

ALERT: HEALTH CARE REFORM BILL

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IRS ISSUES FINAL GUIDANCE ON THE SMALL EMPLOYER TAX CREDIT

Included in the Patient Protection and Affordable Care Act (PPACA) enacted in March 2010 is a small business health care tax credit designed to encourage and assist small businesses and small tax-exempt organizations in offering health insurance coverage to their employees. The IRS issued **Notice 2010-82** on December 2, 2010, providing final guidance for small employers eligible to claim the health care tax credit for the 2010 calendar tax year. If an employer is a fiscal year taxpayer, with a tax year beginning, for example, on July 1, 2010, the credit first applies to the taxable year beginning on July 1, 2010 and ending on June 30, 2011.

BACKGROUND

A health care tax credit is available to for-profit and nonprofit “qualified” small employers that provide health care coverage to their employees. In order to be a “qualified employer,” the following requirements must be met:

- The employer must have fewer than 25 full-time equivalent employees (FTEs) for the year
- Average annual wages for the employees for the year must be less than \$50,000 per FTE
- The employer must pay the premium under a “qualifying arrangement”

The credit is available for 2010 through 2013 and for any two years after 2014. During 2010-2013, an eligible small employer may claim a credit of up to 35% (25% for tax-exempt employers) of its credit-eligible health insurance premiums. As of January 1, 2014, an eligible small employer may claim a credit of up to 50% of its premium contributions under a qualified health plan offered through a state-based exchange for the first two years the employer offers an exchange-based plan.

The credits are completely phased out for employers that have 25 or more full-time equivalent employees or that pay average wages of \$50,000 or more per year. Thus, the maximum credit goes to smaller employers – those with 10 or fewer full-time equivalent employees – paying average annual wages of \$25,000 or less per year.

The IRS previously provided initial guidance in IRS Notice 2010-44, which generally addressed four issues:

- Employers eligible for the tax credit
- Calculation of the credit
- Claiming the credit
- Transitional relief for the 2010 taxable year

Please see **Health Care Reform Alert Vol. 3, # 5 – “Health Care Reform Bill: Impact on Small Employers”** for additional information regarding Notice 2010-44.

The new guidance in Notice 2010-82 provides clarification on employers eligible for the tax credit, determination of who are employees, what a “qualified arrangement” is, as well as several tools needed to claim the credit.

TOOLS TO CLAIM THE 2010 CREDIT

The tools that a small employer needs to claim the tax credit are included in the most recent guidance. First there is the new Form 8941 **“Credit for Small Employers Health Insurance Premium”** and a revised Form 990-T. Also included are instructions for Form 8941. Form 8941 is to be used by eligible small businesses to determine the tax credit which is then included as part of its general business credit on its income tax return. Note that any tax health care tax credit received reduces the employer’s allowable deduction for health insurance premiums.

Form 8941 is also used by tax-exempt organizations to determine their refundable credits, which are then reported on Form 990-T. The refundable credit goes against the tax-exempt employer’s income tax withholding and Medicare tax liability; thus, even if the employer has no taxable income, the employer may still receive a refund, as long as it does not exceed its tax liability.

Frequently Asked Questions are also available on the IRS website for additional guidance.

A qualified employer should be sure to consult with its tax adviser to ensure proper application of the small employer tax credit.

EMPLOYERS’ ELIGIBILITY FOR THE CREDIT

The new guidance clarifies that a broad range of employers will meet the eligibility requirements for the health care tax credit. First, the Notice clarifies that in order for a tax-exempt organization to be eligible for the credit, the organization must be “described in Code section 501 (c) and exempt from taxation under Code section 501(a).” Thus, an employer that is an agency or instrumentality of the federal government, or of any local, state or Indian tribal government is not a qualified employer unless it meets the Code section 501 requirements.

Next, it addresses the fact that an employer is not required to perform services in a trade or business in order to be a small employer and to be eligible for the credit. Therefore, a household


employer, for example, that otherwise satisfies the requirements of a qualified small employer is eligible for the credit.

Furthermore, guidance on employers located outside the U.S. is provided. In order to be eligible for the tax credit, the health insurance coverage must be offered by a health insurance issuer who is subject to the insurance laws of one or more of the 50 states plus the District of Columbia. Therefore, a small employer located outside of the U.S. (including an employer located in a U.S. territory) may only claim the tax credit for the paid health insurance premiums of its employees if the coverage is issued in and regulated by one of the 50 states or the District of Columbia.

