by Code § 125(i) to \$2,500 (indexed annually for plan years beginning after December 31, 2013). See IRS Notice 2012-40, 2012-26 IRB 1046, for more information about the application of the limitation. Additional employer contributions are not limited by Code § 125(i).

The Code, ERISA, and the PHS Act impose various requirements on group health plans, but certain of these requirements do not apply to a group health plan in relation to its provision of excepted benefits. Code § 9831(b), ERISA § 732(b), PHS Act §§ 2722(b) and 2763. Although a health FSA is a group health plan within the meaning of Code § 9832(a), ERISA § 733(a), and PHS Act § 2791(a), a health FSA may be considered to provide only excepted benefits if other group health plan coverage not limited to excepted benefits is made available for the year to employees by the employer, but only if the arrangement is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the arrangement for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election). 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. §146.145(c)(3)(v).

## **D. Affordable Care Act Guidance**

### **1. Market Reforms — In General**

The Affordable Care Act contains certain market reforms that apply to group health plans (the market reforms).<sup>2</sup> In accordance with Code § 9831(a)(2) and ERISA § 732(a), the 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, and, in accordance with Code § 9831(b), ERISA § 732(b), and PHS Act §§ 2722(b) and 2763, the market reforms also do not apply to a group health plan in relation to its provision of excepted benefits described in Code § 9832(c), ERISA § 733(c) and PHS Act § 2791(c).<sup>3</sup> Excepted benefits include, among other things, accident-only coverage, disability income, certain limited-scope dental and vision benefits, certain long-term care benefits, and certain health FSAs.

The market reforms specifically addressed in this notice are:<sup>4</sup>

(a) PHS Act § 2711 which provides that a group health plan (or a health insurance issuer offering group health insurance coverage) may not establish any annual limit on the dollar amount of benefits for any individual—this rule does not prevent a group health plan, or a health insurance issuer offering group health insurance coverage, from placing an annual limit, with respect to any individual, on specific covered benefits that are not essential health benefits<sup>5</sup> to the extent that such limits are otherwise permitted under applicable law (the annual dollar limit prohibition); and

(b) PHS Act § 2713 which requires non-grandfathered group health plans (or health insurance issuers offering group health insurance plans) to provide certain preventive services without imposing any cost-sharing requirements for these services (the preventive services requirements).

<sup>2</sup> Section 1001 of the ACA added new PHS Act §§ 2711-2719. Section 1563 of the ACA (as amended by ACA § 10107(b)) added Code § 9815(a) and ERISA § 715(a) to incorporate the provisions of part A of title XXVII of the PHS Act into the Code and ERISA, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by these references are sections 2701 through 2728. Accordingly, these referenced PHS Act sections (i.e., the market reforms) are subject to shared interpretive jurisdiction by the Departments.<sup>3</sup>

See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010). See also Affordable Care Act Implementation FAQs Part III, Question 1, available at <http://www.dol.gov/ebsa/faqs/faq-aca3.html> and at [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs3.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html).

<sup>4</sup> The Departments previously addressed HRAs and the requirements under PHS Act § 2715 (summary of benefits and coverage and uniform glossary). See 77 Fed. Reg. 8668, 8670-8671 (February 14, 2012); see also Affordable Care Act Implementation FAQs Part VIII, Question 6, available at <http://www.dol.gov/ebsa/faqs/faq-aca8.html> and at [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs8.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html) and see page 1 of the Instruction Guide for Group Coverage, available at <http://www.dol.gov/ebsa/pdf/SBCInstructionsGroup.pdf>.

<sup>5</sup> See ACA § 1302(b) for the definition of “essential health benefits”.

## 2. Prior Guidance on the Application of the Market Reforms to HRAs

The preamble to the interim final regulations implementing the annual dollar limit prohibition states that if an HRA is integrated with other coverage as part of a group health plan and the other coverage alone would comply with the annual dollar limit prohibition, the fact that benefits under the HRA by itself are limited does not fail to comply with the annual dollar limit prohibition because the combined benefit satisfies the requirements. Further, the preamble states that in the case of a standalone HRA that is limited to retirees, the exemption from the requirements of the Code and ERISA relating to the Affordable Care Act for plans with fewer than two current employees means that the retiree-only HRA is not subject to the annual dollar limit prohibition. 75 Fed. Reg. 37188, 37190-37191 (June 28, 2010).

On January 24, 2013, the Departments issued FAQs that address the application of the annual dollar limit prohibition to certain HRA arrangements (HRA FAQs).<sup>6</sup> In the HRA FAQs, the Departments state that an HRA is not integrated with primary health coverage offered by an employer unless, under the terms of the HRA, the HRA is available only to employees who are covered by primary group health plan coverage that is provided by the employer and that meets the annual dollar limit prohibition. Further, the HRA FAQs indicate that the Departments intend to issue guidance providing that:

(a) for purposes of the annual dollar limit prohibition, an employer-sponsored HRA cannot be integrated with individual market coverage or with individual policies provided under an employer payment plan, and, therefore, an HRA used to purchase coverage on the individual market under these arrangements will fail to comply with the annual dollar limit prohibition; and

(b) an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in the coverage, and any HRA that credits additional amounts to an individual, when the individual is not enrolled in primary coverage meeting the annual dollar limit prohibition provided by the employer, will fail to comply with the annual dollar limit prohibition.

The HRA FAQs also state that the Departments anticipate that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014 consisting of amounts credited before January 1, 2013, and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013, may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with the annual dollar limit prohibition. If the HRA terms in effect on January 1, 2013 did not prescribe a set amount or amounts to be credited during 2013 or the timing

<sup>6</sup> See Affordable Care Act Implementation FAQs Part XI, available at <http://www.dol.gov/ebsa/faqs/faq-aca11.html> and at [http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs11.html](http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html).

for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.

### **3. Prior Guidance on the Application of the Market Reforms to Health FSAs**

Under the interim final rules implementing the annual dollar limit prohibition, a health FSA, as defined in Code § 106(c)(2), is not subject to the annual dollar limit prohibition. See 26 C.F.R. §54.9815-2711T (a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this notice limiting the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

### **4. Prior Guidance on the Application of Code §§ 36B and 5000A**

Section 36B of the Code allows a premium tax credit to certain taxpayers who enroll (or whose family members enroll) in a qualified health plan (QHP) through an Affordable Insurance Exchange (referred to in this notice as an Exchange, and also referred to in other published guidance as a Marketplace). The credit subsidizes a portion of the premiums for the QHP. In general, the premium tax credit may not subsidize coverage for an individual who is eligible for other minimum essential coverage. If the minimum essential coverage is eligible employer-sponsored coverage, however, an individual is treated as eligible for that coverage only if the coverage is affordable and provides minimum value or if the individual enrolls in the coverage.

Coverage provided through Code § 125 plans, employer payment plans, health FSAs, and HRAs are eligible employer-sponsored plans and, therefore, are minimum essential coverage, unless the coverage consists solely of excepted benefits. See Code § 5000A (f)(2) and Treas. Reg. §1.5000A-2, 78 Fed. Reg. 53646, 53658 (August 30, 2013).

Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan and that an employee may use to pay premiums are counted for purposes of determining affordability of an eligible employer-sponsored plan under Code § 36B. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)). Amounts newly made available for the current plan year under an HRA that is integrated with an eligible employer-sponsored plan are counted toward the plan's minimum value percentage for that plan year if the amounts may be used only to reduce cost-sharing for covered medical expenses and the amount counted for this purpose is the amount of expected spending for health care costs in a benefit year. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). See Q&A 11 of this notice for more explanation of the application of these rules to HRAs and other arrangements.

## **III. GUIDANCE**

**A. Guidance on HRAs and Certain other Employer Healthcare Arrangements, Health FSAs, and Employee Assistance Programs or EAPs Under the Joint Jurisdiction of the Departments**

**1. Application of the Market Reform Provisions to HRAs and Certain other Employer Healthcare Arrangements**

**Question 1:** The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply with the annual dollar limit prohibition. May other types of group health plans used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the annual dollar limit prohibition?

**Answer 1:** No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the annual dollar limit prohibition.

For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However the employer payment plan will fail to comply with the annual dollar limit prohibition because (1) an employer payment plan is considered to impose an annual limit up to the cost of the individual market coverage purchased through the arrangement, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

**Question 2:** How do the preventive services requirements apply to an HRA that is integrated with a group health plan?

**Answer 2:** Similar to the analysis of the annual dollar limit prohibition, an HRA that is integrated with a group health plan will comply with the preventive services requirements if the group health plan with which the HRA is integrated complies with the preventive services requirements.

**Question 3:** The HRA FAQs provide that an employer-sponsored HRA cannot be integrated with individual market coverage, and, therefore, an HRA used to purchase coverage on the individual market will fail to comply with the annual dollar limit prohibition. May a group health plan, including an HRA, used to purchase coverage on the individual market be integrated with that individual market coverage for purposes of the preventive services requirements?

**Answer 3:** No. A group health plan, including an HRA, used to purchase coverage on the individual market is not integrated with that individual market coverage for purposes of the preventive services requirements.

For example, a group health plan, such as an employer payment plan, that reimburses employees for an employee's substantiated individual insurance policy premiums must satisfy the market reforms for group health plans. However, the employer payment plan will fail to comply with the preventive services requirements because (1) an employer

payment plan does not provide preventive services without cost-sharing in all instances, and (2) an employer payment plan cannot be integrated with any individual health insurance policy purchased under the arrangement.

**Question 4:** Under what circumstances will an HRA be integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements?

**Answer 4:** An HRA will be integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if it meets the requirements under either of the integration methods described below. Pursuant to this notice, under both methods, integration does not require that the HRA and the coverage with which it is integrated share the same plan sponsor, the same plan document or governing instruments, or file a single Form 5500, if applicable.

### **Integration Method: Minimum Value Not Required**

An HRA is integrated with another group health plan for purposes of the annual dollar limit prohibition and the preventive services requirements if (1) the employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits; (2) the employee receiving the HRA is actually enrolled in a group health plan (other than the HRA) that does not consist solely of excepted benefits, regardless of whether the employer sponsors the plan (non-HRA group coverage); (3) the HRA is available only to employees who are enrolled in non-HRA group coverage, regardless of whether the employer sponsors the non-HRA group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA group coverage, such as a plan maintained by the employer of the employee's spouse); (4) the HRA is limited to reimbursement of one or more of the following—co-payments, co-insurance, deductibles, and premiums under the non-HRA group coverage, as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits; and (5) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA. This opt-out feature is required because the benefits provided by the HRA generally will constitute minimum essential coverage under Code § 5000A (see Q&A 10 of this notice) and will therefore preclude the individual from claiming a Code § 36B premium tax credit.

### **Integration Method: Minimum Value Required**

Alternatively, an HRA that is not limited with respect to reimbursements as required under the integration method expressed above is integrated with a group health plan for purposes of the annual dollar limit prohibition and the preventive services

requirements if (1) the employer offers a group health plan to the employee that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii); (2) the employee receiving the HRA is actually enrolled in a group health plan that provides minimum value pursuant to Code § 36B(c)(2)(C)(ii), regardless of whether the employer sponsors the plan (non-HRA MV group coverage); (3) the HRA is available only to employees who are actually enrolled in non-HRA MV group coverage, regardless of whether the employer sponsors the non-HRA MV group coverage (for example, the HRA may be offered only to employees who do not enroll in the employer's group health plan but are enrolled in other non-HRA MV group coverage, such as a plan maintained by an employer of the employee's spouse); and (4) under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

### **Example (Integration Method: Minimum Value Not Required)**

Facts. Employer A sponsors a group health plan and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA group coverage through a family member. Employer A's HRA is limited to reimbursement of co-payments, co-insurance, deductibles, and premiums under Employer A's group health plan or other non-HRA group coverage (as applicable), as well as medical care (as defined under Code § 213(d)) that does not constitute essential health benefits. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA group coverage. When seeking reimbursement under Employer A's HRA, Employee X attests that the expense for which he seeks reimbursement is a co-payment, co-insurance, deductible, or premium under Employer B's non-HRA group coverage or medical care (as defined under Code § 213(d)) that is not an essential health benefit.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

### **Example (Integration Method: Minimum Value Required)**

Facts. Employer A sponsors a group health plan that provides minimum value and an HRA for its employees. Employer A's HRA is available only to employees who are either enrolled in its group health plan or in non-HRA MV group coverage through a family member. Under the terms of Employer A's HRA, an employee is permitted to permanently opt out of and waive future reimbursements from the HRA both upon

termination of employment and at least annually.

Employer A employs Employee X. Employee X chooses to enroll in non-HRA MV group coverage sponsored by Employer B, the employer of Employee X's spouse, instead of enrolling in Employer A's group health plan. Employer A and Employer B are not treated as a single employer under Code § 414(b), (c), (m), or (o). Employee X attests to Employer A that he is covered by Employer B's non-HRA MV group coverage and that the coverage provides minimum value.

Conclusion. Employer A's HRA is integrated with Employer B's non-HRA MV group coverage for purposes of the annual dollar limit prohibition and the preventive services requirements.

**Question 5:** May an employee who is covered by both an HRA and a group health plan with which the HRA is integrated, and who then ceases to be covered under the group health plan that is integrated with the HRA, be permitted to use the amounts remaining in the HRA?

**Answer 5:** Whether or not an HRA is integrated with other group health plan coverage, unused amounts that were credited to an HRA while the HRA was integrated with other group health plan coverage may be used to reimburse medical expenses in accordance with the terms of the HRA after an employee ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms. Note that coverage provided through an HRA, other than coverage consisting solely of excepted benefits, is an eligible employer-sponsored plan and, therefore, minimum essential coverage under Code § 5000A.

**Question 6:** Does an HRA impose an annual limit in violation of the annual dollar limit prohibition if the group health plan with which an HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits (but limits the coverage to the HRA's maximum benefit)?

**Answer 6:** In general, an HRA integrated with a group health plan imposes an annual limit in violation of the annual dollar limit prohibition if the group health plan with which the HRA is integrated does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit. This situation should not arise for a group health plan funded through non-grandfathered health insurance coverage in the small group market, as small group market plans must cover all categories of essential health benefits, with the exception of pediatric dental benefits, if pediatric dental benefits are available through a stand-alone dental plan offered in accordance with 45 C.F.R. §155.1065.<sup>7</sup>

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<sup>7</sup> Small group market plans will not be considered to fail to meet qualified health plan certification standards based solely on the fact that they exclude coverage of pediatric dental benefits that are otherwise required under ACA § 1302(b)(1)(J) where a stand-alone dental plan is also available. See

However, under the integration method available for plans that provide minimum value described under Q&A 4 of this notice, if a group health plan provides minimum value under Code § 36B(c)(2)(C)(ii), an HRA integrated with that group health plan will not be treated as imposing an annual limit in violation of the annual dollar limit prohibition, even if that group health plan does not cover a category of essential health benefits and the HRA is available to cover that category of essential health benefits and limits the coverage to the HRA's maximum benefit.

## 2. Application of the Market Reforms to Certain Health FSAs

**Question 7:** How do the market reforms apply to a health FSA that does not qualify as excepted benefits?

**Answer 7:** The market reforms do not apply to a group health plan in relation to its provision of benefits that are excepted benefits. Health FSAs are group health plans but will be considered to provide only excepted benefits if the employer also makes available group health plan coverage that is not limited to excepted benefits and the health FSA is structured so that the maximum benefit payable to any participant cannot exceed two times the participant's salary reduction election for the health FSA for the year (or, if greater, cannot exceed \$500 plus the amount of the participant's salary reduction election).<sup>8</sup> See 26 C.F.R. §54.9831-1(c)(3)(v), 29 C.F.R. §2590.732(c)(3)(v), and 45 C.F.R. § 146.145(c)(3)(v). Therefore, a health FSA that is considered to provide only excepted benefits is not subject to the market reforms.

If an employer provides a health FSA that does not qualify as excepted benefits, the health FSA generally is subject to the market reforms, including the preventive services requirements. Because a health FSA that is not excepted benefits is not integrated with a group health plan, it will fail to meet the preventive services requirements.<sup>9</sup>

The Departments understand that questions have arisen as to whether HRAs that are not integrated with a group health plan may be treated as a health FSA as defined in Code § 106(c)(2). Notice 2002-45, 2002-02 CB 93, states that, assuming that the maximum amount of reimbursement which is reasonably available to a participant under an HRA is not substantially in excess of the value of coverage under the HRA, an HRA is a health FSA as defined in Code § 106(c)(2). This statement was intended to clarify the rules limiting the payment of long-term care expenses by health FSAs. The Departments are also considering whether an HRA may be treated as a health FSA for purposes of the exclusion from the annual dollar limit prohibition. In any event, the

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ACA § 1302(b)(4)(F) and Question 5, CMS QHP Dental Frequently Asked Questions, May 31, 2013, [https://www.regtap.info/uploads/library/PM\\_QHP\\_DentalFAQsV2\\_5cr\\_060313.pdf](https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf).

