



Health Care Reform LEGISLATIVE BRIEF

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Affordable Care Act (ACA) Violations—Penalties and Excise Taxes

The Affordable Care Act (ACA) includes numerous reforms for group health plans and creates new compliance obligations for employers and health plan sponsors. The ACA, for example, requires health plans to eliminate pre-existing condition exclusions and provide coverage for preventive care services without cost-sharing. Some of the reforms for health plans apply to all health plans, while others apply only to nongrandfathered plans or to insured plans in the small group market.

Starting in 2015, the ACA requires applicable large employers (ALEs) to either provide affordable, minimum value health coverage to full-time employees or face penalties. Employers and plan sponsors must also comply with new reporting and disclosure requirements, such as the health coverage reporting requirements under Internal Revenue Code (Code) Sections 6055 and 6056. In addition, the ACA imposes several taxes and fees on health plan sponsors, such as the transitional reinsurance fee and the tax on high-cost employer plans.

Failing to comply with the ACA’s requirements can cause **severe consequences** for an employer. The potential consequences vary depending on the ACA requirement that is involved and the nature and extent of the violation. Employers should keep these consequences in mind as they continue to work on ACA compliance.

GROUP HEALTH PLAN REFORMS

Code Section 4980D imposes an excise tax for a group health plan’s failure to comply with certain requirements, including the ACA’s reforms for group health plans. Failing to comply with a group health plan requirement may trigger an excise tax of **\$100 per day** with respect to each individual to whom the failure relates.

ACA Requirements

The \$100 per individual, per day excise tax may be triggered by a violation of any of the following ACA requirements for group health plans:

Requirement	Compliance Date	Affected Group Health Plans
Coverage for adult children up to age 26	Plan years beginning on or after Sept. 23, 2010 (limited exemption for grandfathered plans for plan years prior to Jan. 1, 2014)	Health plans offering dependent coverage
No lifetime or annual limits on the dollar value of essential health benefits (EHB)	For lifetime limits, plan years beginning on or after Sept. 23, 2010 For annual limits, plan years beginning on or after Jan. 1, 2014 (restricted annual limits phased in for 2010 to 2013)	All health plans Exceptions apply for integrated HRAs and FSAs offered under a cafeteria plan. These plans are not subject to the prohibition on annual limits.

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Requirement	Compliance Date	Affected Group Health Plans
No coverage rescissions, except in cases of fraud or intentional material misrepresentation	Plan years beginning on or after Sept. 23, 2010	All health plans
No pre-existing condition exclusions	Plan years beginning on or after Sept. 23, 2010, for enrollees under age 19 Plan years beginning on or after Jan. 1, 2014, for all other enrollees	All health plans
Coverage of preventive health services without cost-sharing	Plan years beginning on or after Sept. 23, 2010	Nongrandfathered health plans (certain exceptions apply to the contraceptive coverage mandate)
Patient protections (designation of primary care provider, designation of pediatrician as primary care provider, patient access to obstetrical and gynecological care and improved access to emergency services)	Plan years beginning on or after Sept. 23, 2010	Nongrandfathered health plans
Improved internal claims and appeals process, including external review requirements	Plan years beginning on or after Sept. 23, 2010	Nongrandfathered health plans
Uniform summary of benefits and coverage (SBC) requirement	First open enrollment period beginning on or after Sept. 23, 2012, for participants enrolling during open enrollment For other participants, first plan year beginning on or after Sept. 23, 2012	All health plans
No waiting periods in excess of 90 days	Plan years beginning on or after Jan. 1, 2014	All health plans
Nondiscrimination rules for fully insured health plans	Effective date is delayed until guidance is released	Nongrandfathered, fully insured health plans
Limits on cost-sharing (out-of-pocket maximum for EHB)	Plan years beginning on or after Jan. 1, 2014	Nongrandfathered health plans
Coverage for approved clinical trials	Plan years beginning on or after Jan. 1, 2014	Nongrandfathered health plans

