

Health Care Reform Gets REAL for Businesses

Your guide to meeting the new federal
health care requirements



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Special thanks to the Washington Restaurant Association and the National Restaurant Association for their contribution of this Health Care Supplement.

How Health Care Reform is Funded

An overview of health care reform can't be presented without details on how the law will be funded. The law included several tax and information reporting changes and fees in order to pay for the legislation. The following are examples of changes that could impact the taxes or operation of a small or large restaurant company.

- **Medicare Contribution Tax.** Modifies the existing 3.8% Medicare tax to include unearned income (net investment income). Applies to modified adjusted gross income of more than \$250,000 for joint filers, \$200,000 for single filers. Net investment income is defined as interest, dividends, royalties, rents, gross income from trade or business involving passive activities and net gain from disposition of property (other than property held in a trade or business). Begins 2013.
- **Broaden Medicare Hospital Insurance tax for high-income taxpayers.** Increases FICA tax from 1.45% to 2.35% on individual taxpayers earning more than \$200,000/\$250,000 for married couples filing jointly. Begins in 2013.
- **Expansion of information reporting.** Requires businesses that pay any amount greater than \$600 during the year to corporate providers of property and services to file an information report, a 1099 form, with each provider and with the IRS. Information reporting already is required on payments for services to non-corporate providers. Applies to payments made after December 31, 2011.
- **Employer W-2 reporting of value of health benefits.** Requires employers to disclose the value of health benefits provided by the employer for each employee's health insurance coverage on the annual W-2 form. Begins in taxable years after December 31, 2010.
- **Modification of itemized deduction for medical expenses.** Raises the 7.5% AGI floor on medical

expenses deduction to 10%; AGI floor for individuals age 65 and older (and their spouses) remains at 7.5% through 2016.

- **Increase in additional tax on distributions from HSA and Archer MSA's not used for qualified medical expenses** from 10% to 20%.
- **Limitation on health flexible spending arrangements under cafeteria plans.** Limits amount of contributions to health FSAs to \$2,500 per year beginning in 2011. Indexed by CPI-U starting in 2013.
- **Elimination of Medicare Part D prescription subsidy deduction for employers as a business expense.** Begins 2013.
- **Excise tax on high cost employer-sponsored health coverage.** Levies a 40% excise tax on insurance companies and plan administrators for any health care coverage plan that is above the premium threshold of \$10,200 for single coverage and \$27,500 for family coverage (subject to adjustment for unexpected increase in medical costs prior to effective date). The tax is applied to the amount in excess of the threshold amount. The tax applies to self-insured plans and plans sold in the group market, but not to plans sold on individual market. Threshold is indexed to CPI. Begins in 2018.
- **Time for payment of corporate estimate taxes.** Increase by 15.75% the required corporate estimated tax payments factor for corporations with assets of at least \$1 billion for payments due in July, August and September 2014.
- **Health insurance provider employee expenses.** Limits deduction on remuneration to officers, employees, directors and service providers.

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Key Health Care Definitions

Large employers

Starting in 2014, large employers will be required to provide affordable health insurance coverage for their full time employees. Large employers are defined under the health care law as those with 50 or more full time equivalent employees. Employers who do not provide “affordable” coverage to their employees may be liable to pay an annual penalty of up to \$2,000 per full time employee. The penalty is calculated on a monthly basis; federal agencies will need to issue regulations to explain exactly how this will work.

Small employers

Businesses with fewer than 50 full time equivalents are exempt from the law’s health care coverage requirements and penalties.

Full time employee

A full time employee is defined as a person who averages at least 30 hours of service per week in any given month.

Full time equivalent

Part time workers’ combined hours count toward the number of full time equivalent employees for the purposes of the 50 full time employee equivalent threshold. However, businesses are not required to provide health coverage or pay a penalty for any part time employees.

Part time employee

- A part time employee is defined as a person who averages fewer than 30 hours a week in any given month.
- Employers are not required to provide health care coverage or pay penalties for part time employees.
- Employers must use part time employees’ hours solely for purposes of determining whether the business qualifies for the small business threshold.

Seasonal workers

- Seasonal workers are defined as those who work 120 or fewer days a year.
- Seasonal employees’ hours are not counted for purposes of determining whether an employer meets the 50 full time equivalent small business threshold.

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for more information.