<sup>8</sup> An HRA is paid for solely by the employer and not provided pursuant to salary reduction election or otherwise under a Code § 125 plan. IRS Notice 2002-45, 2002-02 CB 93.

<sup>9</sup> Under the interim final rules implementing the annual dollar limit prohibition, a health FSA is not subject to the annual dollar limit prohibition, regardless of whether the health FSA is considered to provide only excepted benefits. See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45

C.F.R. §147.126(a)(2)(ii). See Q&A 8 of this notice regarding the restriction of the exemption from the annual dollar limit prohibition to a health FSA that is offered through a Code § 125 plan.

treatment of an HRA as a health FSA that is not excepted benefits would not exempt the HRA from compliance with the other market reforms, including the preventive services requirements, which the HRA would fail to meet because the HRA would not be integrated with a group health plan. This analysis applies even if an HRA reimburses only premiums.

**Question 8:** The interim final regulations regarding the annual dollar limit prohibition contain an exemption for health FSAs (as defined in Code § 106(c)(2)). See 26 C.F.R. §54.9815-2711T(a)(2)(ii), 29 C.F.R. §2590.715-2711(a)(2)(ii), and 45 C.F.R. §147.126(a)(2)(ii). Does this exemption apply to a health FSA that is not offered through a Code § 125 plan?

**Answer 8:** No. The Departments intended for this exemption from the annual dollar limit prohibition to apply only to a health FSA that is offered through a Code § 125 plan and thus subject to a separate annual limitation under Code § 125(i). There is no similar limitation on a health FSA that is not part of a Code § 125 plan, and thus no basis to imply that it is not subject to the annual dollar limit prohibition.

To clarify this issue, the Departments intend to amend the annual dollar limit prohibition regulations to conform to this Q&A 8 retroactively applicable as of September 13, 2013. As a result, a health FSA that is not offered through a Code § 125 plan is subject to the annual dollar limit prohibition and will fail to comply with the annual dollar limit prohibition.

### 3. Guidance on Employee Assistance Programs

**Question 9:** Are benefits under an employee assistance program or EAP considered to be excepted benefits?

**Answer 9:** The Departments intend to amend 26 C.F.R. §54.9831-1(c), 29 C.F.R. §2590.732(c), and 45 C.F.R. §146.145(c) to provide that benefits under an employee assistance program or EAP are considered to be excepted benefits, but only if the program does not provide significant benefits in the nature of medical care or treatment. Excepted benefits are not subject to the market reforms and are not minimum essential coverage under Code § 5000A. Until rulemaking is finalized, through at least 2014, the Departments will consider an employee assistance program or EAP to constitute excepted benefits only if the employee assistance program or EAP does not provide significant benefits in the nature of medical care or treatment. For this purpose, employers may use a reasonable, good faith interpretation of whether an employee assistance program or EAP provides significant benefits in the nature of medical care or treatment.

#### **B. Guidance Under the Sole Jurisdiction of the Treasury Department and the IRS on HRAs and Code § 125 Plans**

**Question 10:** Is an HRA that has fewer than two participants who are current employees on the first day of the plan year (for example, a retiree-only HRA) minimum essential coverage for purposes of Code §§ 5000A and 36B?

**Answer 10:** Yes. The Treasury Department and the IRS understand that some employers are considering making amounts available under standalone retiree-only HRAs to retired employees so that the employer would be able to reimburse medical expenses, including the purchase of an individual health insurance policy. For this purpose, the standalone HRA would constitute an eligible employer-sponsored plan under Code § 5000A(f)(2), and therefore the coverage would constitute minimum essential coverage under Code § 5000A, for a month in which funds are retained in the HRA (including amounts retained in the HRA during periods of time after the employer has ceased making contributions). As a result, a retiree covered by a standalone HRA for any month will not be eligible for a Code § 36B premium tax credit for that month. Note that unlike other HRAs, the market reforms generally do not apply to a retiree-only HRA and therefore would not impact an employer's choice to offer a retiree-only HRA.<sup>10</sup>

**Question 11:** How are amounts newly made available under an HRA treated for purposes of Code § 36B?

**Answer 11:** An individual is not eligible for individual coverage subsidized by the Code § 36B premium tax credit if the individual is eligible for employer-sponsored coverage that is affordable (premiums for self-only coverage do not exceed 9.5 percent of household income) and that provides minimum value (the plan's share of costs is at least 60 percent). If an employer offers an employee both a primary eligible employer-sponsored plan and an HRA that would be integrated with the primary plan if the employee enrolled in the plan, amounts newly made available for the current plan year under the HRA may be considered in determining whether the arrangement satisfies either the affordability requirement or the minimum value requirement, but not both. Amounts newly made available for the current plan year under the HRA that an employee may use only to reduce cost-sharing for covered medical expenses under the primary employer-sponsored plan count only toward the minimum value requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25916 (May 3, 2013) (proposed regulations, to be codified, in part, once final, at 26 C.F.R. §1.36B-6(c)(4), (c)(5)). Amounts newly made available for the current plan year under the HRA that an employee may use to pay premiums or to pay both premiums and cost-sharing under the primary employer-sponsored plan count only toward the affordability requirement. See Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit, 78 Fed. Reg. 25909, 25914 (May 3, 2013)

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<sup>10</sup> See the preamble to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34538, 34539 (June 17, 2010).

(proposed regulations; to be codified, in part, once final, at 26 C.F.R. §1.36B-2(c)(3)(v)(A)(5)).

Even if an HRA is integrated with a plan offered by another employer for purposes of the annual dollar limit prohibition and the preventive services requirements (see Q&A 4 of this notice), the HRA does not count toward the affordability or minimum value requirement of the plan offered by the other employer. Additionally, if an employer offers an HRA on the condition that the employee does not enroll in non-HRA coverage offered by the employer and instead enrolls in non-HRA coverage from a different source, the HRA does not count in determining whether the employer's non-HRA coverage satisfies either the affordability or minimum value requirement.

For purposes of the Code § 36B premium tax credit, the requirements of affordability and minimum value do not apply if an employee enrolls in any employer-sponsored minimum essential coverage, including coverage provided through a Code § 125 plan, an employer payment plan, a health FSA, or an HRA, but only if the coverage offered does not consist solely of excepted benefits. See 26 C.F.R. §1.36B-2(c)(3)(vii). If an employee enrolls in any employer-sponsored minimum essential coverage, the employee is ineligible for individual coverage subsidized by the Code § 36B premium tax credit.

**Question 12:** Section 125(f)(3) of the Code, effective for taxable years beginning after December 31, 2013, provides that the term “qualified benefit” does not include any QHP (as defined in ACA § 1301(a)) offered through an Exchange.<sup>11</sup> This prohibits an employer from providing a QHP offered through an Exchange as a benefit under the employer's Code § 125 plan. Some states have already established Exchanges and employers in those states may have Code § 125 plan provisions that allow employees to enroll in health coverage through the Exchange as a benefit under a Code § 125 plan. If the employer's Code § 125 plan operates on a plan year other than a calendar year, may the employer continue to provide the Exchange coverage through a Code § 125 plan after December 31, 2013?

**Answer 12:** For Code § 125 plans that as of September 13, 2013 operate on a plan year other than a calendar year, the restriction under Code § 125(f)(3) will not apply before the first plan year of the Code § 125 plan that begins after December 31, 2013. Thus, for the remainder of a plan year beginning in 2013, a QHP provided through an Exchange as a benefit under a Code § 125 plan will not result in all benefits provided under the Code § 125 plan being taxable. However, individuals may not claim a Code § 36B premium tax credit for any month in which the individual was covered by a QHP provided through an Exchange as a benefit under a Code § 125 plan.

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<sup>11</sup> This rule does not apply with respect to any employee if the employee's employer is a qualified employer (as defined in ACA § 1312(f)(2)) offering the employee the opportunity to enroll through an Exchange in a qualified health plan in a group market. See Code § 125(f)(3)(B).

#### IV. APPLICABILITY DATE AND RELIANCE PERIOD

This notice applies for plan years beginning on and after January 1, 2014, but taxpayers may apply the guidance provided in this notice for all prior periods. If legislative action by any State, local, or Indian tribal government entity is necessary to modify the terms of a pre-existing HRA, a health FSA that does not qualify as excepted benefits, an employer payment plan, or other similar arrangement, sponsored by any State, local, or Indian tribal government entity, as an employer, to avoid a failure to comply with the market reforms (including action to terminate such arrangement) and such action may only be taken by a State, local, or Indian tribal government entity legislative body, the applicability date of the portions of this notice under which such arrangement would otherwise fail to comply with the market reforms is extended to the later of (1) January 1, 2014, or (2) the first day of the first plan year following the first close of a regular legislative session of the applicable legislative body after September 13, 2013.

#### V. FOR FURTHER INFORMATION

The Departments have coordinated on the guidance and other information contained in this notice. The guidance in this notice is being issued in substantially identical form by DOL, and guidance is being issued by HHS to reflect that HHS concurs in the application of the laws under its jurisdiction as set forth in this notice. Questions concerning the information contained in this notice may be directed to the IRS at 202-927-9639, the DOL's Office of Health Plan Standards and Compliance Assistance at 202-693-8335, or HHS at 410-786-1565. Additional information for employers regarding the Affordable Care Act is available at [www.healthcare.gov](http://www.healthcare.gov), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), and at [www.business.usa.gov](http://www.business.usa.gov).

## Employer Health Care Arrangements

**Q1. What are the consequences to the employer if the employer does not establish a health insurance plan for its own employees, but reimburses those employees for premiums they pay for health insurance (either through a qualified health plan in the Marketplace or outside the Marketplace)?**

Under IRS Notice 2013-54, such arrangements are described as employer payment plans. An employer payment plan, as the term is used in this notice, generally does not include an arrangement under which an employee may have an after-tax amount applied toward health coverage or take that amount in cash compensation. As explained in Notice 2013-54, these employer payment plans are considered to be group health plans subject to the market reforms, including the prohibition on annual limits for essential health benefits and the requirement to provide certain preventive care without cost sharing. Notice 2013-54 clarifies that such arrangements cannot be integrated with individual policies to satisfy the market reforms. Consequently, such an arrangement fails to satisfy the market reforms and may be subject to a \$100/day excise tax per applicable employee (which is \$36,500 per year, per employee) under section 4980D of the Internal Revenue Code.

## **Q2. Where can I get more information?**

On Sept. 13, 2013, the IRS issued [Notice 2013-54](#), which explains how the Affordable Care Act's market reforms apply to certain types of group health plans, including health reimbursement arrangements (HRAs), health flexible spending arrangements (health FSAs) and certain other employer healthcare arrangements, including arrangements under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy.

DOL has issued a notice in substantially identical form to Notice 2013-54, [DOL Technical Release 2013-03](#), and HHS will shortly issue guidance to reflect that it concurs with Notice 2013-54. On Jan. 24, 2013, [DOL](#) and [HHS](#) issued FAQs that addressed the application of the Affordable Care Act to HRAs.

## **Affordable Care Act: Questions and Answers on Over-the-Counter Medicines and Drugs**

### **1. How are the rules changing for reimbursing the cost of over-the-counter medicines and drugs from health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs)?**

A. Section 9003 of the Affordable Care Act established a new uniform standard for medical expenses. Effective Jan. 1, 2011, distributions from health FSAs and HRAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.

### **2. How are the rules changing for distributions from health savings accounts (HSAs) and Archer Medical Savings Accounts (Archer MSAs) that are used to reimburse the cost of over-the-counter medicines and drugs?**

A. In accordance with Section 9003 of the Affordable Care Act, only prescribed medicines or drugs (including over-the-counter medicines and drugs that are prescribed) and insulin (even if purchased without a prescription) will be considered qualifying medical expenses and subject to preferred tax treatment.

### **3. When will the changes become effective?**

A. The changes are effective for purchases of over-the-counter medicines and drugs without a prescription after Dec. 31, 2010. The changes do not affect purchases of over-the-counter medicines and drugs in 2010, even if they are reimbursed after Dec. 31, 2010.

### **4. How do I prove that I have purchased an over-the-counter medicine or drug with a prescription so that I can get reimbursed from my employer's health FSA or an HRA?**

A. If your employer's health FSA or HRA reimburses these expenses, you would provide the prescription (or a copy of the prescription or another item showing that a

prescription for the item has been issued) and the customer receipt (or similar third-party documentation showing the date of the sale and the amount of the charge). For example, documentation could consist of a customer receipt issued by a pharmacy that reflects the date of sale and the amount of the charge, along with a copy of the prescription; or it could consist of a customer receipt that identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase and an Rx number.

**5. How does this change affect over-the-counter medical devices and supplies?**

A. The new rule does not apply to items for medical care that are not medicines or drugs. Thus, equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits will still qualify for reimbursement by a health FSA or HRA if purchased after Dec. 31, 2010, and a distribution from an HSA or Archer MSA for the cost of such items will still be tax-free, regardless of whether the items are purchased using a prescription.

**6. Will I need a prescription to use my health FSA, HRA, HSA or Archer MSA funds for insulin purchases after Dec. 31, 2010?**

A. No. You can continue to use your health FSA, HRA, HSA or Archer MSA funds to purchase insulin without a prescription after Dec. 31, 2010.

**7. I use health FSA funds for my co-pays and deductibles. Will I still be able to reimburse those expenses with health FSA funds after Dec. 31, 2010?**

A. Yes. Co-pays and deductibles continue to be reimbursable from a health FSA after Dec. 31, 2010. Similarly, funds from an HRA can continue to be used for these expenses and a distribution from an HSA or Archer MSA for these purposes will be tax-free.

**8. My company gives me two extra months beyond the end of the year to submit claims for health FSA expenses incurred during the year. What happens if I purchase over-the-counter medicines or drugs without a prescription in 2010 but do not submit the claim for those expenses until January 2011? Will they qualify for reimbursement?**

A. Yes. The new restriction on plan reimbursements for the cost of over-the-counter medicines or drugs without a prescription applies only to purchases that are made after 2010.

**9. My company's health FSA includes a provision for a grace period, so that if I don't spend all of the money in my health FSA by Dec. 31 in a given year, I can still use the amount left in my health FSA at the end of the year to reimburse expenses I incur during the first 2 ½ months of the following year. If I buy over-the-counter medicines or drugs without a prescription during the 2 ½ month grace period of 2011, can I still use the amount left in my health FSA at the end of 2010 to reimburse those expenses?**

A. No. The change applies to purchases made on or after Jan. 1, 2011. Thus, even if your employer's plan includes the 2 ½ month grace period provision, the cost of over-

the-counter medicines and drugs purchased without a prescription during the first 2 ½ months of 2011 will not be eligible to be reimbursed by a health FSA.

**10. If my health FSA or HRA issues a debit card that I use to pay for over-the-counter medicines or drugs, will I still be able to use the card to purchase over-the-counter medicines or drugs after Dec. 31, 2010?**

A. Generally, yes, if you have a prescription for the medicine or drug. For expenses incurred in 2010, you may continue to use an FSA or HRA debit card to purchase over-the-counter medicines or drugs (whether or not you have a prescription) at pharmacies and from mail order and web-based vendors that sell prescription drugs. Starting after Jan. 15, 2011, you may continue to use an FSA or HRA debit card to purchase over-the-counter medicines or drugs at these vendors, so long as you obtain a prescription for the medicine or drug, the prescription is presented to the pharmacist, and the medication is dispensed by the pharmacist and given an Rx number.

For further information, including guidance on purchases of over-the-counter medicines and drugs from health care providers other than pharmacies and mail order and web-based vendors (such as physicians or hospitals), see [IRS Notice 2011-5](#). For guidance on debit card purchases at “90 percent pharmacies,” see [IRS Notice 2010-59](#).

**11. The ACA removed over-the-counter medicines and drugs from the list of reimbursable qualified medical items if purchased without a prescription. If you have an HSA, Archer MSA, health FSA, or HRA, how will the change in the law affect reporting on Form W-2? Do the reimbursements for items that are not qualified medical expenses need to be included as taxable wages on employees’ Forms W-2?**

A. If you have an HSA or an Archer MSA, distributions for expenses that are not qualifying medical expenses (including over-the-counter medicines and drugs purchased without a prescription) will be included in your gross income and subject to an additional tax of 20%. The income tax and additional tax are reported on Form 8889 for an HSA distribution and on Form 8853 for an Archer MSA distribution. You complete these forms and attach them to your Form 1040 when you file your income tax return. Distributions from an HSA or an Archer MSA are not included as taxable wages and do not affect your Form W-2.