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Requirement	Compliance Date	Affected Group Health Plans
No discrimination based on health status (including rules for wellness programs)	Plan years beginning on or after Jan. 1, 2014	Nongrandfathered health plans (final regulations on wellness plans apply to both nongrandfathered and grandfathered health plans)
Comprehensive health insurance coverage (EHB requirement)	Plan years beginning on or after Jan. 1, 2014	Nongrandfathered insured health plans in the small group market
No discrimination against health care providers acting within the scope of license	Plan years beginning on or after Jan. 1, 2014	Nongrandfathered health plans

Reporting and Paying the Tax

For health plans sponsored by a single employer, the **tax is imposed on the plan sponsor**. In most cases, the plan sponsor is the employer. The excise tax does not apply to health plans sponsored by governmental employers, and it does not apply to health insurance issuers. However, the excise tax does apply to health plans sponsored by churches.

Any applicable excise taxes must be reported on [IRS Form 8928](#), "Return of Certain Excise Taxes under Chapter 43 of the Internal Revenue Code." [Instructions](#) for Form 8928 are also available.

An employer must file Form 8928 and pay the excise tax by the due date of the employer's federal income tax return, without taking into account any extensions. Filers may obtain an automatic six-month extension of time for filing Form 8928, but obtaining an extension does not extend the time to pay the excise taxes that are due.

Amount of Tax

The penalty for not complying with the ACA's group health plan reforms is generally \$100 per day, per individual, per violation, subject to the following minimum and maximum amounts:

- If a compliance failure is discovered by the IRS on audit, the **minimum excise tax** is generally \$2,500. However, if the violations are significant, the minimum excise tax increases to \$15,000.
- For single employer plans, the **maximum excise tax** for unintentional failures is the lesser of 10 percent of the aggregate amount paid by the employer during the preceding tax year for group health plan coverage or \$500,000.

Exceptions

There are some exceptions to the excise tax for group health plan violations. The excise tax may not apply if the failure is not discovered when exercising reasonable diligence, or if it is due to reasonable cause and is corrected within 30 days after the entity knew (or in exercising reasonable diligence, should have known) that the failure existed. A failure is corrected if it is retroactively undone to the extent possible and the affected beneficiary is placed in a financial position as good as he or she would have been in if the failure had not occurred.

In addition, small employers with insured health plans may be exempt from the excise tax for certain failures if the violation was solely because of the health insurance coverage offered by the insurer. A small employer for this purpose is an employer with an average of 50 or fewer employees on business days during the preceding calendar year.

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SUMMARY OF BENEFITS AND COVERAGE

The ACA establishes a penalty of up to **\$1,000** for each willful failure to provide the SBC. Failing to provide the SBC may also trigger an excise tax of **\$100 per day**, per individual, as discussed above.

Compliance Relief

However, the Departments of Labor, Health and Human Services and the Treasury (Departments) have stated that their approach to implementation emphasizes assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and comply with the SBC requirement. According to [FAQs](#) issued by the Departments in May 2014, this enforcement relief will continue to apply until further guidance is issued.

The ACA also requires health plans and issuers to provide at least **60 days' advance notice** of any material modifications to plan terms that take effect during a plan year and are not reflected in the most recently provided SBC. A willful failure to provide this 60-day advance notice may trigger a \$1,000 penalty and an excise tax of \$100 per day, per individual.

EMPLOYER COVERAGE MANDATE

The ACA's employer shared responsibility rules are often referred to as the "pay or play" rules or the employer mandate. Under these rules, beginning in 2015, ALEs may face penalties if one or more of their full-time employees obtains a subsidy through an Exchange. An ALE is an employer with, on average, at least 50 full-time employees, including full-time equivalents (FTEs), during the preceding calendar year. An individual may be eligible for a subsidy either because the ALE does not offer health plan coverage or the employer offers coverage that is either not "affordable" or does not provide "minimum value" (MV).