Health Insurance Exchanges

Each state is required to set up an “exchange” or a marketplace for offering qualified health insurance plans by Jan. 1, 2014. A state may defer, if unable to set up an exchange, to the U.S. Department of Health and Human Services to establish and operate an exchange in that state. Individual and small group plans will be offered on the exchanges. States have discretion whether to open up the exchanges in 2017 to the large group market.

Who Will Be Able to Use Them? Are There Any Subsidies?

Those eligible for use of the exchange must meet one or more of the following criteria:

- Work at companies with fewer than 100 employees
- Work for a company that does not provide health insurance
- Self-employed
- Unemployed
- Retired, but not eligible for Medicare
- Small business
- After 2017, medium and large businesses

If you can't afford to purchase health insurance, under the health care reform bill, subsidies are available from the government to assist with the payment of insurance premiums, up to 400% of the federal poverty line. A sliding scale, based on need, will be used to determine how much help you can get in terms of paying your premiums.

How Will They Operate? How Will They be Funded?

Federal money will be provided to help fund state exchange start-ups. States can also cooperate with each other in multi-state exchanges, creating larger pools of “customers.”

However, there are rules to being listed on the exchanges. To participate on an exchange, plans must provide standard information such as enrollment details, number of claims denied and cost share requirements. The exchange must offer plans that cover a specific essential health benefits package, which has still not been determined by the Department of Health and Human Services. Overseers are expected to make sure that the insurers listed on their exchanges follow certain criteria. Plans must be “in the interest” of buyers, according to the authors of the bill.

State health insurance regulators must have rubrics for determining which insurers certify to offer their products on the exchange. Additionally, there has to be a standard format for presenting the options and costs in a way that allows buyers to efficiently compare their options. Presumably, this means that states will bar insurance companies that do not meet “quality standards” from selling on the exchanges.

The Department of Health and Human Services will determine the minimum benefits as defined by law, and insurance companies subsequently may determine premiums per benefit package based on coverage level. States can require insurers to justify rate increases and prices. Insurers will have to be more transparent about their pricing, and how they spend their revenues, especially if they want to be included on the exchanges.

Definition of Employer in Health Care Reform Legislation

For purposes of calculating the number of full time employees employed by a single employer:

A single employer is defined by “common control” as laid out in Internal Revenue Code Section 414 (b), (c), (m), (o)² and is based on percentage of ownership and control in two or more restaurants.

The threshold to be defined as a single employer:

If two or more restaurants have the same five or fewer owners, collectively owning at least 80% of the shares or interest (either by vote or value), those restaurants shall be considered a single employer.

Examples:

1. If a single business owns 100% of three individual S-Corps, for the purposes of health care, the three S-Corps would be treated as a single employer because the same owner controls at least 80% of each. The full time employees of all three would be added together to determine if the employer is above or below the small business (50 full-time employee) exemption threshold.
2. If business 1 and 2 own 90% of business A (split 45/45) and 50% of business B (split 25/25), restaurants A and B would not be considered a single employer since business 1 and 2 only own 50% of restaurant B.
3. If business 1 and 2 own 90% of business A (split 45/45) and 80% of business B (split 40/40), restaurants A and B would be considered a single employer since business 1 and 2 own 80% of business B. The full time employees of businesses A and B would be added together to determine if the employer is above or below the small business (50 full-time employee) exemption threshold.

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DETERMINE

Who is Considered a Large Employer?

Only employers with more than 50 full time equivalent employees are subject to the coverage requirements and possible penalty liability of the Patient Protection and Affordable Health Care Act. Employers must determine if they fall above or below the threshold of 50 full time equivalents using a formula. It is based on a definition of full time employment as 30 hours or more a week on average in a given month.

If an employer is above the threshold of 50 full time equivalents using this formula, they are subject to the coverage requirements and possible penalty liabilities in the law:

- _____ Number of full time employees (employees who average 30 hours or more a week during a month)
- + _____ Hours worked by all part time employees in a month, divided by 120 hours
- = _____ Number of full time equivalents

REMINDER: Part time workers' combined hours count toward the number of full time equivalent employees for the purposes of calculating the 50 full time equivalent threshold. However, businesses are not required to offer minimum essential health coverage or pay a penalty for any part time employees.

If an employer's workforce exceeds 50 full time equivalent employees (not including seasonal workers), the employer must offer coverage for those seasonal employees who are full time.

The employer does not pay a penalty on the first 30 full time employees if they do not provide coverage.

Example: If a business has 80 part time workers (who work the equivalent of 40 full time employees) and 40 full time employees, the employer has 80 full time equivalent employees. The business must then offer coverage to the 40 full time employees or pay a penalty because it has more than 50 full time equivalents.