## 4 Questions and Answers on the Net Investment Income Tax

Find out if the [Net Investment Income Tax](#) applies to you.

### Basics of the Net Investment Income Tax

#### 1. What is the Net Investment Income Tax (NIIT)?

The Net Investment Income Tax is imposed by section 1411 of the Internal Revenue Code. The NIIT applies at a rate of 3.8% to certain net investment income of individuals, estates and trusts that have income above the statutory threshold amounts.

#### 2. When did the Net Investment Income Tax take effect?

The Net Investment Income Tax went into effect on Jan. 1, 2013. The NIIT affects income tax returns of individuals, estates and trusts, beginning with their first tax year beginning on (or after) Jan. 1, 2013. It does not affect income tax returns for the 2012 taxable year filed in 2013.

### Who Owes the Net Investment Income Tax

#### 3. What individuals are subject to the Net Investment Income Tax?

Individuals will owe the tax if they have Net Investment Income and also have modified adjusted gross income over the following thresholds:

Filing Status	Threshold Amount
Married filing jointly	\$250,000
Married filing separately	\$125,000
Single	\$200,000
Head of household (with qualifying person)	\$200,000
Qualifying widow(er) with dependent child	\$250,000

Taxpayers should be aware that these threshold amounts are not indexed for inflation.

If you are an individual who is exempt from Medicare taxes, you still may be subject to the Net Investment Income Tax if you have Net Investment Income and also have modified adjusted gross income over the applicable thresholds.

#### 4. What is modified adjusted gross income for purposes of the Net Investment Income Tax?

For the Net Investment Income Tax, modified adjusted gross income is adjusted gross income (Form 1040, Line 37) increased by the difference between amounts excluded from gross income under section 911(a)(1) and the amount of any deductions (taken into account in computing adjusted gross income) or exclusions disallowed under section 911(d)(6) for amounts described in section 911(a)(1). In the case of taxpayers with income from controlled foreign corporations (CFCs) and passive foreign investment companies (PFICs), they may have additional adjustments to their AGI. See section 1.1411-10(e) of the final regulations.

#### 5. What individuals are not subject to the Net Investment Income Tax?

Nonresident Aliens (NRAs) are not subject to the Net Investment Income Tax. If an NRA is married to a U.S. citizen or resident and has made, or is planning to make, an election under section 6013(g) or 6013(h) to be treated as a resident alien for purposes of filing as Married Filing Jointly, the final regulations provide these couples special rules and a corresponding section 6013(g) / (h) election for the NIIT.

A dual-resident individual, within the meaning of regulation §301.7701(b)-7(a)(1), who determines that he or she is a resident of a foreign country for tax purposes pursuant to an income tax treaty between the United States and that foreign country and claims benefits of the treaty as a nonresident of the United States is considered a NRA for purposes of the NIIT.

A dual-status individual, who is a resident of the United States for part of the year and a NRA for the other part of the year, is subject to the NIIT only with respect to the portion of the year during which the individual is a United States resident. The threshold amount (described in # 3 above) is not reduced or prorated for a dual-status resident.

#### **6. What estates and trusts are subject to the Net Investment Income Tax?**

Estates and trusts are subject to the Net Investment Income Tax if they have undistributed Net Investment Income and also have adjusted gross income over the dollar amount at which the highest tax bracket for an estate or trust begins for such taxable year under section 1(e) (for tax year 2013, this threshold amount is \$11,950). Generally, the threshold amount for the upcoming year is updated by IRS each fall in a revenue procedure. For 2014, the threshold amount is \$12,150 (See [Rev. Proc. 2013-35](#)).

There are special computational rules for certain unique types of trusts, such as Qualified Funeral Trusts, Charitable Remainder Trusts and Electing Small Business Trusts, which can be found in the final regulations (see # 20 below).

#### **7. What estates and trusts are not subject to the Net Investment Income Tax?**

The following trusts are not subject to the Net Investment Income Tax:

1. Trusts that are exempt from income taxes imposed by Subtitle A of the Internal Revenue Code (e.g., charitable trusts and qualified retirement plan trusts exempt from tax under section 501, and Charitable Remainder Trusts exempt from tax under section 664).
2. A trust or decedent's estate in which all of the unexpired interests are devoted to one or more of the purposes described in section 170(c)(2)(B).
3. Trusts that are classified as "grantor trusts" under sections 671-679.
4. Trusts that are not classified as "trusts" for federal income tax purposes (e.g., Real Estate Investment Trusts and Common Trust Funds).
5. Electing Alaska Native Settlement Trusts.
6. Perpetual Care (Cemetery) Trusts.

## What is Included in Net Investment Income

### 8. What is included in Net Investment Income?

In general, investment income includes, but is not limited to: interest, dividends, capital gains, rental and royalty income, non-qualified annuities, income from businesses involved in trading of financial instruments or commodities and businesses that are passive activities to the taxpayer (within the meaning of section 469). To calculate your Net Investment Income, your investment income is reduced by certain expenses properly allocable to the income (see #13 below).

### 9. What are some common types of income that are not Net Investment Income?

Wages, unemployment compensation; operating income from a non-passive business, Social Security Benefits, alimony, tax-exempt interest, self-employment income, Alaska Permanent Fund Dividends (see Rev. Rul. 90-56, 1990-2 CB 102) and distributions from certain Qualified Plans (those described in sections 401(a), 403(a), 403(b), 408, 408A or 457(b)).

### 10. What kinds of gains are included in Net Investment Income?

To the extent that gains are not otherwise offset by capital losses, the following gains are common examples of items taken into account in computing Net Investment Income:

1. Gains from the sale of stocks, bonds, and mutual funds.
2. Capital gain distributions from mutual funds.
3. Gain from the sale of investment real estate (including gain from the sale of a second home that is not a primary residence).
4. Gains from the sale of interests in partnerships and S corporations (to the extent the partner or shareholder was a passive owner). See section 1.1411-7 of the 2013 proposed regulations.

### 11. Does this tax apply to gain on the sale of a personal residence?

The Net Investment Income Tax does not apply to any amount of gain that is excluded from gross income for regular income tax purposes. The pre-existing statutory exclusion in section 121 exempts the first \$250,000 (\$500,000 in the case of a married couple) of gain recognized on the sale of a principal residence from gross income for regular income tax purposes and, thus, from the NIIT.

**Example 1:** A, a single filer, earns \$210,000 in wages and sells his principal residence that he has owned and resided in for the last 10 years for \$420,000. A's cost basis in the home is \$200,000. A's realized gain on the sale is \$220,000. Under section 121, A may exclude up to \$250,000 of gain on the sale. Because this gain is excluded for regular income tax purposes, it is also excluded for purposes of determining Net Investment Income. In this example, the Net Investment Income Tax does not apply to the gain from the sale of A's home.

**Example 2:** B and C, a married couple filing jointly, sell their principal residence that they have owned and resided in for the last 10 years for \$1.3 million. B and C's cost basis in the home is \$700,000. B and C's realized gain on the sale is \$600,000. The recognized gain subject to regular income taxes is \$100,000 (\$600,000 realized gain less the \$500,000 section 121 exclusion). B and C have \$125,000 of other Net Investment

Income, which brings B and C's total Net Investment Income to \$225,000. B and C's modified adjusted gross income is \$300,000 and exceeds the threshold amount of \$250,000 by \$50,000. B and C are subject to NIIT on the lesser of \$225,000 (B's Net Investment Income) or \$50,000 (the amount B and C's modified adjusted gross income exceeds the \$250,000 married filing jointly threshold). B and C owe Net Investment Income Tax of \$1,900 (\$50,000 X 3.8%).

**Example 3:** D, a single filer, earns \$45,000 in wages and sells her principal residence that she has owned and resided in for the last 10 years for \$1 million. D's cost basis in the home is \$600,000. D's realized gain on the sale is \$400,000. The recognized gain subject to regular income taxes is \$150,000 (\$400,000 realized gain less the \$250,000 section 121 exclusion), which is also Net Investment Income. D's modified adjusted gross income is \$195,000. Since D's modified adjusted gross income is below the threshold amount of \$200,000, D does not owe any Net Investment Income Tax.

**12. Does Net Investment Income include interest, dividends and capital gains of my children that I report on my Form 1040 using Form 8814?**

The amounts of Net Investment Income that are included on your Form 1040 by reason of Form 8814 are included in calculating your Net Investment Income. However, the calculation of your Net Investment Income does not include (a) amounts excluded from your Form 1040 due to the threshold amounts on Form 8814 and (b) amounts attributable to Alaska Permanent Fund Dividends.

**13. What investment expenses are deductible in computing NII?**

In order to arrive at Net Investment Income, Gross Investment Income (items described in items 7-11 above) is reduced by deductions that are properly allocable to items of Gross Investment Income. Examples of deductions, a portion of which may be properly allocable to Gross Investment Income, include investment interest expense, investment advisory and brokerage fees, expenses related to rental and royalty income, tax preparation fees, fiduciary expenses (in the case of an estate or trust) and state and local income taxes.

**14. Will I have to pay both the 3.8% Net Investment Income Tax and the additional .9% Medicare tax?**

You may be subject to both taxes, but not on the same type of income.

The 0.9% Additional Medicare Tax applies to individuals' wages, compensation and self-employment income over certain thresholds, but it does not apply to income items included in Net Investment Income. See more information on the [Additional Medicare Tax](#).

**How the Net Investment Income Tax is Reported and Paid**

**15. If I am subject to the Net Investment Income Tax, how will I report and pay the tax?**

Individuals, estates, and trusts will use [Form 8960](#) and [instructions](#) to compute their Net Investment Income Tax.

For individuals, the tax will be reported on, and paid with, the Form 1040. For estates and trusts, the tax will be reported on, and paid with, the Form 1041.

**16. Is the Net Investment Income Tax subject to the estimated tax provisions?**

The Net Investment Income Tax is subject to the estimated tax provisions. Individuals, estates and trusts that expect to be subject to the tax in 2013 or thereafter should adjust their income tax withholding or estimated payments to account for the tax increase in order to avoid underpayment penalties. For more information on tax withholding and estimated tax, see Publication 505, Tax withholding and Estimated Tax.

**17. Can tax credits reduce my NIIT liability?**

Any federal income tax credit that may be used to offset a tax liability imposed by subtitle A of the Code may be used to offset the NII. However, if the tax credit is allowed only against the tax imposed by chapter 1 of the Code (regular income tax), those credits may not reduce the NIIT. For example, foreign income tax credits (sections 27(a) and 901(a)) and the general business credit (section 38) are allowed as credits only against the tax imposed by chapter 1 of the Code, and therefore may not be used to reduce your NIIT liability. If you take foreign income taxes as an income tax deduction (versus a tax credit), some (or all) of the deduction amount may deducted against NII.

**18. Does the tax have to be withheld from wages?**

No, but you may request that additional income tax be withheld from your wages.

**Examples of the Calculation of the Net Investment Income Tax**

**19. Single taxpayer with income less than the statutory threshold.**

Taxpayer, a single filer, has wages of \$180,000 and \$15,000 of dividends and capital gains. Taxpayer's modified adjusted gross income is \$195,000, which is less than the \$200,000 statutory threshold. Taxpayer is not subject to the Net Investment Income Tax.

**20. Single taxpayer with income greater than the statutory threshold.**

Taxpayer, a single filer, has \$180,000 of wages. Taxpayer also received \$90,000 from a passive partnership interest, which is considered Net Investment Income. Taxpayer's modified adjusted gross income is \$270,000.

Taxpayer's modified adjusted gross income exceeds the threshold of \$200,000 for single taxpayers by \$70,000. Taxpayer's Net Investment Income is \$90,000.

The Net Investment Income Tax is based on the lesser of \$70,000 (the amount that Taxpayer's modified adjusted gross income exceeds the \$200,000 threshold) or \$90,000 (Taxpayer's Net Investment Income). Taxpayer owes NIIT of \$2,660 (\$70,000 x 3.8%).

## Additional Information

### 21. Other than these FAQs, is there additional information available about the Net Investment Income Tax?

Yes. You can find additional information about the NIIT in the 2013 [final regulations](#) and in a new 2013 [proposed regulation](#) published on Dec. 2, 2013.

### 22. The proposed regulations that were published on Dec. 5, 2012, are effective for tax years beginning after Dec. 31, 2013, but the Net Investment Income Tax went into effect on Jan. 1, 2013. May I rely on those proposed regulations, the proposed regulations published on Dec. 2, 2013, and/or the final regulations, also published on Dec. 2, 2013, for guidance on the Net Investment Income Tax during 2013?

Yes. For taxable years beginning before Jan. 1, 2014 (e.g., calendar year 2013), taxpayers may rely on the 2012 proposed regulations (published on Dec. 5, 2012), the 2013 proposed regulations (published on Dec. 2, 2013), or the 2013 final regulations (published on Dec. 2, 2013) for purposes of completing Form 8960. However, to the extent that taxpayers take a position in a taxable year beginning before Jan. 1, 2014 that is inconsistent with the final regulations, and such position affects the treatment of one or more items in a taxable year beginning after Dec. 31, 2013, then such taxpayer must make reasonable adjustments to ensure that their Net Investment Income Tax liability in the taxable years beginning after Dec. 31, 2013 is not inappropriately distorted. For example, reasonable adjustments may be required to ensure that no item of income or deduction is taken into account in computing net investment income more than once, and that carry-forwards, basis adjustments and other similar items are adjusted appropriately.

**Related Item:** [Forms and Publications](#)

## Find out if Additional Medicare Tax applies to you

As of January 1, 2013, you're liable for a 0.9 percent Additional Medicare Tax on your wages, Railroad Retirement Tax Act compensation, and self-employment income — combined with your spouse's wages, RRTA compensation, and self-employment income if filing a joint return — that exceed the threshold amount for your filing status:

Filing Status	Threshold Amount
Married filing jointly	\$250,000
Married filing separately	\$125,000
Single	\$200,000
Head of household (with qualifying person)	\$200,000
Qualifying widow(er) with child	\$200,000

Filing Status	Threshold Amount
Married filing jointly	\$250,000
Married filing separately	\$125,000
Single	\$200,000
Head of household (with qualifying person)	\$200,000
Qualifying widow(er) with child	\$200,000

You must combine wages and self-employment income to determine if your income exceeds the threshold amount based on your filing status. A self-employment loss should not be considered for purposes of this tax. RRTA compensation should be separately compared to the threshold.

Your employer has a responsibility to withhold Additional Medicare Tax on wages it pays to you in excess of \$200,000 in a calendar year, without regard to your filing status, wages paid to you by another employer, or income that you may have from other sources.

Your employer **does not** combine the wages for married couples to determine whether to withhold Additional Medicare Tax. If you also have self-employment income, your employer **does not** consider that income – or that of your spouse - in determining whether to withhold Additional Medicare Tax.

Because your employer considers only the wage it pays, you may owe more Additional Medicare Tax than your employer withholds, depending on your filing status, other wages, RRTA compensation and self-employment income.

Too little withholding or failure to pay enough quarterly estimated taxes could lead to an estimated tax penalty. If you think you will owe more than the amount of tax withheld from your paycheck, you can make up the difference by making estimated tax payments and/or by requesting additional income tax withholding using Form W-4, Employee's Withholding Allowance Certificate.

If you are liable for Additional Medicare Tax, you will calculate it on your individual income tax return using Form 8959, Additional Medicare Tax. Any Additional Medicare Tax withheld by your employer will also be reported on Form 8959 and applied against all taxes shown on your income tax return, including any Additional Medicare Tax liability.

You can find additional information on Additional Medicare Tax, including [questions and answers](#), on IRS.gov by entering “Additional Medicare Tax” in the search box. For more information about withholding and estimated tax payments, read IRS [Publication 505](#), Tax Withholding and Estimated Tax.

## Questions and Answers for the Additional Medicare Tax

On Nov. 26, 2013, the IRS issued final regulations ([TD 9645](#)) implementing the Additional Medicare Tax as added by the Affordable Care Act (ACA). The Additional Medicare Tax applies to wages, railroad retirement (RRTA) compensation, and self-employment income over certain thresholds. Employers are responsible for withholding the tax on wages and RRTA compensation in certain circumstances.

## **BASIC FAQs**

### **1. When did Additional Medicare Tax start?**

Additional Medicare Tax went into effect in 2013 and applies to wages, compensation, and self-employment income above a threshold amount received in taxable years beginning after Dec. 31, 2012.