DETERMINING EMPLOYEES

Previously, guidance in Notice 2010-44 provided that for determining the number of employees, sole proprietors, partners in a partnership, shareholders owning more than 2% of the stock in an S corporation, and any owner of more than 5% of other businesses are not taken into account. Notice 2010-82 confirms the above exclusions and that these exclusions include spouses and family members. Thus, none of the mentioned individuals are counted for the purpose of determining an employer’s number of employees, nor is the premium paid for health care coverage for these individuals eligible for the tax credit.

For determining an employer’s number of full-time equivalent employees and in computing average annual wages, the guidance confirms that leased employees are included in the calculation. However, the premiums for health insurance coverage paid by the leasing organization (the lesser) is not taken into consideration by the service recipient (the lessee) when computing the health care tax credit.



Finally, the guidance addresses the question of whether a minister will be counted as an employee in determining an employer's number of employees. Whether a minister is counted as an employee is based on the common law test. If self-employed, the minister is not taken into account for FTE count and wage computation, whereas, if the minister is an employee, the minister is taken into account. As this appears to be a circular argument, and it is not the purpose of this *Alert* to determine an individual's employment status, further information on the IRS common law test for determining worker status can be found by [clicking here](#).

"QUALIFYING ARRANGEMENT" EXPLANATION

A qualifying arrangement is one in which the employer pays premiums for each employee enrolled in health insurance coverage offered by the employer in an amount equal to a uniform percentage (not less than 50%) of premium cost of the coverage. Thus, the first requirement of a qualifying arrangement is that it must be coverage offered by a health insurance issuer. A health insurance issuer is an entity licensed to engage in the business of insurance and is subject to state law regulating insurance. Thus, self-insured plans are not health insurance coverage for purposes of the tax credit and, as such, any employer contributions to a self-insured plan are not deemed a qualifying arrangement. Self-insured plans would include Health Reimbursement Arrangements (HRAs) and health Flexible Spending Accounts (FSAs). Furthermore, Health Savings Accounts in and of themselves are not health insurance coverage and also are not considered "qualifying arrangements."

Notwithstanding the above, there is an exception to the self-insured plan as a qualifying arrangement. The guidance clarifies that a small employer church plan that self-insures its coverage can qualify for the tax credit, even though the coverage is not provided by a health insurance issuer. This exception is based on another federal law which provides that a church plan is subject to state enforcement as if the church plan were an insurer licensed by the state. ***However, this rule applies solely for the purpose of eligibility for the small business tax credit.***

Furthermore, there is clarification for certain employers contributing to multi-employer health and welfare plans. In the case of a small employer making contributions to a multi-employer plan – contributions which are used to pay premiums for employees' health insurance coverage – these contributions are treated as premiums paid by the employer for purposes of the tax credit. However, in this situation, there is an additional requirement that 100% of the cost of coverage for all employees covered by the multi-employer plan be paid from employer contributions. Also, if employer contributions are used to pay for benefits other than health insurance coverage, such as life or disability benefits, then the employer is permitted to rely on information provided by the plan to determine the allocation of the contribution that is used to purchase health insurance.

UNIFORMITY REQUIREMENT

As previously noted, in order to receive the credit an eligible small employer must pay a uniform percentage (not less than 50%) of the premium for each employee enrolled in health insurance coverage offered by the employer. Although this appears to be a simple determination, the complexity of uniform coverage rests on the number of plans offered by the employer, the number of tiers offered and whether the employer has "list billing" (i.e., separate premium based on the age or other factors of the employee) or "composite billing" (i.e., a single aggregate premium for a group of covered employees).

In the simplest scenario, an employer offering only one benefit plan, providing for self-only coverage which has composite billing, the uniform premium percentage is met if the employer pays the same amount toward the premium for each employee receiving self-only coverage under the plan, so long as that amount is equal to at least 50% of the self-only premium.