Large Employer Responsibilities

Starting in 2014, the health reform law requires large employers to offer affordable health insurance coverage to their full time employees. If an employer does not provide affordable minimum essential coverage, they may be liable to pay a penalty of up to \$2,000 per full time employee annually. The penalty is assessed on a monthly basis, at a rate of \$167 per full time employee. Penalty payments are not tax-deductible for employers.

Penalties are triggered only if a full time employee of a large employer receives a federal premium tax credit to purchase a health insurance plan in a health insurance "exchange" (see page 7). The exchanges will be established in each state and also across state lines, and are designed to serve as a marketplace for individuals and small groups to purchase private health insurance plans. Individuals are eligible for tax credits on a sliding scale if their incomes are up to four times the federal poverty level (\$10,830 for an individual and \$22,050 for a family of four in 2010).

the Size and Responsibility of YOUR BUSINESS

Possible Outcomes for Large Employers

The following provides examples of how large employers—i.e., those with more than 50 full time equivalents—will be affected by the penalties and other requirements.

- 1) If a large employer DOES NOT OFFER minimum essential health care coverage to all of their full time employees and their dependents* and at least one full time employee uses the premium tax credit to obtain coverage on the exchange:
 - Employers must pay an annual penalty of \$2,000 per full time employee (\$167 with respect to any month).
 - In calculating the assessment, an employer may discount the number of full time employees by 30.
- 2) If a large employer DOES OFFER minimum essential coverage to their full time employees and dependents, but it is unaffordable to at least one full time employee who uses a federal premium tax credit to obtain coverage on the exchange:
 - Employers must pay the lesser of:
 - An annual penalty of \$3,000 for each full time employee receiving a federal premium tax credit (\$250 with respect to any month), or,
 - \$2,000 multiplied by the total number of full time employees (minus the first 30 employees)—this is to assure that those who offer coverage are not penalized more than those who do not offer coverage.

In general, employees whose employers offer coverage are not eligible to receive premium tax credits to obtain coverage in the exchange. However, Congress wanted to ensure that employer-sponsored coverage would be affordable for employees.

Consequently, a full time employee with an offer of employer-sponsored coverage is eligible for a premium tax credit only if the plan's share of the total allowed costs of benefits is less than 60% of the costs OR the full time employee's required contribution under the employer's plan exceeds 9.5% of the employee's income. (It is anticipated that household income will be determined by the employee's previous years' tax filings and certified by the IRS and state exchange).