### **2. What is the rate of Additional Medicare Tax?**

The rate is 0.9 percent.

### **3. When are individuals liable for Additional Medicare Tax?**

An individual is liable for Additional Medicare Tax if the individual's wages, compensation, or self-employment income (together with that of his or her spouse if filing a joint return) exceed the threshold amount for the individual's filing status:

<b>Filing Status</b>	<b>Threshold Amount</b>
Married filing jointly	\$250,000
Married filing separate	\$125,000
Single	\$200,000
Head of household (with qualifying person)	\$200,000
Qualifying widow(er) with dependent child	\$200,000

### **4. What wages are subject to Additional Medicare Tax?**

All wages that are currently subject to Medicare Tax are subject to Additional Medicare Tax if they are paid in excess of the applicable threshold for an individual's filing status. For more information on what wages are subject to Medicare Tax, see the chart, Special Rules for Various Types of Services and Payments, in section 15 of Publication 15, (Circular E), Employer's Tax Guide.

### **5. What Railroad Retirement Tax Act (RRTA) compensation is subject to Additional Medicare Tax?**

All RRTA compensation that is currently subject to Medicare Tax is subject to Additional Medicare Tax if it is paid in excess of the applicable threshold for an individual's filing status. All FAQs that discuss the application of the Additional Medicare Tax to wages also apply to RRTA compensation, unless otherwise indicated.

### **6. Are nonresident aliens and U.S. citizens living abroad subject to Additional Medicare Tax?**

There are no special rules for nonresident aliens and U.S. citizens living abroad for purposes of this provision. Wages, other compensation, and self-employment income that are subject to Medicare tax will also be subject to Additional Medicare Tax if in excess of the applicable threshold.

### **7. Will I also owe net investment income tax on my income that is subject to Additional Medicare Tax?**

No. The tax imposed by section 1411 on an individual's net investment income is not applicable to wages, RRTA compensation, or self-employment income. Thus, an individual will not owe net investment income tax on these categories of income,

regardless of the taxpayer's filing status. See more information on the [Net Investment Income Tax](#).

## INDIVIDUAL FAQs

### Wages, RRTA Compensation, and Self-Employment Income

**8. Will an individual owe Additional Medicare Tax on all wages, RRTA compensation and self-employment income or just the wages, RRTA compensation and self-employment income in excess of the threshold for the individual's filing status?**

An individual will owe Additional Medicare Tax on wages, compensation and self-employment income (and that of the individual's spouse if married filing jointly) that exceed the applicable threshold for the individual's filing status. Medicare wages and self-employment income are combined to determine if income exceeds the threshold. A self-employment loss is not considered for purposes of this tax. RRTA compensation is separately compared to the threshold.

**9. Are wages that are not paid in cash, such as fringe benefits, subject to Additional Medicare Tax?**

Yes. The value of taxable wages not paid in cash, such as noncash fringe benefits, are subject to Additional Medicare Tax, if, in combination with other wages, they exceed the individual's applicable threshold. Noncash wages are subject to Additional Medicare Tax withholding, if, in combination with other wages paid by the employer, they exceed the \$200,000 withholding threshold.

**10. Are tips subject to Additional Medicare Tax?**

Yes. Tips are subject to Additional Medicare Tax, if, in combination with other wages, they exceed the individual's applicable threshold. Tips are subject to Additional Medicare Tax withholding, if, in combination with other wages paid by the employer, they exceed the \$200,000 withholding threshold.

### Withholding and Estimated Tax Payments

(See [Publication 505](#), Tax Withholding and Estimated Tax, for more information)

**11. Will Additional Medicare Tax be withheld from an individual's wages?**

An employer must withhold Additional Medicare Tax from wages it pays to an individual in excess of \$200,000 in a calendar year, without regard to the individual's filing status or wages paid by another employer. An individual may owe more than the amount withheld by the employer, depending on the individual's filing status, wages, compensation, and self-employment income. In that case, the individual should make estimated tax payments and/or request additional income tax withholding using Form W-4, Employee's Withholding Allowance Certificate.

**12. Will Additional Medicare Tax be withheld from an individual's compensation subject to Railroad Retirement Tax Act (RRTA) taxes?**

An employer must withhold Additional Medicare Tax from RRTA compensation it pays to an individual in excess of \$200,000 in a calendar year without regard to the individual's filing status or compensation paid by another employer. An individual may owe more than the amount withheld by the employer, depending on the individual's

filing status, wages, compensation, and self-employment income. In that case, the individual should make estimated tax payments and/or request additional income tax withholding using Form W-4, Employee's Withholding Allowance Certificate.

**13. Can I request additional withholding specifically for Additional Medicare Tax?**

No. However, if you anticipate liability for Additional Medicare Tax, you may request that your employer withhold an additional amount of income tax withholding on Form W-4. The additional income tax withholding will be applied against your taxes shown on your individual income tax return (Form 1040), including any Additional Medicare Tax liability.

**14. If my employer withholds Additional Medicare Tax from my wages in excess of \$200,000, but I won't owe the tax because my spouse and I file a joint return and we won't meet the \$250,000 threshold for joint filers, can I ask my employer to stop withholding Additional Medicare Tax?**

No. Your employer must withhold Additional Medicare Tax on wages it pays to you in excess of \$200,000 in a calendar year. Your employer cannot honor a request to cease withholding Additional Medicare Tax if it is required to withhold it. You will claim credit for any withheld Additional Medicare Tax against the total tax liability shown on your individual income tax return (Form 1040).

**15. What should I do if I have two jobs and neither employer withholds Additional Medicare Tax, but the sum of my wages exceeds the threshold at which I will owe the tax?**

If you anticipate that you will owe Additional Medicare Tax but will not satisfy the liability through Additional Medicare Tax withholding (for example, because you will not be paid wages in excess of \$200,000 in a calendar year by an employer), you should make estimated tax payments and/or request additional income tax withholding using Form W-4.

**16. Will I need to make estimated tax payments for Additional Medicare Tax?**

If you anticipate that you will owe Additional Medicare Tax but will not satisfy the liability through Additional Medicare Tax withholding and did not request additional income tax withholding using Form W-4, you may need to make estimated tax payments. You should consider your estimated total tax liability in light of your wages, other compensation, and self-employment income, and the applicable threshold for your filing status when determining whether estimated tax payments are necessary.

**17. Does an individual who makes estimated tax payments to pay an expected liability for Additional Medicare Tax need to identify the payments as specifically for this tax?**

No. An individual cannot designate any estimated payments specifically for Additional Medicare Tax. Any estimated tax payments that an individual makes will apply to any and all tax liabilities on the individual income tax return (Form 1040), including any Additional Medicare Tax liability.

**Calculating Additional Medicare Tax**

**18. Will individuals calculate Additional Medicare Tax liability on their income tax returns?**

Yes. Individuals will calculate Additional Medicare Tax liability on their individual income tax returns (Form 1040), using Form 8959, Additional Medicare Tax. Individuals will also report Additional Medicare Tax withheld by their employers on their individual income tax returns. Any Additional Medicare Tax withheld by an employer will be applied against all taxes shown on an individual's income tax return, including any Additional Medicare Tax liability.

**19. How do individuals calculate Additional Medicare Tax if they have wages subject to Federal Insurance Contributions Act (FICA) tax and self-employment income subject to Self-Employment Contributions Act (SECA) tax?**

Individuals with wages subject to FICA tax and self-employment income subject to SECA tax calculate their liabilities for Additional Medicare Tax in three steps:

Step 1. Calculate Additional Medicare Tax on any wages in excess of the applicable threshold for the filing status, without regard to whether any tax was withheld.

Step 2. Reduce the applicable threshold for the filing status by the total amount of Medicare wages received, but not below zero.

Step 3. Calculate Additional Medicare Tax on any self-employment income in excess of the reduced threshold.

**Example 1.** C, a single filer, has \$130,000 in wages and \$145,000 in self-employment income.

1. C's wages are not in excess of the \$200,000 threshold for single filers, so C is not liable for Additional Medicare Tax on these wages.
2. Before calculating the Additional Medicare Tax on self-employment income, the \$200,000 threshold for single filers is reduced by C's \$130,000 in wages, resulting in a reduced self-employment income threshold of \$70,000.
3. C is liable to pay Additional Medicare Tax on \$75,000 of self-employment income (\$145,000 in self-employment income minus the reduced threshold of \$70,000).

**Example 2.** D and E are married and file jointly. D has \$150,000 in wages and E has \$175,000 in self-employment income.

1. D's wages are not in excess of the \$250,000 threshold for joint filers, so D and E are not liable for Additional Medicare Tax on D's wages.
2. Before calculating the Additional Medicare Tax on E's self-employment income, the \$250,000 threshold for joint filers is reduced by D's \$150,000 in wages resulting in a reduced self-employment income threshold of \$100,000.
3. D and E are liable to pay Additional Medicare Tax on \$75,000 of self-employment income (\$175,000 in self-employment income minus the reduced threshold of \$100,000).

**Example 3.** F, who is married filing separate, has \$175,000 in wages and \$50,000 in self-employment income.

1. F is liable to pay Additional Medicare Tax on \$50,000 of his wages (\$175,000 minus the \$125,000 threshold for married persons who file separate).
2. Before calculating the Additional Medicare Tax on self-employment income, the \$125,000 threshold for married persons who file separate is reduced by F's \$175,000 in wages to \$0 (reduced, but not below zero).

3. F is liable to pay Additional Medicare Tax on \$50,000 of self-employment income (\$50,000 in self-employment income minus the reduced threshold of \$0).
4. In total, F is liable to pay Additional Medicare Tax on \$100,000 (\$50,000 of his wages and \$50,000 of his self-employment income).

**Example 4.** G, a head of household filer, has \$225,000 in wages and \$50,000 in self-employment income. G's employer withheld Additional Medicare Tax on \$25,000 (\$225,000 minus the \$200,000 withholding threshold).

1. G is liable to pay Additional Medicare Tax on \$25,000 of her wages (\$225,000 minus the \$200,000 threshold for head of household filers).
2. Before calculating the Additional Medicare Tax on self-employment income, the \$200,000 threshold for head of household filers is reduced by G's \$225,000 in wages to \$0 (reduced, but not below zero).
3. G is liable to pay Additional Medicare Tax on \$50,000 of self-employment income (\$50,000 in self-employment income minus the reduced threshold of \$0).
4. In total, G is liable to pay Additional Medicare Tax on \$75,000 (\$25,000 of her wages and \$50,000 of her self-employment income).
5. The Additional Medicare Tax withheld by G's employer will be applied against all taxes shown on her individual income tax return, including any Additional Medicare Tax liability.

**20. How do individuals calculate Additional Medicare Tax if they have compensation subject to RRTA taxes and wages subject to FICA tax?**

Compensation subject to RRTA taxes and wages subject to FICA tax are not combined to determine Additional Medicare Tax liability. The threshold applicable to an individual's filing status is applied separately to each of these categories of income.

**Example.** J and K, are married and file jointly. J has \$190,000 in wages subject to Medicare tax and K has \$150,000 in compensation subject to RRTA taxes. J and K do not combine their wages and RRTA compensation to determine whether they are in excess of the \$250,000 threshold for a joint return. J and K are not liable to pay Additional Medicare Tax because J's wages are not in excess of the \$250,000 threshold and K's RRTA compensation is not in excess of the \$250,000 threshold.

**21. How do individuals calculate Additional Medicare Tax if they have compensation subject to RRTA taxes and self-employment income subject to SECA tax?**

The threshold applicable to an individual's filing status is applied separately to RRTA compensation and self-employment income. In calculating Additional Medicare Tax on self-employment income, an individual does not reduce the applicable threshold for the taxpayer's filing status by the total amount of RRTA compensation.

**Example.** F and G are married and file jointly. F has \$160,000 in self-employment income and G has \$140,000 in compensation subject to RRTA taxes. The \$140,000 of RRTA compensation does not reduce the threshold at which Additional Medicare Tax applies to self-employment income. F and G are not liable to pay Additional Medicare Tax because F's self-employment income is not in excess of the \$250,000 threshold and G's RRTA compensation is not in excess of the \$250,000 threshold.

**Community Property**

**22. How does a married filing separate spouse in a community property state calculate Additional Medicare Tax on wages subject to FICA tax and self-employment income**

## subject to SECA tax?

Individuals who are married filing separate spouses in a community property state will calculate their Additional Medicare Tax liability, using the married filing separate threshold amount of \$125,000, without regard to the income tax treatment of the community property income:

- Each spouse will calculate Additional Medicare Tax based on his or her own wages.
- Only the spouse carrying on the trade or business generating the self-employment income will calculate Additional Medicare Tax on the self-employment income because the self-employment tax rules contain a provision that overrides community income treatment (section 1402(a)(5) of the Internal Revenue Code).

**Example:** A and B live in a community property state and are married filing separate. A has \$200,000 in wages and B has \$100,000 in self-employment income. A is liable for Additional Medicare Tax on \$75,000, the amount by which A's wages exceed the \$125,000 threshold for married filing separate. B's self-employment income of \$100,000 does not exceed the \$125,000 threshold, so B does not owe Additional Medicare Tax.

### **23. How do married filing separate spouses living in a community property state determine their credit for Additional Medicare Tax withheld on wages, their credit for income tax withholding or their credit for estimated tax payments?**

The credit for any Additional Medicare Tax withheld on wages applies only to the wage earner. However, in community property states, half of any income tax withholding on one spouse's wages will be credited to the other spouse. By contrast, each spouse can take full credit for the estimated tax payments that he or she made. However, if married filing separate spouses made joint estimated tax payments, either spouse can claim all of the estimated tax paid, or they may agree to divide it between them. If they cannot agree on how to divide it, each spouse may claim credit for the portion of the estimated tax payments that equals the total estimated tax paid times the tax shown on the spouse's separate return, divided by the combined total of the tax shown on both spouses' returns.

As a result, an individual living in a community property state who is a married filing separate spouse and who anticipates Additional Medicare Tax liability should be aware that the credit for any additional income tax withholding will be split between both spouses but that estimated tax payments can be fully claimed by the spouse who made them or, if made jointly, divided between them as agreed or in proportion to their tax liability.

**Example.** C and D are married filing separate spouses living in a community property state. C has \$150,000 in self-employment income and D has \$240,000 in wages. C is liable for Additional Medicare Tax on \$25,000 of self-employment income, the amount by which C's self-employment income exceeds the \$125,000 threshold for married filing separate. D is liable for Additional Medicare Tax on \$115,000 of wages, the amount by which D's wages exceed the \$125,000 married filing separate threshold. D's employer will only withhold Additional Medicare Tax on the amount of D's wages that exceed \$200,000, in this case \$40,000. D must pay the remaining Additional Medicare Tax liability on \$75,000 through increased income tax withholding, estimated tax payments, or payment with D's income tax return. If D requests additional federal income tax

withholding, half of this additional withholding must be credited to C. However, if D makes estimated tax payments, these payments will be credited entirely to D. If C and D make joint estimated tax payments, these payments may be divided between them as agreed or in proportion to their tax liability.

#### **Reporting Additional Medicare Tax**

#### **24. How do I report Additional Medicare Tax when I file my tax return?**

You will report Additional Medicare Tax on Form 8959, Additional Medicare Tax, and attach Form 8959 to your income tax return.

#### **25. Who is required to file Form 8959, Additional Medicare Tax?**

If you are liable for Additional Medicare Tax and/or your employer withheld Additional Medicare Tax from your wages or compensation, you must file Form 8959.

If your Medicare wages and tips on all Forms W-2, Wage & Tax Statement, plus self-employment income - combined with your spouse's Medicare wages and tips and self-employment income if you're filing a joint return - are more than the threshold amount for your filing status on the chart in FAQ #3, you are liable for Additional Medicare Tax on the amount that exceeds the threshold. You must file Form 8959.

Also, if your RRTA compensation on all Forms W-2 - combined with your spouse's RRTA compensation if you're filing a joint return (but NOT combined with any Medicare wages and tips or self-employment income) - is more than the threshold amount for your filing status on the chart in FAQ #3, you are liable for Additional Medicare Tax on the amount that exceeds the threshold. You must file Form 8959.

#### **26. My wages and self-employment income or my RRTA compensation exceed the threshold for my filing status, but my employer already withheld 0.9% from my wages. Do I have to file Form 8959?**

Yes. If you have met the threshold for Additional Medicare Tax based on your filing status, wages, compensation, and self-employment income, it is possible that you will owe more or less Additional Medicare Tax than the amount that was withheld by your employer. Therefore, even if your employer withheld the 0.9% Additional Medicare Tax from your wages or compensation above the \$200,000 withholding threshold, you must file Form 8959, Additional Medicare Tax, to ensure that you are reporting and paying the correct amount.