However, an employer using composite billing and offering more than one tier of coverage (such as employee plus one, or family coverage) must first satisfy the self-only uniform coverage and then must also satisfy uniformity for the other tiers of coverage that are more expensive than self-only coverage. This uniformity of coverage can be satisfied in one of two ways: (1) by paying an amount for each employee enrolled in the tier (the same for all employees) that is no less than the amount the employer would have contributed toward self-only coverage for that employee, or (2) by meeting the basic uniformity rule (uniform amount of at least 50% of the premium) separately for each tier of coverage.

ONE PLAN WITH LIST BILLING

An employer using list billing, and only offering one plan with self-only coverage, can meet the uniformity requirement in one of two ways. First, the employer could use the standard uniformity rule and pay a uniform amount of not less than 50% of the premium charged for each employee. Since list billing means the premiums vary among employees, the amount paid for each employee will vary, but the percentage must be uniform and must be at least 50%. On the other hand, the employer could convert the individual premiums for self-only coverage into an “employer-computed composite” rate and apply a different rule. Under this alternate rule, the employer will satisfy uniformity if, to the extent an employee contribution is required, each employee receiving self-only coverage pays a uniform amount that is no more than 50% of the employer-computed composite rate. The “employer-computed composite rate” for a tier of coverage is the average rate determined by adding the premiums for that tier of coverage for all employees eligible to participate in the employer’s health insurance plan (whether or not they actually receive coverage under the plan or under that tier of coverage) and dividing by the total number of such eligible employees.


EXAMPLE

For the 2011 taxable year, Employer receives a list billing premium quote from Health Insurance Issuer W for health insurance coverage for each of Employer’s four employees. For Employee L, age 20, the self-only premium is \$3,000 per year and the family premium is \$8,000. For Employees M, N and O, each age 40, the self-only premium is \$5,000 per year and the family premium is \$10,000. The total self-only premium for the four employees is \$18,000 ($\$3,000 + (3 \times 5,000)$). Employer calculates an employer-computed composite self-only rate of \$4,500 ($\$18,000 \div 4$).

Employer offers to make contributions such that each employee would need to pay \$2,000 of the premium for self-only coverage. Under this arrangement, Employer would contribute \$1,000 toward self-only coverage for L and \$3,000 toward self-only coverage for M, N and O. In the event an employee elects family coverage, Employer would make the same contribution (\$1,000 for L or \$3,000 for M, N or O) toward the family premium.

Employer satisfies the uniformity requirement because it offers and makes contributions based on an employer-calculated composite self-only rate such that, to receive self-only coverage, each employee must pay a uniform amount which is not more than 50% of the composite rate, and it allows employees to use the same employer contributions toward family coverage.

When an employer’s health insurance plan offers more than one tier of coverage, the employer has two ways to satisfy the uniformity requirement for each tier of coverage that is more expensive than self-only coverage. First, the employer satisfies the requirements by paying toward the premium for each employee covered under that tier of coverage an amount equal to the amount that the employer would have contributed



with respect to that employee for self-only coverage, calculated based upon either the actual premium that would have been charged by the insurer for that employee for self-only coverage or the employer-computed composite rate for self-only coverage. Alternatively, the employer may use the second method described above for self-only coverage for each tier by substituting the employer-computed composite rate for that tier of coverage for the employer-computed composite rate for self-only coverage.

EMPLOYERS OFFERING MORE THAN ONE PLAN

An employer that offers more than one health insurance plan, for example, by offering different benefits packages (e.g., an HMO and a PPO), cannot just aggregate the plans for meeting the uniformity requirement, but must satisfy the requirement for each plan offered. An employer can satisfy the requirement in two ways.

- **PLAN-BY-PLAN METHOD.** Using this method, the employer satisfies the uniformity requirement on a plan-by-plan basis by evaluating the premiums with respect to each plan using the rules explained above. In doing so, the premiums the employer pays for each plan do not need to be identical, so long as they satisfy the uniformity requirement for each of the plans.

EXAMPLE MORE THAN ONE PLAN COMPOSITE BILLING

In 2011, Employer offers two health insurance plans, Plan A and Plan B, both of which use composite billing. The premiums for Plan A are \$5,000 per year for self-only coverage and \$10,000 for family coverage. The premiums for Plan B are \$7,000 per year for self-only coverage and \$13,000 for family coverage. Employees can elect self-only or family coverage under either Plan A or Plan B. Employer pays \$3,000 (60% of the premium) for each employee electing self-only coverage under Plan A, \$3,000 (30% of the premium) for each employee electing family coverage under Plan A, \$3,500 (50% of the premium) for each employee electing self-only coverage under Plan B, and \$3,500 (27% of the premium) for each employee electing family coverage under Plan B.