The amount of the pay or play penalty generally depends on whether an employer offers coverage to **substantially all** full-time employees and their dependents. In general, "substantially all" means 95 percent of an employer's full-time employees and dependents. However, under a special transition provision for 2015 (and any calendar months during the 2015 plan year that fall in 2016), "substantially all" means 70 percent of an employer's full-time and employees and dependents.

Effective Date

ALEs with 100 or more full-time (and FTE) employees must comply with the pay or play rules starting in 2015. ALEs that have fewer than 100 full-time (and FTE) employees will generally have an additional year, until 2016, to comply.

Penalty for Not Offering Coverage to Substantially All Full-time Employees

Once the pay or play rules take effect, an ALE will be subject to a penalty if any of its full-time employees receives a subsidy toward an Exchange plan. The monthly penalty assessed on ALEs that do not offer coverage to substantially all full-time employees and their dependents will be equal to the number of full-time employees (minus 30) multiplied by 1/12 of \$2,000 for any applicable month.

Transition relief for 2015 allows employers with 100 or more full-time employees (including FTEs) to reduce their full-time employee count by 80 when calculating the penalty. This relief applies for 2015 plus any calendar months of 2016 that fall within the employer's 2015 plan year.

Penalty for Offering Coverage

Employers that do offer coverage to substantially all full-time employees and dependents may still be subject to penalties if at least one full-time employee obtains a subsidy in an Exchange plan because the employer did not offer coverage to all full-time employees, or the employer's coverage is unaffordable or does not provide MV.

The monthly penalty assessed on an ALE for each full-time employee who receives a premium credit will be 1/12 of \$3,000 for any applicable month. However, the total penalty for an employer would be limited to the penalty amount for not offering coverage to substantially all full-time employees.

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PENALTIES RELATED TO REPORTING REQUIREMENTS

The Internal Revenue Code also includes the following general penalties that apply for violations of reporting requirements, including those imposed under the ACA:

- Failure to file correct information returns (under Code Section 6721); and
- Failure to furnish correct payee statements (under Code Section 6722).

However, penalties may be waived if the failure is due to reasonable cause and not to willful neglect. Penalties may be reduced if the reporting entity corrects the failure within a certain period of time. Also, lower annual maximums apply for reporting entities that have average annual gross receipts of up to \$5,000,000 for the most recent 3 taxable years.

On June 29, 2015, President Obama signed the [Trade Preferences Extension Act of 2015](#) into law, which **increases the penalties** for failure to file correct information returns or provide individual statements under Code Sections 6721 or 6722. **These changes are effective for information returns and individual statements required to be filed or provided after Dec. 31, 2015.** The increased penalty amounts are as follows:

Penalty Type	Per Violation		Annual Maximum		Annual Maximum for Employers with ≤\$5 Million in Gross Receipts	
	Old Amount	New Amount	Old Amount	New Amount	Old Amount	New Amount
General	\$100	\$250	\$1.5 million	\$3 million	\$500,000	\$1 million
Corrected within 30 days	\$30	\$50	\$250,000	\$500,000	\$75,000	\$175,000
Corrected after 30 days, but before August 1	\$60	\$100	\$500,000	\$1.5 million	\$200,000	\$500,000
Intentional disregard	\$250*	\$500*	None		N/A	

*For failures due to intentional disregard of the filing requirement will be equal to the greater of either the listed penalty amount or 10 percent of the aggregate amount of the items required to be reported correctly.

FORM W-2 REPORTING—AGGREGATE COST OF HEALTH CARE

The ACA requires employers to report the aggregate cost of employer-sponsored group health plan coverage on their employees' Forms W-2. Until the IRS issues further guidance, this reporting requirement is **optional for small employers** (those that file fewer than 250 Forms W-2). Beginning in 2012, the IRS made the reporting requirement **mandatory for large employers**. Thus, the W-2 reporting requirement is currently mandatory for large employers, but optional for small employers.

Violations of the ACA's W-2 reporting requirement are subject to the existing rules on filing Forms W-2. See the penalty amounts under Sections 6721 and 6722, described above, for employers that fail to comply with the W-2 reporting requirement.