#### **27. My wages and self-employment income or my RRTA compensation do NOT exceed the threshold for my filing status, but my employer withheld 0.9 percent from my wages; do I need to file Form 8959?**

Yes. If your employer withheld the 0.9% Additional Medicare Tax from your wages or compensation, and you will not meet the threshold based on your filing status, then the amount that was withheld from your wages or compensation may be refundable to you. Therefore, you need to file Form 8959, Additional Medicare Tax, to document the withholding and to receive a refund of any tax that was withheld in excess of the total tax owed on your individual income tax return.

**28. If I performed services for a business and believe my pay from the business was not for services as an independent contractor, and the business did not withhold my share of Social Security, Medicare and Additional Medicare Tax, how do I report this uncollected Social Security, Medicare tax and Additional Medicare Tax?**

You must file Form 8919, Uncollected Social Security and Medicare Tax on Wages, to report your wages and compute any Social Security and Medicare taxes due. You must also file Form 8959, Additional Medicare Tax, to compute any Additional Medicare Tax due. Attach Forms 8919 and 8959 to your income tax return (Form 1040).

**29. If I received tip income that I did not report to my employer, how do I report Social Security, Medicare and Additional Medicare Tax on these unreported tips?**

You must file Form 4137, Social Security and Medicare Tax on Unreported Tip Income, to report unreported tips and compute any Social Security and Medicare taxes due. You must also file Form 8959, Additional Medicare Tax, to compute any Additional Medicare Tax due. Attach Forms 4137 and 8959 to your income tax return (Form 1040).

#### Wage Repayments

**30. How does an individual claim a refund of Additional Medicare Tax on a repayment to an employer of wage payments received in a prior year?**

In the case of a repayment of wages received by an individual in a year for which he or she has filed Form 1040, the individual should make a claim for refund for the Additional Medicare Tax paid using Form 1040X, Amended U.S. Individual Income Tax. See the Instructions for Form 1040X.

### **EMPLOYER and PAYROLL SERVICE PROVIDER FAQs**

#### Withholding

**31. When must an employer withhold Additional Medicare Tax?**

Effective Jan. 1, 2013, an employer must withhold Additional Medicare Tax on wages it pays to an employee in excess of \$200,000 in a calendar year. An employer has this withholding obligation even though an employee may not be liable for Additional Medicare Tax because, for example, the employee's wages together with that of his or her spouse do not exceed the \$250,000 threshold for joint return filers. Any withheld Additional Medicare Tax will be credited against the total tax liability shown on the individual's income tax return (Form 1040).

**32. Is an employer liable for Additional Medicare Tax even if it does not withhold it from an employee's wages?**

An employer that does not deduct and withhold Additional Medicare Tax as required is liable for the tax unless the tax that it failed to withhold from the employee's wages is paid by the employee. An employer is not relieved of its liability for payment of any Additional Medicare Tax required to be withheld unless it can show that the tax has been paid by filing Forms 4669 and 4670. Even if not liable for the tax, an employer that does not meet its withholding, deposit, reporting, and payment responsibilities for Additional Medicare Tax may be subject to all applicable penalties.

**33. Is an employer required to notify an employee when it begins withholding Additional Medicare Tax?**

No. There is no requirement that an employer notify its employee.

**34. Is there an “employer match” for Additional Medicare Tax (as there is with the regular Medicare tax)?**

No. There is no employer match for Additional Medicare Tax.

**35. May an employee request additional withholding specifically for Additional Medicare Tax?**

No. However, an employee who anticipates liability for Additional Medicare Tax may request that his or her employer withhold an additional amount of income tax withholding on Form W-4. This additional income tax withholding will be applied against all taxes shown on the individual’s income tax return (Form 1040), including any Additional Medicare Tax liability.

**36. If an employee requests that I stop withholding Additional Medicare Tax from wages in excess of the \$200,000 withholding threshold, because the employee and spouse file a joint return and won't meet the \$250,000 threshold for joint filers, should I stop withholding Additional Medicare Tax?**

No. As an employer, you must withhold Additional Medicare Tax on wages you pay to your employee in excess of the \$200,000 withholding threshold in a calendar year. You cannot honor a request to cease withholding Additional Medicare Tax because you are required to withhold it. Your employee will claim credit for any withheld Additional Medicare Tax against the total tax liability shown on their individual income tax return (Form 1040).

**37. If an employee’s annual Medicare wages are expected to be over \$200,000, will an employer withhold Additional Medicare Tax from the beginning of the year or only after Medicare wages are actually paid in excess of \$200,000 year-to-date?**

An employer is required to begin withholding Additional Medicare Tax in the pay period in which it pays wages in excess of \$200,000 to an employee.

**38. If a single payment of wages to an employee exceeds the \$200,000 withholding threshold, will an employer withhold Additional Medicare Tax on the entire payment?**

No. Additional Medicare Tax withholding applies only to wages paid to an employee that are in excess of \$200,000 in a calendar year. Withholding rules for this tax are different than the income tax withholding rules for supplemental wages in excess of \$1,000,000 as explained in Publication 15, section 7.

**Example.** M received \$180,000 in wages through Nov. 30, 2013. On Dec. 1, 2013, M’s employer paid her a bonus of \$50,000. M’s employer is required to withhold Additional Medicare Tax on \$30,000 of the \$50,000 bonus and may not withhold Additional Medicare Tax on the other \$20,000. M’s employer also must withhold Additional Medicare Tax on any other wages paid in December 2013.

**39. I have two employees who are married to each other. Each earns \$150,000, so I know that their combined wages will exceed the threshold applicable to married couples that file jointly. Do I need to withhold Additional Medicare tax?**

No. An employer does not combine wages it pays to two employees to determine whether to withhold Additional Medicare Tax. An employer is required to withhold

Additional Medicare Tax only when it pays wages in excess of \$200,000 in a calendar year to an employee.

**40. What should an employer do if an employee receives wages that are not paid in cash, such as taxable fringe benefits, from which Additional Medicare Tax cannot be withheld?**

If an employee receives wages from an employer in excess of \$200,000 and the wages include taxable noncash fringe benefits, the employer calculates wages for purposes of withholding Additional Medicare Tax in the same way that it calculates wages for withholding Medicare tax. The employer is required to withhold Additional Medicare Tax on total wages, including taxable noncash fringe benefits, in excess of \$200,000. The value of taxable noncash fringe benefits must be included in wages and the employer must withhold the applicable Additional Medicare Tax and deposit the tax under the rules for employment tax withholding and deposits that apply to taxable noncash fringe benefits. Additional information on how to withhold tax on taxable noncash fringe benefits is available in Publication 15 (Circular E), section 5, and Publication 15-B, section 4.

**41. If an employee receives tips and other wages in excess of \$200,000 in the calendar year, how is Additional Medicare Tax paid on the tips?**

To the extent that tips and other wages exceed \$200,000, an employer applies the same withholding rules for Additional Medicare Tax as it does currently for Medicare tax. An employer withholds Additional Medicare Tax on the employee's reported tips from wages it pays to the employee.

If the employee does not receive enough wages for the employer to withhold all the taxes that the employee owes, including Additional Medicare Tax, the employee may give the employer money to pay the rest of the taxes. If the employee does not give the employer money to pay the taxes, then the employer makes a current period adjustment on Form 941, Employer's QUARTERLY Federal Tax Return (or the employer's applicable employment tax return), to reflect any uncollected employee social security, Medicare, or Additional Medicare Tax on reported tips. However, unlike the uncollected portion of the regular (1.45%) Medicare tax, the uncollected Additional Medicare Tax is not reported in box 12 of Form W-2 with code B.

The employee may need to make estimated tax payments to cover any shortage. More information about this process of giving an employer money for taxes is available in Publication 531, Reporting Tip Income.

**42. If a former employee receives group-term life insurance coverage in excess of \$50,000 and the cost of the coverage, in combination with other wages, exceeds \$200,000, how does an employer report Additional Medicare Tax on this?**

The imputed cost of coverage in excess of \$50,000 is subject to social security and Medicare taxes, and to the extent that, in combination with other wages, it exceeds \$200,000, it is also subject to Additional Medicare Tax withholding. However, when group-term life insurance over \$50,000 is provided to an employee (including retirees) after his or her termination, the employee share of Social Security and Medicare taxes and Additional Medicare Tax on that period of coverage is paid by the former employee

with his or her tax return and is not collected by the employer. In this case, an employer should report this income as wages on Form 941, Employer's QUARTERLY Federal Tax Return (or the employer's applicable employment tax return), and make a current period adjustment to reflect any uncollected employee social security, Medicare, or Additional Medicare Tax on group-term life insurance. However, unlike the uncollected portion of the regular (1.45%) Medicare tax, an employer may not report the uncollected Additional Medicare Tax in box 12 of Form W-2 with code N.

**43. For employees who receive third-party sick pay, will wages paid by an employer and by the third party need to be aggregated to determine whether the \$200,000 withholding threshold has been met?**

Yes. Wages paid by an employer and by the third party need to be aggregated to determine whether the \$200,000 withholding threshold has been met. The same rules that currently assign responsibility for sick pay reporting and payment of Medicare tax based on which party is treated as the employer (that is, the employer, the employer's agent, or a third party that is not the employer's agent) apply also to Additional Medicare Tax. For more information on sick pay, see Publication 15-A, Employer's Supplemental Tax Guide, and Notice 91-26, 1991-2 C.B. 619.

**44. If an employee has amounts deferred under a nonqualified deferred compensation (NQDC) plan, when is the nonqualified deferred compensation taken into account as wages for purposes of withholding Additional Medicare Tax?**

An employer calculates wages for purposes of withholding Additional Medicare Tax from nonqualified deferred compensation (NQDC) in the same way that it calculates wages for withholding the existing Medicare tax from NQDC. Thus, if an employee has amounts deferred under a nonqualified deferred compensation plan and the NQDC is taken into account as wages for FICA tax purposes under the special timing rule described in §31.3121(v)(2)-1(a)(2) of the Employment Tax Regulations, the NQDC would likewise be taken into account under the special timing rule for purposes of determining an employer's obligation to withhold Additional Medicare Tax. Additional information about the special timing rules for NQDC is in Publication 957, Reporting Back Pay and Special Wage Payments to the Social Security Administration.

**45. For a company that goes through a merger or acquisition, will the wages from the predecessor and successor employers be combined to determine whether the \$200,000 withholding threshold has been met?**

When corporate acquisitions meet certain requirements, wages paid by the predecessor are treated as if paid by the successor for purposes of applying the social security wage base and for applying the Additional Medicare Tax withholding threshold (that is, \$200,000 in a calendar year). For more information on acquisitions under the predecessor-successor rules, see [Rev. Proc. 2004-53, 2004-2 C.B. 320](#); Schedule D (Form 941), Report of Discrepancies Caused by Acquisitions, Statutory Mergers, or Consolidations; and the Instructions for Schedule D (Form 941).

**46. Should an employer combine an employee's wages for services performed for all of its subsidiaries if it has an employee who performs services for more than one subsidiary in its company, but the payroll is paid through one of the subsidiaries?**

An employer is required to withhold Additional Medicare Tax on wages paid to an employee in excess of \$200,000 in a calendar year. When an employee is performing services for multiple subsidiaries of a company, and each subsidiary is an employer of the employee with regard to the services the employee performs for that subsidiary, the wages paid by the payor on behalf of each subsidiary should be combined only if the payor is a common paymaster. Publication 15-A, section 7 contains more information on common paymasters. The wages are not combined for purposes of the \$200,000 withholding threshold if the payor is not a common paymaster.

**47. I am a common paymaster that pays wages to an employee who is concurrently employed by related corporations. Should I combine this employee's wages for purposes of determining whether wages are paid in excess of the \$200,000 withholding threshold?**

Yes. Liability to withhold Additional Medicare Tax with respect to wages disbursed by the common paymaster is computed as if there was a single employer, just as it is for application of the social security wage base. See section 7 of Publication 15-A for more information on common paymasters.

**48. If an agent pays wages to an employee on behalf of an employer (under an approved Form 2678, Employer Appointment of Agent), then, for purposes of determining whether wages are paid in excess of the \$200,000 withholding threshold, should the agent combine those wages with wages paid to that same employee: 1) directly by the employer, 2) by the same agent on behalf of a different employer, or 3) by another agent on behalf of the same employer?**

No. Wages paid by an agent with an approved Form 2678 on behalf of an employer are not combined with wages paid to the same employee by any of the above other parties in determining whether to withhold Additional Medicare Tax.

**49. I use an employee leasing company. How should wages be determined for purposes of the \$200,000 withholding threshold?**

An employer is required to withhold Additional Medicare Tax on wages paid to an employee in excess of \$200,000 in a calendar year. Generally, if you provide wages in excess of the \$200,000 withholding threshold to the employee leasing company to pay to an employee that performs services for you, Additional Medicare Tax should be withheld from the wages in excess of \$200,000. Taxpayers should be aware that the employer is ultimately responsible for the deposit and payment of federal tax liabilities. Even though you forward tax payments to a third party to make the tax deposits, you may be responsible as the employer for the tax liability.

### **Reporting Additional Medicare Tax and Correcting Errors**

**50. When an employer deposits Additional Medicare Tax through the Electronic Federal Tax Payment System (EFTPS), does it need to separate Additional Medicare Tax from regular Medicare tax?**

No. When providing the deposit detail, regular Medicare tax and Additional Medicare Tax are entered as one combined amount.

**51. How does an employer report Additional Medicare Tax on Form 941, Form 941-PR or Form 941-SS?**

Line 5d has been added to Form 941, Form 941-PR and Form 941-SS. On this line, employers report any individual's wages paid during the quarter that is in excess of the \$200,000 withholding threshold for the year as well as the withholding liability for Additional Medicare Tax on those wages.

**NOTE:** Report only wages & tips subject to Additional Medicare Tax withholding and Additional Medicare Tax on Line 5d. Report Medicare wages & tips and Medicare tax on Line 5c.

**52. How does an employer report Additional Medicare Tax on Form W-2?**

There is no change to the boxes on Form W-2. An employer will enter the total employee Medicare tax (including any Additional Medicare Tax) withheld on Medicare wages and tips in box 6 ("Medicare tax withheld"). A railroad employer will report Additional Medicare Tax in box 14.

**53. If an employer under withholds Additional Medicare Tax (for example, fails to withhold the tax when it pays the employee wages in excess of \$200,000 in a calendar year) and discovers the error in the same year the wages are paid but after its Form 941 is filed, how can the employer correct this error?**

An employer is liable for Additional Medicare Tax required to be withheld, whether or not it deducts the tax from wages it pays to the employee. If the employer fails to withhold the correct amount of Additional Medicare Tax from wages it pays to an employee and discovers the error in the same year it pays the wages, the employer may correct the error by making an interest-free adjustment on the appropriate corrected return (for example, Form 941-X). Once the employer has discovered the error, the employer should deduct the correct amount of Additional Medicare Tax from other wages or other remuneration, if any, it pays to the employee on or before the last day of the calendar year. However, even if the employer is not able to deduct the correct amount of Additional Medicare Tax from other wages or other remuneration it pays to the employee, the employer must report and pay the correct amount of Additional Medicare Tax on its return. If the employer pays Additional Medicare Tax without having deducted it from wages or other remuneration it pays to the employee, the obligation of the employee to the employer with respect to the payment is a matter for settlement between the employer and the employee. For more information on adjustments, see section 13 of Pub 15 or visit the IRS website and enter the keywords: Correcting Employment Taxes.

**54. If an employer over withholds Additional Medicare Tax (for example, withholds the tax before it pays the employee wages in excess of \$200,000 in a calendar year) and discovers the error in the same year the wages are paid, how can the employer correct this error?**

The employer may correct the error by making an interest-free adjustment on the appropriate corrected return (for example, Form 941-X). The employer must first repay or reimburse the over withheld amount to the employee prior to the end of the calendar year in which it paid the wages. If the employer does not repay or reimburse the employee the amount of over collected Additional Medicare Tax before the end of the year in which the wages were paid, the employer can not correct the error via an interest-free adjustment. In this case, the employer should report the amount of withheld Additional Medicare Tax on the employee's Form W-2 so that the employee may obtain

credit for Additional Medicare Tax withheld on the employee's individual income tax return. For more information on adjustments, see section 13 of Pub 15 or visit the IRS website and enter the keywords: Correcting Employment Taxes.