Employer's contributions of 60% of the premiums for self-only coverage and the same dollar amounts toward the premium for family coverage under Plan A, and of 50% of the premium for self-only of coverage and the same dollar amount toward the premium for family coverage under Plan B, satisfy the uniformity rule on a plan-by-plan basis; therefore the employer's contributions to both plans satisfy the uniformity requirement.

- **REFERENCE PLAN METHOD.** Under this method, an employer may designate a "reference plan" and make employer contributions by first determining a level of employer contributions for each employee that would satisfy uniformity if each eligible employee enrolled in the reference plan. The employer must then allow each employee to apply that amount toward either the reference plan or the cost of coverage under any of the other health insurance plans the employer makes available. In order to use this method, the employer must satisfy what is called an "anti-abuse rule." **This rule requires that the self-only composite rate for the reference plan be at least 66% of the self-only composite rate for each non-reference plan for which the employer claims the credit.** For this purpose, the self-only composite rate for a plan using composite billing is what the insurer charges for self-only coverage, and the self-only composite rate for a plan using list billing is the employer-computed composite rate for self-only coverage.

EXAMPLE MORE THAN ONE PLAN COMPOSITE BILLING USING REFERENCE PLAN METHOD

In 2011, Employer offers two health insurance plans, Plan A and Plan B, both of which use composite billing. The premiums for Plan A are \$5,000 per year for self-only coverage and \$10,000 for family coverage. The premiums for Plan B are \$7,000 per year for self-only coverage and \$13,000 for family coverage. Employees can elect self-only or family coverage under either Plan A or Plan B.

The employer designates Plan A as the reference plan. Employer pays \$2,500 (50% of the premium) for each employee electing self-only coverage under Plan A

and pays \$2,500 of the premium for each employee electing family coverage under Plan A or either self-only or family coverage under Plan B. The self-only composite rate for Plan A (\$5,000) is greater than 66% of the self-only composite rate for Plan B (\$7,000). ($\$5,000 \div \$7,000 = 71\%$). Employer's contribution of \$2,500 toward the premium of each employee enrolled under Plan A or Plan B satisfies the uniformity requirement.

TRANSITION RELIEF FOR THE 2010 TAX YEAR

As reported in the Willis Alert addressing IRS Notice 2010-44 there is transition relief that is intended to make it easier for employers to meet the contribution arrangement requirements and qualify for the credit for the 2010 tax year. The transition relief in IRS Notice 2010-44 allows an employer to satisfy the contribution arrangement requirement for 2010 even if the percentage of premiums it pays is not uniform for all employees, so long as the employer pays at least 50% of the premium for each employee enrolled in the health insurance coverage offered by the employer to its employees. When applying this transition relief, the employer uses the premium for single (employee-only) coverage. Therefore, if an employee is receiving coverage that is more expensive than single coverage (such as family or self-plus-one coverage), the employer will satisfy the 50% requirement with respect to that employee by contributing an amount that is not less than what 50% of the single-coverage premium would be for that employee (even if it is less than 50% of the premium for the coverage the employee is actually receiving).

CONCLUSION

Final guidance on the health insurance tax credit has arrived just in time as small employers start to consider their income tax filing requirements. Credits are available, so a small employer should review its health insurance coverage situation to see if it can take advantage of the credit. Furthermore, as some of the requirements have twists and turns, particularly the uniform percentage requirement, any tax credit issue should be addressed with a professional tax adviser.

KEY CONTACTS

US BENEFITS OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 437 6900

Burlington, VT
802 264 9536

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
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212 915 8802

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Knoxville, TN
865 588 8101

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Nashville, TN
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Reston, VA
703 435 7078

Richmond, VA
804 527 2343

Rockville, MD
301 692 3025

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770 425 6700

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305 421 6208

Mobile, AL
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Tallahassee, FL
850 385 3636

Tampa, FL
813 490 6808
813 289 7996

Vero Beach, FL
772 469 2842

MIDWEST

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312 288 7700
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