There are some exceptions to the Form W-2 reporting penalties. For example, a penalty will not apply if the employer can show that the failure was due to reasonable cause and not to willful neglect. In general, the employer must be able to show that:

- The failure was due to an event beyond the employer's control or due to significant mitigating factors; and
- The employer acted in a responsible manner and took steps to avoid the failure.

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EMPLOYER REPORTING—CODE SECTIONS 6055 & 6056

The ACA created new reporting requirements under Code Sections 6055 and 6056. Under these new reporting rules, certain employers will be required to provide information to the IRS about the health plan coverage they offer (or do not offer) to their employees. Related statements must also be provided to employees. These new reporting requirements apply to:

- **Employers with self-insured health plans (Code § 6055)**—Every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage must file an annual return with the IRS, reporting information for each individual who is provided with this coverage. Related statements must also be provided to individuals.
- **ALEs with at least 50 full-time employees, including FTEs (Code § 6056)**—ALEs subject to the ACA’s shared responsibility provisions must file a return with the IRS that reports the terms and conditions of the health care coverage provided to the employer’s full-time employees for the calendar year. Related statements must also be provided to employees.

In an effort to minimize any burdens and streamline the reporting process, the IRS allows reporting entities to use a single, combined form for reporting the information required under both Section 6055 and 6056.

These reporting requirements were set to take effect in 2014. However, on July 2, 2013, the Treasury delayed these requirements for one year, until 2015. **The first returns will be due in 2016 for coverage provided in 2015.** However, short term relief from penalties is available in 2015 for reporting entities that make good faith efforts to comply with the information reporting requirements.

TYPE OF REPORTING	AFFECTED EMPLOYERS	REQUIRED INFORMATION	DEADLINES
Code §6055 —Reporting of health coverage by health insurance issuers and sponsors of self-insured plans	Employers with self-insured health plans	Information on each individual provided with coverage (helps the IRS administer the ACA’s individual mandate)	IRS filing deadline is Feb. 28 (March 31 if filed electronically) of the year following the calendar year to which the return relates. The first returns are due by Feb. 29, 2016 (Feb. 28, 2016, being a Sunday), or March 31, 2016, if filed electronically.
Code §6056 —ALE health coverage reporting	Applicable large employers (those with at least 50 full-time employees, including FTEs)	Terms and conditions of health plan coverage offered to full-time employees (helps the IRS administer the ACA’s employer shared responsibility penalty)	Employee statements must be provided by Jan. 31 of the year immediately following the calendar year to which the statements relate. The first employee statements are due by Feb. 1, 2016 (Jan. 31, 2016, being a Sunday). Reporting entities showing good cause may be allowed an extension of up to 30 days to furnish statements.

A reporting entity that fails to comply with the Section 6055 or Section 6056 reporting requirements may be subject to the general reporting penalties for failure to file correct information returns and failure to furnish correct payee statements under Code Sections 6721 and 6722. However, penalties may be waived if the failure is due to reasonable cause and not to willful neglect. Penalties may be reduced if the reporting entity corrects the failure within a certain period of time. Also, lower annual maximums apply for reporting entities that have average annual gross receipts of up to \$5,000,000 for the most recent 3 taxable years.

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Compliance Relief

For returns and statements filed and furnished in 2016 to report offers of coverage in 2015, the IRS will not impose penalties on reporting entities that can show they made good faith efforts to comply with the reporting requirements. Relief is available only for incorrect or incomplete information reported on the return or statement, including Social Security numbers, TINs or dates of birth. No relief is provided for reporting entities that do not make a good faith effort to comply with these reporting requirements or that fail to timely file an information return or statement.

PCORI FEES

Health insurance issuers and self-funded group health plans must pay fees to finance comparative effectiveness research. These research fees are called Patient-centered Outcomes Research Institute fees (PCORI fees). The fees apply for plan years ending on or after Oct. 1, 2012. The PCORI fees do not apply for plan years ending on or after Oct. 1, 2019. For calendar year plans, the research fees are effective for the 2012 through 2018 plan years.