**55. If an employer over withholds Additional Medicare Tax (for example, withholds the tax before it pays the employee wages in excess of \$200,000 in a calendar year) from an employee's wages, should the employer file a claim for refund for the Additional Medicare Tax?**

No. An employer can only claim a refund of overpaid Additional Medicare Tax if it did not deduct or withhold the overpaid Additional Medicare Tax from the employee's wages. For more information on claims for refund, see section 13 of Pub 15 or visit the IRS website and enter the keywords: Correcting Employment Taxes.

**56. If an employer under withholds Additional Medicare Tax (for example, fails to withhold the tax when it pays the employee wages in excess of \$200,000 in a calendar year) and discovers the error in a subsequent year, should the employer correct this error by making an interest-free adjustment?**

No. If an employer under withholds Additional Medicare Tax and does not discover the error in the same year wages were paid, the employer can not correct the error by making an interest-free adjustment. However, to the extent the employer can show that the employee paid Additional Medicare Tax, the under withheld amount will not be collected from the employer. The employer will remain subject to any applicable penalties.

**57. If an employer over withholds Additional Medicare Tax (for example, withholds the tax before it pays the employee wages in excess of \$200,000 in a calendar year) and discovers the error in a subsequent year, should the employer correct this error by making an interest-free adjustment?**

No. If an employer withholds more than the correct amount of Additional Medicare Tax from wages paid to an employee and does not discover the error in the same year the wages were paid, the employer can not correct the error by making an interest-free adjustment. In this case, the employer should report the amount of withheld Additional Medicare Tax on the employee's Form W-2 so that the employee may obtain credit for Additional Medicare Tax withheld. Additional Medicare Tax withholding will be applied against the taxes shown on the employee's individual income tax return (Form 1040).

#### Wage Repayments

**58. How should employers treat repayment by an employee of wage payments received by the employee in a prior year for Additional Medicare Tax purposes (for example, sign on bonuses paid to employees that are subject to repayment if certain conditions are not satisfied)?**

Employers cannot make an adjustment or file a claim for refund for Additional Medicare Tax withholding when there is a repayment of wages received by an employee in a prior year because the employee determines liability for Additional Medicare Tax on the employee's income tax return for the prior year. In the case of a repayment of wages received by the employee in a year for which the employee has filed Form 1040, the employee should make a claim for refund for the Additional Medicare Tax paid using

Form 1040X, Amended U.S. Individual Income Tax Return. See the Instructions for Form 1040X.

**ADDITIONAL INFORMATION**

Please visit the [forms, instructions and publications](#) page for items listed in these FAQs.

## 5 Affordable Care Act Tax Provisions

Check out the new [Affordable Care Act Tax Provisions Home Page](#)

Información en Español: [Disposiciones de La Ley del Cuidado de Salud de Bajo Precio](#)

### *Update*

The open enrollment period to purchase health insurance coverage for 2014 through the [Health Insurance Marketplace](#) ran from Oct. 1, 2013, through March 31, 2014. If you are seeking information about how to obtain health care coverage or financial assistance to purchase health care coverage for you and your family, visit the Health and Human Services website, [HealthCare.gov](#).

### *Effect of Sequestration on Small Business Health Care Tax Credit*

Pursuant to the requirements of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended, refund payments issued to certain small tax-exempt employers claiming the refundable portion of the Small Business Health Care Tax Credit under Internal Revenue Code Section 45R, are subject to sequestration. This means that refund payments processed on or after Oct. 1, 2013, and on or before Sept. 30, 2014, to a Section 45R applicant will be reduced by the fiscal year 2014 sequestration rate of 7.2 percent, irrespective of when the original or amended tax return was received by the IRS. The sequestration reduction rate will be applied unless and until a law is enacted that cancels or otherwise impacts the sequester, at which time the sequestration reduction rate is subject to change.

Affected taxpayers will be notified through correspondence that a portion of their requested payment was subject to the sequester reduction and the amount.

### **IRC §7216, Disclosure or Use of Information by Tax Return Preparers**

Final [Treasury Regulations](#) on rules and consent requirements relating to the disclosure or use of tax return information by tax return preparers became effective Dec. 28, 2012. For additional information about how these apply to services and education related to the Affordable Care Act, please see our [questions and answers](#).

### **Medical Loss Ratio (MLR)**

Beginning in 2011, insurance companies are required to spend a specified percentage of premium dollars on medical care and quality improvement activities, meeting a medical loss ratio (MLR) standard. Insurance companies that are not meeting the MLR standard will be required to provide rebates to their consumers beginning in 2012. For information on the federal tax consequences to an insurance company that pays a MLR rebate and an individual policyholder who receives a MLR rebate, as well as information on the federal tax consequences to employees if a MLR rebate stems from a group health insurance policy, see our [frequently asked questions](#).

### **Reporting Employer Provided Health Coverage in Form W-2**

The Affordable Care Act requires employers to report the cost of coverage under an employer-sponsored group health plan on an employee's Form W-2, Wage and Tax Statement, in Box 12, using Code DD. Many employers are eligible for transition relief

for tax-year 2012 and beyond, until the IRS issues final guidance for this reporting requirement.

The amount reported does not affect tax liability, as the value of the employer excludible contribution to health coverage continues to be excludible from an employee's income, and it is not taxable. This reporting is for informational purposes only, to show employees the value of their health care benefits.

More information about the reporting can be found on [Form W-2 Reporting of Employer-Sponsored Health Coverage](#).

#### **Net Investment Income Tax**

A new Net Investment Income Tax went into effect on Jan. 1, 2013. The 3.8 percent Net Investment Income Tax applies to individuals, estates and trusts that have certain investment income above certain threshold amounts. On Nov. 26, 2013, the IRS and the Treasury Department issued [final regulations](#), which provide guidance on the general application of the Net Investment Income Tax and the computation of Net Investment Income. In addition, on Nov. 26, 2013, the IRS and the Treasury Department issued [proposed regulations](#) on the computation of net investment income as it relates to certain specific types of property. Comments may be submitted electronically, by mail or hand delivered to the IRS. For additional information on the Net Investment Income Tax, see our [questions and answers](#).

#### **Additional Medicare Tax**

A new Additional Medicare Tax went into effect on Jan. 1, 2013. The 0.9 percent Additional Medicare Tax applies to an individual's wages, Railroad Retirement Tax Act compensation and self-employment income that exceeds a threshold amount based on the individual's filing status. The threshold amounts are \$250,000 for married taxpayers who file jointly, \$125,000 for married taxpayers who file separately and \$200,000 for all other taxpayers. An employer is responsible for withholding the Additional Medicare Tax from wages or compensation it pays to an employee in excess of \$200,000 in a calendar year. On Nov. 26, 2013, the IRS and the Department of the Treasury issued [final regulations](#) which provide guidance for employers and individuals relating to the implementation of Additional Medicare Tax, including the requirement to withhold Additional Medicare Tax on certain wages and compensation, the requirement to report Additional Medicare Tax, and the employer process for adjusting underpayments and overpayments of Additional Medicare Tax. In addition, the regulations provide guidance on the employer and individual processes for filing a claim for refund for an overpayment of Additional Medicare Tax. For additional information on the Additional Medicare Tax, see our [questions and answers](#).

#### **Minimum Value**

On April 26, 2012, the Department of the Treasury and IRS issued [Notice 2012-31](#), which provides information and requested public comment on an approach to determining whether an eligible employer-sponsored health plan provides minimum value. Additionally, on April 30, 2013, the Treasury Department and the IRS issued [proposed regulations](#) relating to minimum value of eligible employer-sponsored plans and other rules regarding the premium tax credit. Starting in 2014, whether such a

plan provides minimum value will be relevant to eligibility for the premium tax credit and application of the employer shared responsibility payment.

### **Information Reporting on Health Coverage by Employers**

On March 5, 2014, the Department of the Treasury and IRS issued [final regulations](#) on employer health insurance coverage information reporting. The information reporting relates to health insurance coverage that is offered by certain employers, referred to as applicable large employers, and reporting is to be provided by each member of an applicable large employer. Additionally, on July 9, 2013, the Department of the Treasury and the IRS issued [Notice 2013-45](#), announcing transition relief for 2014 from this annual information reporting. Learn more about this reporting requirement by reading the [fact sheet](#) issued by the U.S. Department of the Treasury.

### **Information Reporting on Health Coverage by Insurers**

On March 5, 2014, the Department of the Treasury and IRS issued [final regulations](#) on minimum essential coverage information reporting. The information reporting is to be provided by health insurance issuers, certain sponsors of self-insured plans, government agencies and certain other parties that provide health coverage. Additionally, on July 9, 2013, the Department of the Treasury and the IRS issued [Notice 2013-45](#) announcing transition relief for 2014 from this annual information reporting. Learn more about this reporting requirement by reading the [fact sheet](#) issued by the U.S. Department of the Treasury.

### **Disclosure of Return Information**

On Aug. 13, 2013, the Department of the Treasury and the IRS issued [final regulations](#) with rules for disclosure of return information to the Department of Health and Human Services that will be used to carry out eligibility determinations for advance payments of the premium tax credit, Medicaid and other health insurance affordability programs. For additional information on the final regulations, see our [questions and answers](#).

### **Small Business Health Care Tax Credit**

This credit helps small businesses and small tax-exempt organizations afford the cost of covering their employees and is specifically targeted for those with low- and moderate-income workers. The credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. In general, the credit is available to small employers that pay at least half the cost of single coverage for their employees. On June 26, 2014, the Department of Treasury and the IRS issued [final regulations](#) on the credit, which include information on the requirement to purchase health insurance coverage through the Small Business Health Options Program (SHOP) Marketplace. The final regulations are applicable for taxable years beginning in or after 2014. Additionally, IRS [Notice 2014-06](#) provides transition relief for employers in certain counties in Washington and Wisconsin with no SHOP coverage available. For taxable years beginning in 2010 through 2013, taxpayers can rely on the guidance in the [proposed regulations](#), [Notice 2010-44](#) and [Notice 2010-82](#). Learn more by browsing our page on the [Small Business Health Care Tax Credit for Small Employers](#).

## **Application of the Affordable Care Act to Health Reimbursement Arrangements, Health Flexible Spending Arrangements and Certain Other Employer Healthcare Arrangements**

The Affordable Care Act's market reforms apply to group health plans. On Sept. 13, 2013, the IRS issued [Notice 2013-54](#), which explains how the Affordable Care Act's market reforms apply to certain types of group health plans, including health reimbursement arrangements (HRAs), health flexible spending arrangements (health FSAs) and certain other employer healthcare arrangements, including arrangements under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy. The notice also provides guidance on employee assistance programs or EAPs and on section 125(f)(3), which prohibits the use of pre-tax employee contributions to cafeteria plans to purchase coverage on an Affordable Insurance Exchange (also known as a [Health Insurance Marketplace](#)). The notice applies for plan years beginning on and after Jan. 1, 2014, but taxpayers may apply the guidance provided in the notice for all prior periods.

DOL has issued a notice in substantially identical form to Notice 2013-54, [DOL Technical Release 2013-03](#), and HHS will shortly issue guidance to reflect that it concurs with Notice 2013-54. On Jan. 24, 2013, [DOL](#) and [HHS](#) issued FAQs that addressed the application of the Affordable Care Act to HRAs.

On Jan. 9, 2014, [DOL](#) and [HHS](#) issued FAQs that addressed, among other things, future rules relating to excepted benefits.

### **Health Flexible Spending Arrangements**

Effective Jan. 1, 2011, the cost of an over-the-counter medicine or drug cannot be reimbursed from Flexible Spending Arrangements (FSAs) or health reimbursement arrangements unless a prescription is obtained. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles. This standard applies only to purchases made on or after Jan. 1, 2011. A similar rule went into effect on Jan. 1, 2011, for Health Savings Accounts (HSAs), and Archer Medical Savings Accounts (Archer MSAs). Employers and employees should take these changes into account as they make health benefit decisions. For more information, see news release [IR-2010-95](#), [Notice 2010-59](#), [Revenue Ruling 2010-23](#) and our [questions and answers](#). FSA and HRA participants can continue using debit cards to buy prescribed over-the-counter medicines, if requirements are met. For more information, see news release [IR-2010-128](#) and [Notice 2011-5](#). Additionally, [Notice 2013-57](#) provides information about the definition of preventive care for purposes of high deductible health plans associated with HSAs.

In addition, starting in 2013, there are new rules about the amount that can be contributed to an FSA. [Notice 2012-40](#) provides information about these rules and flexibility for employers applying the new rules. On Oct. 31, 2013, the Department of the Treasury and IRS issued [Notice 2013-71](#), which provides information on a new \$500 carryover option for employer-sponsored healthcare flexible spending arrangements.

Learn more by reading the [news release](#) issued by the U.S. Department of the Treasury.

Further, [Notice 2013-54](#) provides guidance regarding the application of the Affordable Care Act's market reforms to certain health FSAs.

### **Medical Device Excise Tax**

On Dec. 5, 2012, the IRS and the Department of the Treasury issued [final regulations](#) on the new 2.3-percent medical device excise tax (IRC §4191) that manufacturers and importers will pay on their sales of certain medical devices starting in 2013. On Dec. 5, 2012, the IRS and the Department of the Treasury also issued [Notice 2012-77](#), which provides interim guidance on certain issues related to the medical device excise tax. Additional information is available on the [Medical Device Excise Tax](#) page and [Medical Device Excise Tax FAQs](#) on IRS.gov.

### **Changes to Itemized Deduction for Medical Expenses**

Beginning Jan. 1, 2013, you can claim [deductions for medical expenses](#) not covered by your health insurance when they reach 10 percent of your adjusted gross income. This change affects your 2013 tax return that you will file in 2014. There is a temporary exemption from Jan. 1, 2013, to Dec. 31, 2016, for individuals age 65 and older and their spouses. For additional information, see our [questions and answers](#).

### **Health Insurance Premium Tax Credit**

Starting in 2014, individuals and families can take a new premium tax credit to help them afford health insurance coverage purchased through an Affordable Insurance Exchange (also known as a [Health Insurance Marketplace](#)). The premium tax credit is refundable so taxpayers who have little or no income tax liability can still benefit. The credit also can be paid in advance to a taxpayer's insurance company to help cover the cost of premiums. On May 18, 2012, the Department of the Treasury and the IRS issued [final regulations](#), which provide guidance for individuals who enroll in qualified health plans through Marketplaces and claim the premium tax credit, and for Marketplaces that make qualified health plans available to individuals and employers. On Jan. 30, 2013, the Department of the Treasury and IRS released [final regulations](#) on the premium tax credit affordability test for related individuals. On April 30, 2013, the Department of the Treasury and the IRS issued [proposed regulations](#) relating to minimum value of eligible employer-sponsored plans and other rules regarding the premium tax credit. Additionally, [Notice 2013-41](#), issued on June 26, 2013, provides information for determining whether or when individuals are considered eligible for coverage under certain Medicaid, Medicare, CHIP, TRICARE, student health or state high-risk pool programs. This determination will affect whether the individual is eligible for the premium tax credit. On May 2, 2014, the Department of the Treasury and IRS issued [final regulations](#) on the reporting requirements for Marketplaces. [Notice 2014-23](#) was issued on March 26, 2014, and allows certain victims of domestic abuse to claim the premium tax credit while filing a return using the Married Filing Separately filing status for the 2014 calendar year. For more information on the credit, see our [premium tax credit page](#) and our [questions and answers](#).

### **Individual Shared Responsibility Provision**

Starting in 2014, the Individual Shared Responsibility provision calls for each individual to either have minimum essential coverage for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return. On Aug. 27, 2013, the Department of the Treasury and the IRS issued [final regulations](#) on the Individual Shared Responsibility provision. On Jan. 23, 2014, the Department of the Treasury and the IRS issued [proposed regulations](#) addressing several issues that were identified in the preamble to the final regulations. In particular, the proposed regulations provide that certain limited-benefit Medicaid and TRICARE coverage is not minimum essential coverage. The proposed regulations also address the treatment of health reimbursement arrangements and wellness program incentives for purposes of determining the exemption for individuals who cannot afford employer-sponsored coverage. Comments are due April 28, 2014, and may be submitted electronically, by mail or hand delivered to the IRS. Additionally, because individuals may not be aware that these limited-benefit government health programs are not minimum essential coverage at the time of enrollment, [Notice 2014-10](#), issued on Jan. 23, 2014, provides transition relief from the shared responsibility payment for months in 2014 in which individuals have certain Medicaid coverage or limited-benefit coverage under chapter 55 of title 10, U.S.C. For additional information on the Individual Shared Responsibility provision, the final regulations and [Notice 2013-42](#), see our [ISRP page](#) and [questions and answers](#). Additional information on exemptions and minimum essential coverage is available in [final regulations](#) issued by the U.S. Department of Health & Human Services. The open enrollment period to purchase health insurance coverage for 2014 through the [Health Insurance Marketplace](#) runs from Oct. 1, 2013, through March 31, 2014.