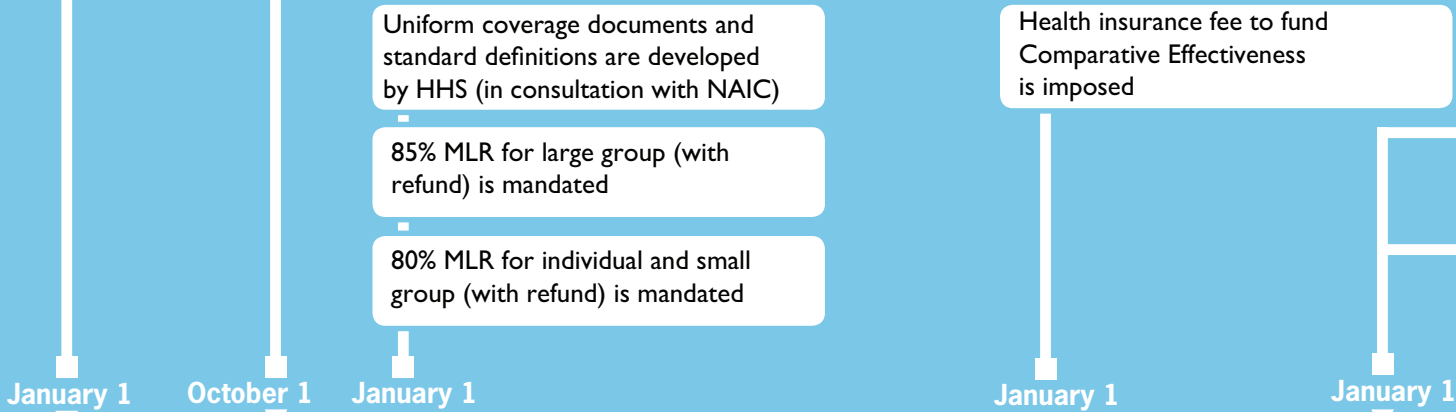
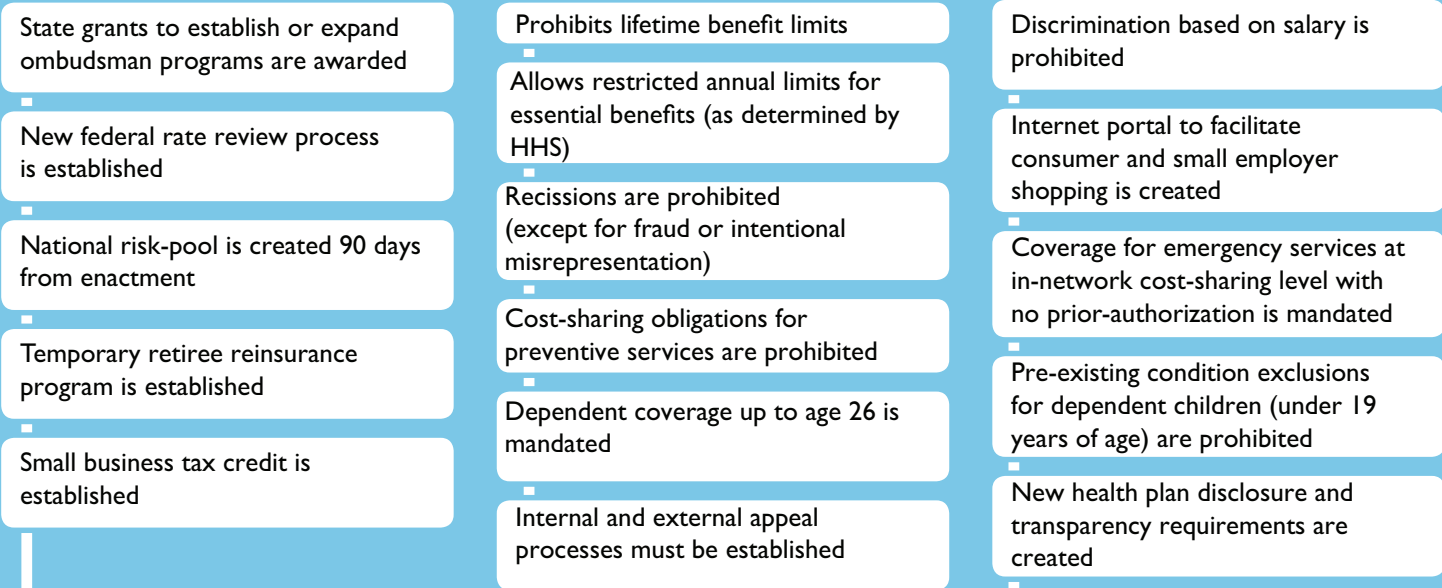
- 3) If a large employer DOES OFFER minimum essential coverage to their full time employees and dependents, but a full time employee's required contribution under the employer's plan would be between 8% and 9.5% of household income.
 - At the employee's request, the employer must provide a free choice voucher—in the amount equal to the monthly employer contribution (to individual or family plan)—to those full time employees to buy coverage on the exchange.
 - If the voucher exceeds the cost of the coverage premium purchased on the exchange, then the full time employee retains the excess.
 - Employees are not eligible both for the free choice voucher and the federal premium tax credit to purchase coverage on the exchange.
 - Employer is allowed a deduction in the amount of the voucher paid as is the case currently for employer contributions.
 - If the employer provides a voucher to a full time employee, the employer is not subject to penalties.

* *Dependents include spouses and children until their 26 birthday. The Health and Human Services Secretary will announce regulations to further define dependents.*