The PCORI fees are due by July 31 of the calendar year following the plan year to which the fee applies.

For plan years ending before Oct. 1, 2013 (that is, 2012 for calendar year plans), the research fee was \$1 multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2013, and before Oct. 1, 2014, the fee is \$2 multiplied by the average number of lives covered under the plan. For plan years ending on or after Oct. 1, 2014, and before Oct. 1, 2015, the fee amount was adjusted to \$2.08 under IRS Notice 2014-56. For plan years ending on or after Oct. 1, 2015, the PCORI fee amount will grow based on increases in the projected per capita amount of National Health Expenditures.

Since the PCORI fee is considered a tax that is reportable on IRS Form 720, any related penalty for failure to file a return or pay a tax likely applies. Under Code Section 6651, the penalty for failing to file a return or pay a tax is the full amount of the tax, plus possible excise taxes ranging from .5 percent to 25 percent of the original tax. However, there are exceptions to the excise taxes for failures that are due to reasonable cause and not due to willful neglect.

REINSURANCE FEES

Health insurance issuers and self-funded group health plans must pay fees to a transitional reinsurance program for the first three years of health insurance Exchange operation (2014 to 2016). The fees will be used to help stabilize premiums for coverage in the individual market. Fully insured plan sponsors do not have to pay the fee directly.

Certain types of coverage are excluded from the reinsurance fees, including HRAs that are integrated with major medical coverage, HSAs, health FSAs and coverage that consists solely of excepted benefits under HIPAA (such as stand-alone vision and dental coverage). Also, self-insured group health plans that do not use a third-party administrator for their core administrative functions are exempt from the requirement to make reinsurance contributions for the 2015 and 2016 benefit years.

The reinsurance program's fees are based on a national contribution rate, which HHS announces annually. For 2014, HHS announced a national contribution rate of \$63 per enrollee per year. For 2015, the national contribution rate is \$44 per enrollee per year. The reinsurance fee is calculated by multiplying the average number of covered lives by the national contribution rate.

According to HHS ([FAQ ID 3341](#)), any reinsurance contribution payment that is not made on time will be subject to the federal debt collection rules. Additionally, reinsurance contributions are considered federal funds that would be subject to the False Claims Act.

"CADILLAC" TAX ON HIGH-COST HEALTH COVERAGE

For taxable years beginning in 2018, the ACA imposes a **40 percent excise tax** on high-cost group health coverage. This tax, also known as the "Cadillac tax," is intended to encourage companies to choose lower-cost health plans for their employees. Found in Code Section 49801, the Cadillac tax provision taxes the amount, if any, by which the monthly cost of an employee's applicable employer-sponsored health coverage exceeds the annual limitation (called

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the employee's excess benefit). For most employees, the initial dollar amount for purposes of calculating an employee's excess benefit is **\$10,200** for individual coverage and **\$27,500** for other than individual coverage.

The tax amount for each employee's coverage will be calculated by the employer and paid by the coverage provider. If the employer or plan sponsor fails to accurately calculate the excess benefit attributable to each coverage provider, and as a result the coverage provider pays too little tax, the employer or plan sponsor will be subject to a tax penalty. The coverage provider will not be assessed any penalty, but will be required to pay the amount of the additional tax.

The penalty amount is:

- 100 percent of the additional excise tax due; and
- Interest on the underpayment.

The penalty will not apply if the employer or plan sponsor can establish that it did not know, and could not have known through reasonable diligence, that the failure existed. In addition, a penalty will not apply if the failure was due to reasonable cause and not willful neglect, so long as:

- It is corrected within 30 days after the employer (or plan sponsor) knew, or through reasonable diligence, would have known that the failure existed; or
- The IRS waives all or any portion of the penalty.

The IRS is expected to issue guidance on the Cadillac tax requirements before they become effective in 2018.

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