### **Health Coverage for Older Children**

Health coverage for an employee's children under 27 years of age is now generally tax-free to the employee. This expanded health care tax benefit applies to various work place and retiree health plans. These changes immediately allow employers with cafeteria plans — plans that allow employees to choose from a menu of tax-free benefit options and cash or taxable benefits — to permit employees to begin making pre-tax contributions to pay for this expanded benefit. This also applies to self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return. Learn more by reading our [news release](#) or this [notice](#).

### **Excise Tax on Indoor Tanning Services**

A 10-percent excise tax on indoor UV tanning services went into effect on July 1, 2010. Payments are made along with [Form 720](#), Quarterly Federal Excise Tax Return. The tax doesn't apply to phototherapy services performed by a licensed medical professional on his or her premises. There's also an exception for certain physical fitness facilities that offer tanning as an incidental service to members without a separately identifiable fee. For more information on the tax and how it is administered, see the [Indoor Tanning Services Tax Center](#).

### **Adoption Credit**

For tax years 2010 and 2011, the Affordable Care Act raised the maximum adoption credit per child and the credit was refundable. For more information related to the adoption credit for tax years 2010 and 2011, see our [news release](#), [tax tip](#), [questions and answers](#), flyer, [Notice 2010-66](#), [Revenue Procedure 2010-31](#), [Revenue Procedure 2010-35](#) and [Revenue Procedure 2011-52](#).

For tax year 2012, the credit has reverted to being nonrefundable, with a maximum amount (dollar limitation) of \$12,650 per child. If you adopted a child in 2012, see [Tax Topic 607](#) for more information.

### **Transitional Reinsurance Program**

The ACA requires all health insurance issuers and self-insured group health plans to make contributions under the transitional Reinsurance Program to support payments to individual market issuers that cover high-cost individuals. For information on the tax treatment of contributions made under the Reinsurance Program, see our [frequently asked questions](#).

### **Medicare Shared Savings Program**

The Affordable Care Act establishes a Medicare shared savings program (MSSP) which encourages Accountable Care Organizations (ACOs) to facilitate cooperation among providers to improve the quality of care provided to Medicare beneficiaries and reduce unnecessary costs. More information can be found in [Notice 2011-20](#), which solicited written comments regarding what additional guidance, if any, is needed for tax-exempt organizations participating in the MSSP through an ACO. This guidance also addresses the participation of tax-exempt organizations in non-MSSP activities through ACOs. Additional [information on the MSSP](#) is available on the Department of Health and Human Services website.

The Centers for Medicare and Medicaid Services has released final regulations describing the rules for the Shared Savings Program and accountable care organizations. [Fact Sheet 2011-11](#) confirms that Notice 2011-20 continues to reflect IRS expectations regarding the Shared Savings Program and ACOs, and provides additional information for charitable organizations that may wish to participate.

### **Qualified Therapeutic Discovery Project Program**

This program was designed to provide tax credits and grants to small firms that show significant potential to produce new and cost-saving therapies, support U.S. jobs and increase U.S. competitiveness. Applicants were required to have their research projects certified as eligible for the credit or grant. IRS [guidance](#) describes the application process.

Submission of certification applications began June 21, 2010, and applications had to be postmarked no later than July 21, 2010, to be considered for the program. Applications that were postmarked by July 21, 2010, were reviewed by both the Department of Health and Human Services (HHS) and the IRS. All applicants were notified by letter dated October 29, 2010, advising whether or not the application for certification was approved. For those applications that were approved, the letter also

provided the amount of the grant to be awarded or the tax credit the applicant was eligible to take.

The IRS published the names of the applicants whose projects were approved as required by law. Listings of [results](#) are available by state.

Learn more by reading the [IRS news release](#), the [news release](#) issued by the U.S. Department of the Treasury, the [page](#) on the HHS website and our [questions and answers](#).

### **Group Health Plan Requirements**

The Affordable Care Act establishes a number of new requirements for group health plans. Interim guidance on changes to the nondiscrimination requirements for group health plans can be found in [Notice 2011-1](#), which provides that employers will not be subject to penalties until after additional guidance is issued. Additionally, [TD 9575](#) and [REG-140038-10](#), issued by DOL, HHS and IRS, provide information on the summary of benefits and coverage and the uniform glossary. [Notice 2012-59](#) provides guidance to group health plans on the waiting periods they may apply before coverage starts. On June 20, 2014, HHS, DOL and IRS issued [final regulations](#) on the ninety-day waiting period limitation..

More information on group health plan requirements is available on the websites of the Departments of [Health and Human Services](#) and [Labor](#) and in additional [guidance](#).

Further, [Notice 2013-54](#) provides guidance regarding the application of the Affordable Care Act's market reforms to certain types of group health plans, including health reimbursement arrangements (HRAs), health flexible spending arrangements (health FSAs) and certain other employer healthcare arrangements, including arrangements under which an employer reimburses an employee for some or all of the premium expenses incurred for an individual health insurance policy.

### **Annual Fee on Health Insurance Providers**

The Affordable Care Act created an annual fee on certain health insurance providers beginning in 2014. On Nov. 26, 2013, the Treasury Department and IRS issued [final regulations](#) on this annual fee imposed on covered entities engaged in the business of providing health insurance for United States health risks.

For additional information visit our [Affordable Care Act Provision 9010 - Health Insurance Providers Fee page](#).

### **Tax-Exempt 501(c)(29) Qualified Nonprofit Health Insurance Issuers**

The Affordable Care Act requires the Department of Health and Human Services (HHS) to establish the Consumer Operated and Oriented Plan program (CO-OP program). It also provides for tax exemption for recipients of CO-OP program grants and loans that meet additional requirements under section 501(c)(29). IRS [Notice 2011-23](#) outlined the requirements for tax exemption under section 501(c)(29) and solicited written comments regarding these requirements as well as the application process. [Revenue Procedure 2012-11](#), issued in conjunction with [temporary regulations](#) and a [notice of proposed](#)

[rulemaking](#), sets out the procedures for issuing determination letters and rulings on the exempt status of organizations applying for recognition of exemption under 501(c)(29).

An [overview of the CO-OP program](#) is available on the HHS website.

### **Medicare Part D Coverage Gap “donut hole” Rebate**

The Affordable Care Act provides a one-time \$250 rebate in 2010 to assist Medicare Part D recipients who have reached their Medicare drug plan's coverage gap. This payment is not taxable. This payment is not made by the IRS. More information can be found at [www.medicare.gov](http://www.medicare.gov).

### **Additional Requirements for Tax-Exempt Hospitals**

The Affordable Care Act added [new requirements](#) for charitable hospitals (see [Notice 2010-39](#) and [Notice 2011-52](#)). On June 26, 2012, the IRS published proposed regulations that provide information on the requirements for charitable hospitals relating to financial assistance and emergency medical care policies, charges for emergency or medically necessary care provided to individuals eligible for financial assistance, and billing and collections. On April 5, 2013, the IRS published proposed regulations on the requirement that charitable hospitals conduct community health needs assessments (CHNAs) and adopt implementation strategies at least once every three years. These proposed regulations also discuss the related excise tax and reporting requirements for charitable hospitals and the consequences for failure to satisfy the section 501(r) requirements. On August 15, 2013, the IRS published [temporary regulations](#) and [proposed regulations](#) providing information on which form to use when making an excise tax payment for failure to meet the CHNA requirements and the due date for filing the form. [Notice 2014-2](#) confirms that hospital organizations can rely on proposed regulations under section 501(r) of the Internal Revenue Code published on June 26, 2012 and April 5, 2013, pending the publication of final regulations or other applicable guidance. [Notice 2014-3](#) contains a proposed revenue procedure that provides correction and disclosure procedures under which certain failures to meet the requirements of section 501(r) will be excused.

### **Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers**

The Affordable Care Act created an annual fee payable beginning in 2011 by certain manufacturers and importers of brand name pharmaceuticals. On Aug. 15, 2011, the IRS issued [temporary regulations](#) and a [notice of proposed rulemaking](#) on the branded prescription drug fee. The temporary regulations describe the rules related to the fee, including how it is computed and how it is paid. On Aug. 5, 2013, the IRS issued [Notice 2013-51](#), which provides additional guidance on the branded prescription drug fee for the 2014 fee year. For information on the fee for the 2012 fee year and for the 2013 fee year, see [Notice 2011-92](#) and [Notice 2012-74](#).

For additional information, visit our [Affordable Care Act Provision 9008 Branded Prescription Drug Fee page](#).

### **Modification of Section 833 Treatment of Certain Health Organizations**

The Affordable Care Act amended section 833 of the Code, which provides special rules for the taxation of Blue Cross and Blue Shield organizations and certain other organizations that provide health insurance. IRS [Notice 2010-79](#) provides transitional relief and interim guidance on the computation of an organization's taxpayer's Medical Loss Ratio (MLR) for purposes of section 833, the consequences of non-application and changes in accounting method. [Notice 2011-04](#) provides additional information and the procedures for qualifying organizations to obtain automatic consent to change its method of accounting for unearned premiums. [Notice 2012-37](#) extends the transitional relief and interim guidance provided in Notice 2010-79 for another year to any taxable year beginning in 2012 and the first taxable year beginning after Dec. 31, 2012.

On January 6, 2014, the IRS issued [final regulations](#) that describe how the MLR for purposes of section 833 is computed.

### **Limitation on Deduction for Compensation Paid by Certain Health Insurance Providers (amended section 162(m))**

The Affordable Care Act amended section 162(m) of the Code to limit the compensation deduction available to certain health insurance providers. The amendment goes into effect for taxable years beginning after Dec. 31, 2012, but may affect deferred compensation attributable to services performed in a taxable year beginning after Dec. 31, 2009. On April 1, 2013, the Treasury Department and IRS issued [proposed regulations](#) on this provision.

### **Employer Shared Responsibility Payment**

The Affordable Care Act establishes that certain employers must offer health coverage to their full-time employees or a shared responsibility payment may apply. On Feb. 10, 2014, the Department of the Treasury and the IRS issued [final regulations](#) on the Employer Shared Responsibility provisions. For additional information on the Employer Shared Responsibility provisions and the proposed regulations, see our [questions and answers](#). On July 9, 2013, the Department of the Treasury and the IRS announced transition relief from the Employer Shared Responsibility provisions for 2014. For more information, please see [Notice 2013-45](#). For additional transition relief generally applicable to 2015, see the preamble to the final regulations.

### **Patient-Centered Outcomes Research Institute Fee**

The Affordable Care Act established the Patient-Centered Outcomes Research Institute. Funded by the Patient-Centered Outcomes Research Trust Fund, the institute will help patients, clinicians, purchasers and policy-makers make informed health decisions by advancing clinical effectiveness research. The trust fund will be funded in part by fees paid by issuers of certain health insurance policies and sponsors of certain self-insured health plans.

The IRS and the Department of the Treasury have issued [final regulations \(PDF\)](#) on this fee. Additional information on the fee is available on the [PCORI](#) page and in our [questions and answers](#) and [chart summary](#). [Form 720](#), Quarterly Federal Excise Tax Return, was revised to provide for the reporting and payment of the PCORI fee. Although Form 720 is a quarterly return, for PCORI, Form 720 is filed **annually only**, by

July 31. If for any reason you need to make corrections after filing your annual Form 720 for PCORI, write “Amended PCORI” at the top of the second filing.

### **Retiree Drug Subsidies**

Under § 139A of the Internal Revenue Code, certain special subsidy payments for retiree drug coverage made under the Social Security Act are not included in the gross income of plan sponsors. Plan sponsors receive these retiree drug subsidy payments based on the allowable retiree costs for certain qualified retiree prescription drug plans. For taxable years beginning on or after Jan. 1, 2013, new statutory rules affect the ability of plan sponsors to deduct costs that are reimbursed through these subsidies. See our [questions and answers](#) for more information.

### **For More Information**

For tips, fact sheets, questions and answers, videos and more, see our [Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance](#) page.

#### **Related Items:**

- [Affordable Care Act Tax Provisions Home Page](#)
- [Affordable Care Act Questions and Answers Page](#)

## **Affordable Care Act of 2010: News Releases, Multimedia and Legal Guidance**

*Check this page for updates*

### **News Releases**

- [IR-2014-27](#), IRS Encourages Small Employers to Check Out Small Business Health Care Tax Credit; Helpful Resources, Tax Tips Available on IRS.gov
- [IR-2014-19](#), IRS Offers Health Care Tax Tips to Help Individuals Understand Tax Provisions in the Affordable Care Act
- [IR-2012-33](#): IRS Encourages Small Employers to Check Out Small Business Health Care Tax Credit
- [IR-2011-120](#), Filing Deadline Extended to March 30 for Some Tax-Exempt Organizations
- [IR-2011-92](#), Treasury, IRS Seek Public Input on Certain Employer Provisions of the Affordable Care Act
- [IR-2011-90](#), As Tax Filing Extension Deadlines Near, IRS and HHS Announce New Round of Outreach to Small Businesses and Practitioners About the Small Business Health Care Tax Credit
- [IR-2011-50](#), Treasury, IRS Seek Public Input on Certain Employer Provisions of the Affordable Care Act
- [IR-2011-31](#), IRS Issues Interim Guidance on Informational Reporting of Employer-Sponsored Health Coverage; Reporting is Voluntary for All Employers for 2011 and Small Employers for 2012
- [IR-2010-128](#), IRS Offers New Guidance on FSA and HRA Debit Cards
- [IR-2010-117](#), IRS Helps Small Employers Claim New Health Care Tax Credit; Forms and Additional Guidance Now Available on Small Business Health Care Tax Credit
- [IR-2010-103](#), IRS Releases Draft W-2 Form for 2011; Announces Relief for Employers

- [IR-2010-100](#), IRS Issues Guidance on Expanded Adoption Credit Available for Tax-Year 2010
- [IR-2010-96](#), IRS Releases Form to Help Small Businesses Claim New Health Care Tax Credit
- [IR-2010-95](#), IRS Issues Guidance Explaining 2011 Changes to Flexible Spending Arrangements
- [IR-2010-79](#), IRS Requests Public Input on Expanded Information Reporting Requirement
- [IR-2010-76](#), IRS Begins Accepting Applications for Qualifying Therapeutic Discovery Project Program
- [IR-2010-74](#), Affordable Care Act Provides Expanded Tax Benefit to Health Professionals Working in Underserved Areas
- [IR-2010-73](#), IRS Issues Regulations on 10-Percent Tax on Tanning Services Effective July 1
- [IR-2010-69](#), Recent Legislation Offers Special Tax Incentives for Small Businesses to Provide Health Care, Hire New Workers
- [IR-2010-63](#), Offers Details on New Small Business Health Care Tax Credit
- [IR-2010-53](#), Tax-Free Employer-Provided Health Coverage Now Available for Children under Age 27
- [IR-2010-48](#), IRS Reaches Out to Millions of Employers on Benefits of New Health Care Tax Credit
- [IR-2010-38](#), New for 2010: Tax Credit Helps Small Employers Provide Health Insurance Coverage

### **Additional Materials**

- [Publication 5152](#), Report changes to the Marketplace as they happen (regarding advance payments of the Premium Tax Credit)
- [Publication 5156](#), Facts about the Individual Shared Responsibility Provision
- [Treasury Department](#), FACT SHEET: Final Regulations Implementing Information Reporting for Employers and Insurers under the Affordable Care Act (ACA)
- [Publication 5093](#), Health Care Law Online Resources
- [Publication 5120](#); Facts about the Premium Tax Credit; Your Credit, Your Choice – Get it Now or Get it Later [English](#) | [Spanish](#)
- [Publication 5121](#); Facts about the Premium Tax Credit; Need help paying for health insurance premiums? [English](#) | [Spanish](#)
- [IRC § 7216](#), Disclosure or Use of Information by Tax Return Preparers, [questions and answers](#)
- [Fact Sheet 2011-11](#), Tax-Exempt Organizations Participating in the Medicare Shared Savings Program through Accountable Care Organizations
- [Treasury Department fact sheet](#) on health insurance premium tax credit
- [Fact Sheet 2011-02](#), Tax Changes for Small Businesses
- [Publication 4894](#), Affordable Care Act Tax Provisions and the IRS
- [Flyer](#) on the adoption tax credit
- [Flyer](#) on changes to health care plans, including FSAs.
- [Flyer](#) on the small business health care tax credit for small employers: [English](#) | [Spanish](#)
- 3 Simple Steps [fact sheet](#) for small employers
- Small business health care tax credit [scenarios](#) for small employers
- Health care [postcard notice](#) for small employers