Health Care Reform Bill Insurance Market Provisions Timeline

(as revised by the House Reconciliation Bill)*

Summary of Select Requirements



2010

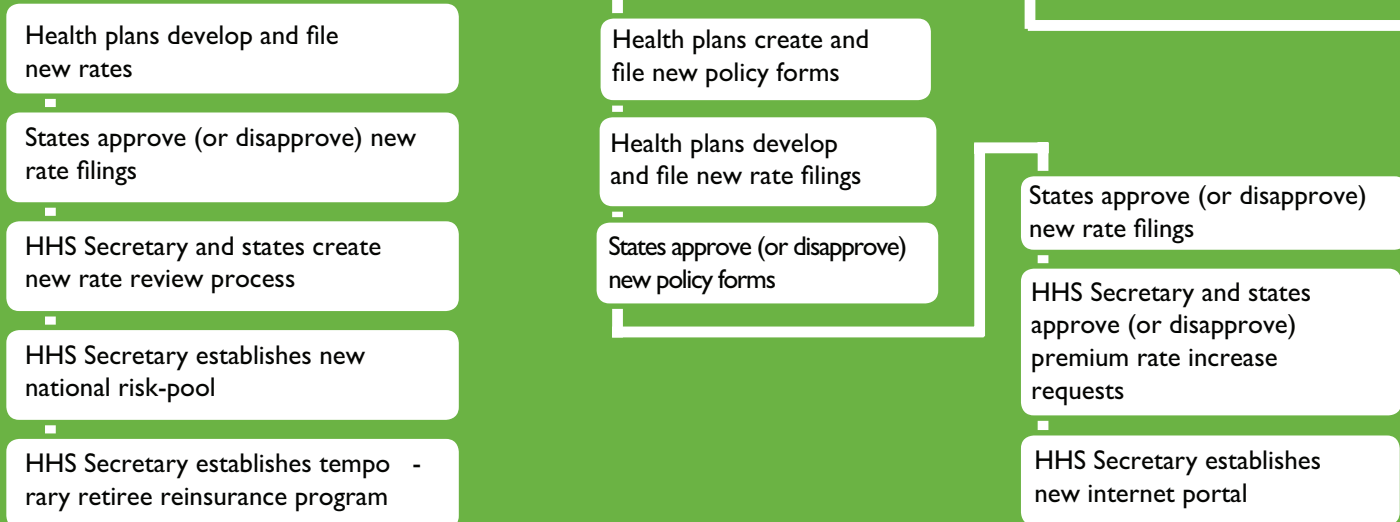
2011

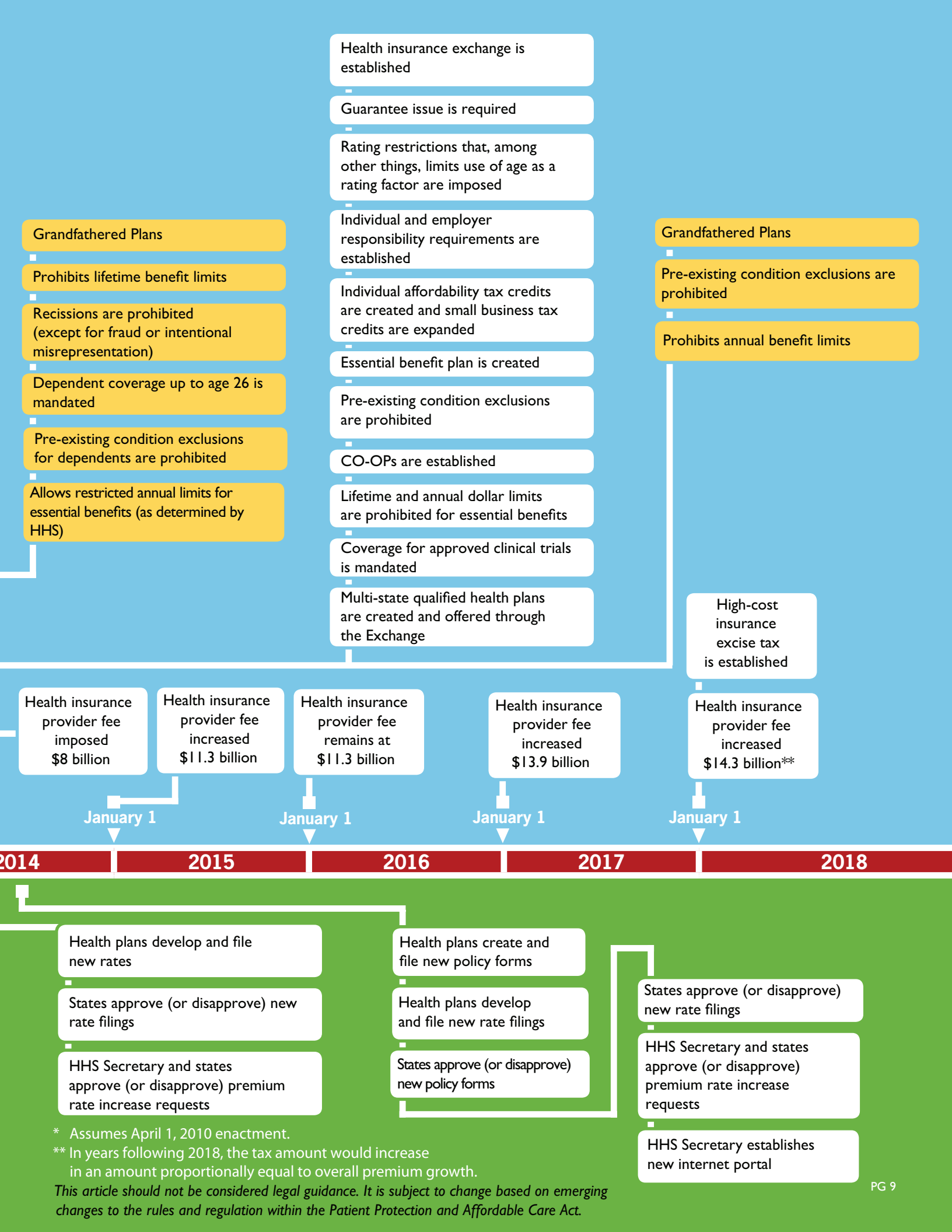
2012

2013

2014

Impact





Health insurance exchange is established

Guarantee issue is required

Rating restrictions that, among other things, limits use of age as a rating factor are imposed

Individual and employer responsibility requirements are established

Individual affordability tax credits are created and small business tax credits are expanded

Essential benefit plan is created

Pre-existing condition exclusions are prohibited

CO-OPs are established

Lifetime and annual dollar limits are prohibited for essential benefits

Coverage for approved clinical trials is mandated

Multi-state qualified health plans are created and offered through the Exchange

Grandfathered Plans

Prohibits lifetime benefit limits

Reversions are prohibited (except for fraud or intentional misrepresentation)

Dependent coverage up to age 26 is mandated

Pre-existing condition exclusions for dependents are prohibited

Allows restricted annual limits for essential benefits (as determined by HHS)

Grandfathered Plans

Pre-existing condition exclusions are prohibited

Prohibits annual benefit limits

High-cost insurance excise tax is established

Health insurance provider fee imposed \$8 billion

Health insurance provider fee increased \$11.3 billion

Health insurance provider fee remains at \$11.3 billion

Health insurance provider fee increased \$13.9 billion

Health insurance provider fee increased \$14.3 billion**

January 1

January 1

January 1

January 1

2014 2015 2016 2017 2018

Health plans develop and file new rates

States approve (or disapprove) new rate filings

HHS Secretary and states approve (or disapprove) premium rate increase requests

Health plans create and file new policy forms

Health plans develop and file new rate filings

States approve (or disapprove) new policy forms

States approve (or disapprove) new rate filings

HHS Secretary and states approve (or disapprove) premium rate increase requests

HHS Secretary establishes new internet portal

* Assumes April 1, 2010 enactment.

** In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.

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Providing Minimum Essential Coverage

Beginning in 2014, large employers must provide minimum essential coverage to full time employees (and their dependents). If this requirement is not met, employers could be liable for penalties. The minimum essential coverage requirement applies to all health insurance plans offered after the date of enactment (March 23, 2010) by employers with 50 or more full time equivalents.

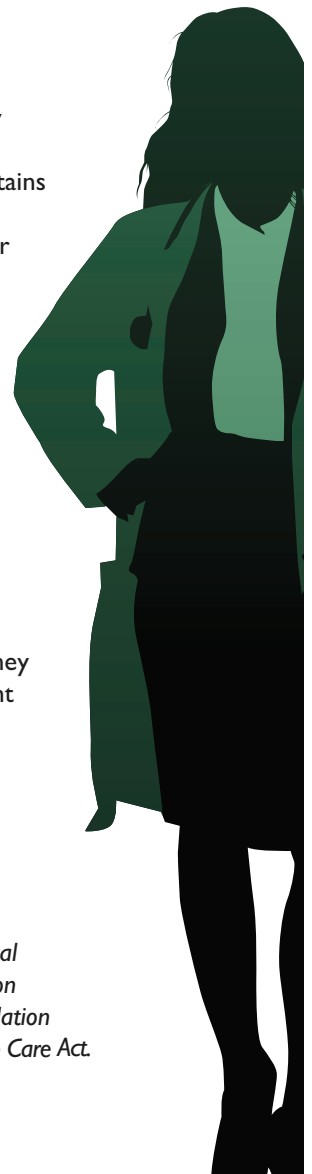
The law defines an essential health benefits package as one that covers vital health benefits, limits cost-sharing and has a specified actuarial value (pays for a specified percentage of costs) as follows:

1. For the individual and small group markets * the law requires the U.S. Secretary of Health and Human Services to define essential health benefits, which must be equal in scope to the benefits of a typical employer plan.
2. For all plans in all markets ** the law prohibits out-of-pocket limits that are greater than the limits for health savings accounts (2010: \$5,950 self, \$11,900 family). For the small group market, the law prohibits deductibles that are greater than \$2,000 for individuals and \$4,000 for families. Indexes the limits and deductible amounts by the percentage increase in average per capita premiums. Limits cost-sharing for such coverage (deductibles, coinsurance, copayments or similar charges—does not include premiums).
3. For the individual and small group markets, the law requires individuals to enroll in one of the following levels of coverage, as offered, under which the plan pays for the specified percentage of costs: Bronze (60% actuarial value), Silver (70%), Gold (80%) or Platinum (90%) level of coverage. The U.S. Secretary of Health and Human Services may issue regulations under which employer contributions to a health savings account may be taken into account in determining the level of coverage for a plan of the employer.
4. In the individual market, individuals under 30 years, not using the tax credit to obtain coverage, can enroll in a catastrophic plan to satisfy the individual responsibility requirement in the legislation. However, a catastrophic plan is not minimum essential coverage and thus cannot be offered by an employer to meet health coverage requirements. A catastrophic plan must cover essential health benefits and at least three primary care visits, but must require cost-sharing up to the health savings account out-of-pocket limits. Also, if an insurer offers a qualified health plan, it must offer a child-only plan (under 21) at the same level of coverage in the individual market.

* Individual market refers to an individual health insurance policy purchased apart from the group market. Small group market contains small group health plans that are open to an employer with 100 or fewer employees. Large group market applies to employers with 101 or more employees. However, in plan years beginning before January 1, 2016, a state may substitute 51 for 101 employees in defining small group market. If employer was considered small and offered a plan through the small group market through the exchange, and increases in size so as not to be, as long as they continue to offer such enrollment to employees they would still be considered small.

** Applies to individual, small group and large group plans.

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Grandfathered Plans

If you are an employer who offered health care coverage as of March 23, 2010, you'll want to be familiar with aspects of the law pertaining to grandfathered plans. These existing plans are recognized by the U.S. Secretary of Health and Human Services. Enrollment in a grandfathered plan satisfies the law's individual mandate to obtain qualified coverage.

If an employer offered coverage to their employees as of March 23, 2010, and maintains that plan as a grandfathered plan, the employees can stay in the grandfathered plan to satisfy the individual mandate in the law that requires everyone to obtain qualified coverage for themselves and their dependents. The grandfathered plan coverage can be continued even if the employee renews their coverage after the March 23, 2010, date. Family members may be added to a grandfathered plan if that was previously allowed by the plan and new hires and current employees can also enroll in the grandfathered plan as well. A grandfathered plan does not lose its status just because an enrollee is no longer covered, assuming someone was continuously covered by the plan since March 23, 2010.

All grandfathered health insurance plans will have to conform to certain insurance reforms six months after enactment. Other reforms are implemented starting in 2014.

- Beginning September 2010:
 - Prohibition on lifetime limits or 'unreasonable' annual limits.
 - Prohibition on rescission of coverage.
 - Requirement to provide coverage to children and adult children up to age 26 (if a plan already provides dependent coverage).
- 2014:
 - Prohibition on pre-existing condition exclusions
 - Prohibition on annual limits.
 - Limitations on excessive waiting periods (not longer than 90 days).

In general, businesses offering health care coverage may continue to offer such coverage to their employees under a "grandfather" provision. However, the government recently laid out rules effective July 12, 2010, that grandfathered plans must follow to maintain such status. Permissible changes to plans include those to premiums, changes to comply with federal or state laws, changes to voluntarily comply with the provisions of the new health care law, and the changing of third party administrators. To maintain their status, grandfathered plans must disclose its status in any plan materials. Recordkeeping by the plan or issuer is also required.

The rules list specific changes that will cause a grandfathered plan to lose its status: elimination of benefits, increases in the percentage of cost-sharing required by an enrollee (coinsurance), increases in the fixed-amount cost-sharing required (copayments, deductibles, out-of-pocket limits), decreases of more than 5% of the employers' contribution rate based on the rate as of March 23, 2010, and changes to annual limits.