## Tax Tips

- [Health Care Tax Tips](#), New Health Care Tax Tips can help you understand important tax provisions
- [Tax Tip 2011-34](#), Seven Facts about the Expanded Adoption Credit
- [Special Edition Tax Tip 2010-07](#), Nine Tips on the 10 Percent Tax on Tanning Services

## Videos

- Tanning Tax Fitness Center Exception: [English](#) | [ASL](#)
- Small Business Health Care Tax Credit: [English](#)

## Podcasts

- [Small Business Health Care Tax Credit](#)

## Webinars

- [Excise Tax on Indoor Tanning Services](#)

## Legal Guidance

### Announcements

- [Announcement 2011-37](#), Portion of Form 990 Schedule H Optional for Tax-Exempt Hospitals for Tax Year 2010
- [Announcement 2011-20](#), Delayed Filing Season for Certain Tax-Exempt Hospitals

### Notices

- [Notice 2014-24](#), Health Insurance Providers Fee; Procedural and Administrative Guidance
- [Notice 2014-23](#), Eligibility for Premium Tax Credit for Victims of Domestic Abuse
- [Notice 2014-10](#), Section 5000A Transition Relief for Individuals with Certain Government-Sponsored Limited-Benefit Health Coverage
- [Notice 2014-2](#), Reliance on Proposed Regulations for Tax-exempt Hospitals
- [Notice 2014-3](#), Proposed Procedures for Charitable Hospitals to Correct and Disclose Failures to Meet § 501(r)
- [Notice 2014-6](#), Section 45R – Transition Relief with Respect to the Tax Credit for Employee Health Insurance Expenses of Certain Small Employers
- [Notice 2013-76](#), Health Insurance Providers Fee; Procedural and Administrative Guidance
- [Notice 2013-71](#), Modification of “Use-or-Lose” Rule For Health Flexible Spending Arrangements (FSAs) and Clarification Regarding 2013-2014 Non-Calendar Year Salary Reduction Elections Under § 125 Cafeteria Plans
- [Notice 2013-54](#), Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements
- [Notice 2013-57](#), Preventive health services required under Public Health Service Act section 2713 and preventive care for purposes of Health Savings Accounts
- [Notice 2013-51](#), Branded Prescription Drug Fee; Guidance for the 2014 Fee Year
- [Notice 2013-45](#), Transition Relief for 2014 Under §§ 6055 (§ 6055 Information Reporting), 6056 (§ 6056 Information Reporting) and 4980H (Employer Shared Responsibility Provisions)
- [Notice 2013-42](#), Transition Relief for Employees and Related Individuals Eligible to Enroll in Eligible Employer-Sponsored Health Plans for Non-Calendar Plan Years that Begin in 2013 and End in 2014

- [Notice-2013-41](#), Eligibility for Minimum Essential Coverage for Purposes of the Premium Tax Credit
- [Notice 2012-77](#), Interim Guidance and Request for Comments; Medical Device Excise Tax; Manufacturers Excise Taxes; Constructive Sale Price; Deposit Penalties
- [Notice 2012-59](#), Guidance on 90-Day Waiting Period Limitation Under Public Health Service Act § 2708
- [Notice 2012-58](#), Determining Full-Time Employees for Purposes of Shared Responsibility for Employers Regarding Health Coverage (§ 4980H)
- [Notice](#) Requesting Information Regarding Stop Loss Insurance
- [Notice 2012-40](#), Health flexible spending arrangements not subject to \$2,500 limit on salary reduction contributions for plan years beginning before 2013 and comments requested on potential modification of use-or-lose rule.
- [Notice 2012-37](#), Extension of Interim Guidance on Modification of Section 833 Treatment of Certain Health Organizations
- [Notice 2012-33](#), Request for Comments on Reporting by Applicable Large Employers on Health Insurance Coverage Under Employer-Sponsored Plans
- [Notice 2012-32](#), Request for Comments on Reporting of Health Insurance Coverage
- [Notice 2012-31](#), Minimum Value of an Employer-Sponsored Health Plan
- [Notice 2012-17](#), Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared responsibility, and Waiting Periods
- [Notice 2012-9](#), Interim Guidance on Informational Reporting to Employees of the Cost of Their Group Health Insurance Coverage
- [Notice 2012-4](#), Certain Filing Changes for Tax-Exempt Organizations
- [Notice 2011-92](#), Branded Prescription Drug Fee; Guidance for the 2012 Fee Year
- [Notice 2011-73](#), Request for Comments on Health Coverage Affordability Safe Harbor for Employers (Section 4980H)
- [Notice](#) Soliciting Comments on Summary of Benefits and Coverage and Uniform Glossary — Templates, Instructions, and Related Materials Under the Public Health Service Act
- [Notice 2011-52](#), Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals
- [Notice 2011-51](#), Extension of Interim Guidance on Modification of Section 833 Treatment of Certain Health Organizations
- [Notice 2011-46](#), Deferral of Dates Related to the 2011 Branded Prescription Drug Fee
- [Notice 2011-36](#), Request for Comments on Shared Responsibility for Employers Regarding Health Coverage (Section 4980H)
- [Notice 2011-35](#), Request for Comments on Funding of Patient-Centered Outcomes Research Through Fees Payable by Issuers of Health Insurance Policies and Self-Insured Health Plan Sponsors
- [Notice 2011-28](#), Interim Guidance on Informational Reporting to Employees of the Cost of Their Group Health Insurance Coverage
- [Notice 2011-23](#), Request for Comments Regarding Application of § 501(c)(29) of the Internal Revenue Code
- [Notice 2011-20](#), which solicits written comments regarding what additional guidance, if any, is needed for tax-exempt organizations participating in the Medicare shared savings program (MSSP) through an accountable care organization (ACO).

- [Notice 2011-5](#), Section 105: Amounts Received under Accident and Health Plans; Section 106: Contributions by Employers to Accident and Health Plans; Section 125: Cafeteria Plans
- [Notice 2011-4](#), Certain Changes in Method of Accounting for Organizations to which Section 833 Applies
- [Notice 2011-2](#), Guidance on the Application of Section 162(m)(6)
- [Notice 2011-1](#), Affordable Care Act Nondiscrimination Provisions Applicable to Insured Group Health Plans
- [Notice 2010-89](#), Request for Comments Regarding the Excise Tax on Medical Devices
- [Notice 2010-82](#), Tax Credit for Employee Health Insurance Expenses of Small Employers
- [Notice 2010-79](#), Modification of Section 833 Treatment of Certain Health Organizations
- [Notice 2010-71](#), Branded Prescription Drug Sales
- [Notice 2010-69](#), Interim Relief with Respect to Form W-2 Reporting of the Cost of Coverage of Group Health Insurance Under § 6051(a)(14)
- [Notice 2010-66](#), Interim Guidance on the Adoption Credit.
- [Notice 2010-63](#), Request for Comments on Requirements Prohibiting Discrimination in Favor of Highly Compensated Individuals in Insured Group Health Plans
- [Notice 2010-59](#), IRS Issues Guidance Explaining 2011 Changes to Flexible Spending Arrangements
- [Notice 2010-51](#), Information Reporting Under the Amendments to Section 6041 for Payments to Corporations and Payments of Gross Proceeds and With Respect to Property (*Note: The amendments referenced in this notice were repealed in April 2011.*)
- [Notice 2010-45](#), Qualifying Therapeutic Discovery Project Credit
- [Notice 2010-44](#), Tax Credit for Employee Health Insurance Expenses of Small Employers
- [Notice 2010-39](#), Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals
- [Notice 2010-38](#), Tax Treatment of Health Care Benefits Provided With Respect to Children Under Age 27
- [Notice Requesting Information](#) Regarding Value-Based Insurance Design in Connection With Preventive Care Benefits
- [Notice of Availability of Interim Procedures](#) for Federal External Review and Model Notices Relating to Internal Claims and Appeals and External Review Under the Patient Protection and Affordable Care Act
- [Notice on Medical Loss Ratios](#) Requesting Comments Regarding Section 2718 of the Public Health Service Act Regulations

#### **Regulations**

- [REG-122706-12](#), Ninety-Day Waiting Period Limitation
- [REG-141036-13 -- Corrections](#)
- [REG-141036-13](#), Minimum Essential Coverage and Other Rules Regarding the Shared Responsibility Payment for Individuals
- [REG-143172-13](#), Amendments to Excepted Benefits
- [REG-130843-13](#), Net Investment Income Tax
- [REG-136630-12](#), Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans
- [REG-132455-11](#), Information Reporting of Minimum Essential Coverage
- [REG-113792-13](#), Tax Credit for Employee Health Insurance Expenses of Small Employers

- [REG-115300-13](#), Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return.
- [REG-120391-10 \(TD 9624\)](#), NPRM on Coverage of Certain Preventive Services under the ACA
- [REG-140789-12](#), Information Reporting for Affordable Insurance Exchanges
- [REG-126633-12](#), Computation of, and Rules Relating to, Medical Loss Ratio
- [REG-125398-12](#), Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit
- [REG-106499-12](#), Community Health Needs Assessments for Charitable Hospitals
- [REG-106796-12](#), The \$500,000 Deduction Limitation for Remuneration Provided by Certain Health Insurance Providers
- [REG-122706-12](#), Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act
- [REG-118315-12](#), Health Insurance Providers Fee; Notice of proposed rulemaking and notice of public hearing
- [REG-148500-12](#), Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage
- [REG-138006-12](#), Shared Responsibility for Employers Regarding Health Coverage
- [REG-130507-11](#), Net Investment Income
- [REG-130074-11](#), Rules Relating to Additional Medicare Tax
- [REG-122707-12](#), Incentives for Nondiscriminatory Wellness Programs in Group Health Plans
- [REG-130266-11](#), Additional Requirements for Charitable Hospitals
- [REG-119632-11](#), Regulations Pertaining to the Disclosure of Return Information to Carry Out Eligibility Requirements for Health Insurance Affordability Programs
- [REG-136008-11](#), Fees on Health Insurance Policies and Self-Insured Plans for the Patient-Centered Outcomes Research Trust Fund
- [REG-120391-10](#), ANPRM requesting comments on alternative ways to meet preventive services requirements by religious organization that objects to the coverage of contraceptive services for religious reasons.
- [REG-125592-10 \(TD 9532\)](#), Requirements for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act — NPRM for Amendment
- [REG-135071-11](#), Application for Recognition as a 501(c)(29) Organization
- [REG-113770-10](#), Taxable Medical Devices
- [REG-140038-10](#), Disclosures of the Summary of Benefits and Coverage and the Uniform Glossary for Group Health Plans and Health Insurance Coverage in the Group and Individual Markets under the Patient Protection and Affordable Care Act
- [REG-131491-10](#), Health Insurance Premium Tax Credit
- [REG-112805-10 \(TD 9544\)](#), Branded Prescriptions Drug Fee
- [REG-120391-10 \(TD 9541\)](#), Requirement for Group Health Plans and Health Insurance Issuers to Provide Coverage of Preventive Services under the Patient Protection and Affordable Care Act - NPRM for Amendment
- [REG-118412-10 \(TD 9506\)](#), Group Health Plans and Health Insurance Coverage Rules Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act - NPRM for Amendment

- [REG-125592-10 \(TD 9494\)](#), Appeals Regulations under the Public Health Services Act section 2719
- [REG-120391-10 \(TD 9493\)](#), Requirement for Group Health Plans and Health Insurance Issuers to Provide Coverage of Preventive Services under the Patient Protection and Affordable Care Act
- [REG-120399-10 \(TD 9491\)](#), Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections
- [REG-118412-10 \(TD 9489\)](#), Group Health Plans and Health Insurance Coverage Rules Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act
- [REG-112841-10 \(TD 9486\)](#), Indoor Tanning Services, Cosmetic Services; Excise Taxes
- [REG-114494-10 \(TD 9482\)](#), Group Health Plans and Health Insurance Issuers Providing Dependent Coverage of Children to Age 26

#### **Revenue Procedures**

- [Revenue Procedure 2012-11](#) sets forth procedures for issuing determination letters and rulings on the exempt status of qualified nonprofit health insurance issuers (QNHIs) described in § 501(c)(29) of the Internal Revenue Code (Code).
- [Revenue Procedure 2011-52](#), Administrative, Procedural, and Miscellaneous. Section 3, Adoption credit
- [Revenue Procedure 2011-24](#) establishes a dispute resolution process for the preliminary fee calculation for the 2011 annual fee imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs.
- [Revenue Procedure 2010-35](#) modifies and supersedes sections 3.03 and 3.14 of Rev. Proc. 2009-50, 2009-45 I.R.B. 617, to reflect the statutory amendments to the adoption credit under § 36C (formerly § 23) and the exclusion for adoption assistance programs under § 137.
- [Revenue Procedure 2010-31](#) provides guidance on safe harbors for determining the finality of foreign adoptions for purposes of the adoption credit.

#### **Revenue Rulings**

- [Revenue Ruling 2013-27](#), Gross Income Defined
- [Revenue Ruling 2010-23](#) obsoletes Rev. Rul. 2003-102, prior guidance on reimbursing expenses for over-the-counter drugs from employer health plans.
- [Revenue Ruling 2010-13](#), Section 45R—Average premium for small group market for determining the small employer health insurance credit

#### **Treasury Decisions (TD)**

- [TD 9672](#), Tax Credit for Employee Health Insurance Expenses of Small Employers
- [TD 9670](#), Disregarded Entities; Religious and Family Member FICA and FUTA Exceptions; Indoor Tanning Services Excise Tax
- [TD 9663](#), Information Reporting for Affordable Insurance Exchanges
- [TD 9661](#), Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans
- [TD 9660 – Correction 2](#)
- [TD 9660 – Correction 1](#)
- [TD 9660](#), Information Reporting of Minimum Essential Coverage

- [TD 9656](#), Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act
- [TD 9655](#), Shared Responsibility for Employers Regarding Health Coverage
- [TD 9651](#), Computation of, and Rules Relating to, Medical Loss Ratio
- [TD 9645](#), Rules Relating to Additional Medicare Tax
- [TD 9644](#), Net Investment Income Tax
- [TD 9643](#), Health Insurance Providers Fee
- [TD 9632](#), Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage
- [TD 9629](#), Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return
- [TD 9628](#), Regulations Pertaining to the Disclosure of Return Information to Carry Out Eligibility Requirements for Health Insurance Affordability Programs
- [TD 9624](#), Final Regulations on Coverage of Certain Preventive Services under the ACA
- [TD 9621](#), Final Regulations on Indoor Tanning Services; Excise Taxes
- [TD 9620](#), Incentives for Nondiscriminatory Wellness Programs in Group Health Plans
- [TD 9611](#), Final regulations providing guidance to individuals related to employees who may enroll in eligible employer-sponsored coverage and who wish to enroll in qualified health plans through Affordable Insurance Exchanges and claim the premium tax credit.
- [TD 9604](#), Taxable Medical Devices
- [TD 9602](#), Fees on Health Insurance Policies and Self-Insured Plans for Patient-Centered Outcomes Research Trust Fund
- [TD 9590](#), Health Insurance Premium Tax Credit
- [TD 9578](#), Final Regulations Authorizing the Exemption of Group Health Plans and Group Health Insurance Coverage Sponsored by Certain Religious Employers from Having to Cover Certain Preventive Health Services under Provisions of the Patient Protection and Affordable Care Act
- [TD 9574](#), Application for Recognition as a 501(c)(29) Organization
- [TD 9575](#), Summary of Benefits and Coverage and Uniform Glossary for Group Health Plans and Health Insurance Coverage in the Group and Individual Markets under the Patient Protection and Affordable Care Act
- [TD 9544](#), Branded Prescription Drug Fee
- [TD 9541](#), Amendment to Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act
- [TD 9532](#), Amendment to Interim Final Regulations Implementing the Requirements Regarding Internal Claims and Appeals and External Review Processes for Group Health Plans and Health Insurance Coverage in the Group and Individual Markets
- [TD 9506](#), Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act
- [TD 9494](#), Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act
- [TD 9493](#), Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act
- [TD 9491](#), Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

- [TD 9489](#), Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan under the Patient Protection and Affordable Care Act
- [TD 9486](#), Final and Temporary Regulations for Indoor Tanning Services; Cosmetic Services; Excise Taxes
- [TD 9482](#), Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 under the Patient Protection and Affordable Care Act

**Related Items:**

- [Affordable Care Act Tax Provisions Home Page](#)
- [Affordable Care Act Questions and Answers Page](#)

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