Additionally, there are transition rules that apply for those who might have made changes before the filing of these rules on June 14, 2010, and also for any changes to plans made between June 14 and September 23, 2010.

More information about the rules that govern grandfathered status can be found at www.restaurant.org/healthcare.



Health Care Reform FAQs

Q: As an employer, do I need to do anything this year now that this is law?

A: The bulk of the employer requirements for coverage and penalties do not begin until 2014. All of the details are not yet known, and action by several federal agencies is required to further define some of the requirements. See page 8 for the implementation timeline.

Q: I heard about small business tax credits. When do they begin and am I eligible?

A: Beginning Jan. 1, 2010, certain small businesses with 10 to 25 full time equivalent employees may qualify for a tax credit for contributing to their employees' health coverage now. More details are coming soon. Check out page 14 for details.

Q: Will I be required to provide health care to my employees?

A: Employers with 50 or more full time equivalent employees (see below) will be required to offer their full time employees a "minimum essential coverage" health benefits package starting in 2014, or pay a penalty for not doing so. Minimum essential coverage has not been fully defined; see more below. See page 10 for specifics.

Q: Will small businesses be required to provide coverage too?

A: No. Employers who have fewer than 50 full time equivalents will not be required to provide coverage.

Q: Do I have to provide coverage for my part time employees?

A: No. Part time employees are counted only in determining whether an employer meets the small-business threshold for coverage under the law. In no case do employers have to provide health care coverage for part time employees or pay penalties for part time employees.

Q: How much will the new requirements cost me?

A: Cost will vary depending on your operation and how minimum coverage is defined through the regulatory process.

Q: Are there penalties for employers, subject to the law, who do not provide coverage?

A: Yes. Employers covered by the law who do not provide coverage will be subject to a penalty of \$2,000 annually per full time employee assessed on a monthly basis, or \$166.67 per month per uninsured employee. Employers may exclude 30 full time employees in calculating their penalty. For example, a covered employer who has 60 full time employees and chooses not to provide coverage would face an annual penalty of \$60,000. [60 total full time employees - 30 full time employees excluded from the calculation = 30; 30 x \$2,000 penalty = \$60,000].

Q: If I provide coverage, do I have to offer it to my new full time employees on day one?

A: No. Employers subject to the law in 2014 are allowed a waiting period of 90 days without penalty. On day 91, they must provide new hires coverage or pay the penalty for not doing so.

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Tax Credits for Health Coverage

Does Your Small Business Qualify for a Break from the IRS?

The Internal Revenue Service offers numerous resources on its website to help employers determine if they qualify for the Small Business Health Care Tax Credit. The site includes a 3-step calculator, Q&A, video and other tools. www.tinyurl.com/smallbiztaxcredit.com

The tax guidance on the IRS website answers specific questions, but here are the basics:

- Eligible small employers are those with no more than 25 full time equivalent employees for the taxable year, the average annual wages of those employees do not exceed \$50,000 and the employer's contribution for the employees for a qualified health plan in the exchange is not less than 50% of the premium. See page 5 for a definition of the exchange.

- The amount of the credit is phased out based on the number of employees and their average wages using a formula. The full credit is available to employers with 10 or fewer employees with average wages less than \$25,000.
- The amount of credit is 50% of the lesser of the aggregate amount of the employer contribution for employees' premiums of qualified health plans offered by the employer in the exchange OR the average premium in the small group market.
- This small business tax credit is considered part of the general business credit and can be used against alternative minimum.
- The small business tax credit expires after six years.

—National Restaurant Association

3 Simple Steps

If you are a small employer (business or tax-exempt) that provides health insurance coverage to your employees, determine if you may qualify for the Small Business Health Care Tax Credit by following these three simple steps:

1 Determine the total number of your employees (not counting owners or family members):

Full time employees:

(enter the number of employees who work at least 40 hours per week)

+

Full time equivalent of part time employees:

(Calculate the number of full time equivalents by dividing the total annual hours of part time employees by 2080.)

= total employees

If the total number of employees is fewer than 25, you are eligible for STEP 2.

2 Calculate the average annual wages of employees (not counting owners or family members):

Take the total annual wages paid to employees:

÷

Divide it by the number of employees from STEP 1:

(total wages ÷ number of employees)

= average wages

If the result is less than \$50,000, AND

↓

3 You pay at least half of the insurance premiums for your employees at the single (employee-only) coverage rate, then you may be able to claim the Small Business Health Care Tax Credit. Find out more information at IRS.gov

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