Affordable Care Act FAQs — Individuals

The Supreme Court's landmark decision on the Affordable Care Act (ACA) has resulted in uncertainties among many individuals, regardless of their tax bracket, personal circumstances or state of residence. Below are some commonly asked questions that address issues ranging from coverage availability to tax credit eligibility. Your CPA can provide the guidance you need to make the most timely, well-informed health care and tax planning decisions.

Coverage Requirement and the Health Insurance Marketplace

Q: What impact does the ACA have on my health care decisions?

A: The ACA generally requires that all individuals have qualifying health insurance coverage, also referred to as Minimum Essential Coverage (MEC), in effect for each month, other than certain short coverage gaps, of 2014 and succeeding years.

If you already have MEC through your employer, a government-sponsored program, a direct purchase from an insurance company or the Health Insurance Marketplace (the Marketplace), you need only to maintain it. However, MEC does not include coverage that provides only limited benefits, such as stand-alone vision or dental care.

If you are without MEC, you can purchase it in the Marketplace, which facilitates the purchase of health insurance in each state in accordance with the ACA.

Q: What is the Health Insurance Marketplace?

A: The Marketplace facilitates the purchase of health insurance in each state in accordance with the ACA. It provides government-regulated and standardized health care plans from which individuals, families and small businesses (businesses with 50 or fewer full-time equivalent employees) can compare health insurance plans based on costs, benefits and other features, and enroll in coverage.

Marketplace plans cover essential health benefits and have four levels: Bronze, Silver, Gold and Platinum, each based on the average percentage that the plan pays toward health care services. The Platinum level generally pays the highest percentages and has the lowest deductibles, co-pays and cost-sharing structure, though it requires the highest premiums.

Q: When is the Marketplace health care enrollment period?

A: In most cases, you can only enroll in health plan coverage through the Marketplace during the Open Enrollment period.

For coverage starting in 2017, Open Enrollment begins Nov. 1, 2016, and closes Jan. 31, 2017. Coverage can start as soon as Jan 1, 2017. (If you enroll between the 1st and 15th of the month, your coverage starts the first day of the next month.)

If you lose eligible coverage, have a child, marry or experience another significant life event, you may qualify for a special 60-day enrollment period in Marketplace health plans outside Open Enrollment periods.

Q: When can I change plan types, for example, from the Platinum Plan with the highest premium to the Bronze Plan with the lowest premium?

A: You are required to remain within your chosen plan for 12 months or until the next Open Enrollment period, even if there has been a change in your health. However, if you qualify for a special enrollment period 60 days following certain life events that involve a change in family status, for example, marriage or birth of a child, or loss of other health coverage, you may change plans at that time.

Q: If I live in one state but work in another, which Marketplace should I use when purchasing coverage?

A: Generally, you should purchase coverage in the Marketplace in the state where you live.

Q: What are the maximum out-of-pocket costs for individual Marketplace plans?

A: The maximum out-of-pocket cost limit for any individual Marketplace plan for 2016 is $6,850 for an individual plan and $13,700 for a family plan.

Exemptions From Coverage

Q: Are there any circumstances under which I can be exempt from the ACA's coverage requirement?

A: You may be exempt from the ACA's coverage requirement if:

- Your minimum required payment for annual premiums is more than 8.13% in 2016 of your annual household income (for certain lowest cost employer-sponsored or Marketplace plans, or
- Your annual income is below the minimum threshold for filing a tax return, or
- You belong to a group specifically exempt from the coverage requirement, such as Christian Scientists or a federally recognized American Indian tribe.

Q: What steps do I need to take for an exemption to apply?

A: The application procedures will depend on your exemption category.

For example, if you are claiming an exemption due to a coverage gap that was less than three months or citizenship status, you can simply claim the exemption when you file your federal tax return.

However, if you are seeking exemption due to religious affiliation or certain situations that prevented you from obtaining coverage (e.g., foreclosure), you must submit an application to the Marketplace to obtain an exemption code that is reported on your tax return.

Keep in mind that the exemption code must be obtained *before* you file your return. Filing the exemption request early will help ensure the timely filing of your return.

Payment for Lack of Coverage

Q: How much is the Individual Shared Responsibility payment?

A: The 2016 payment is the greater of these two amounts:

- 2.5% of your yearly household income. The maximum penalty is the national average premium for a Bronze plan.
- A flat-dollar amount, which is $695 per uninsured person for the year ($347.50 per child under age 18). The maximum penalty per family using this method is $2,085.

For future years, the vfee will increase with inflation.

Also, if you did not enroll in coverage during the Marketplace's Open Enrollment period or qualify for the special enrollment period, your payment will be prorated based on the number of months you are uninsured.

Q: If I do not qualify for an exemption, what are the consequences for not having qualifying coverage for me, my spouse and any dependents?

A: You will be required to make an Individual Shared Responsibility payment for yourself and any non-covered family members for each month that you do not have qualifying coverage, which is due when you file your federal income tax return.

However, there is no payment required for a coverage gap lasting less than three months.

Taxpayer Relief

Q: Is any tax relief available that can lower my out-of-pocket premiums?

A: Individuals may be eligible for the Premium Tax Credit on their federal income tax return if they:

- Purchase insurance through the Marketplace
- Are ineligible for employer or government-plan coverage
- Are within specific low- or moderate-income limits (household income between 100% and 400% of the annual poverty line)
- Cannot be claimed as a dependent by another person

Q: What type of changed circumstances may affect the Premium Tax Credit and should be reported to the Marketplace?

A: Significant events that should be reported include changes in income, marital status or residence; the birth or adoption of a child; or a new job or other change that affect eligibility or access to health care coverage.

Q: How is the Premium Tax Credit applied?

A: When applying for Marketplace coverage, you will provide information such as projected income and family size that is used to estimate your Premium Tax Credit. You can then decide to have some or all of the estimated credit paid in advance to your insurance company to lower your monthly premiums, or wait to claim the credit when you file your return.

If you have the credit paid in advance, the payment will be reconciled with the actual credit when you file your federal income tax return. Any overpayment needs to be paid back to the IRS. If you do not take advance credit payments, you may claim the credit when you file your tax return, which will either reduce your taxes owed or increase your refund.

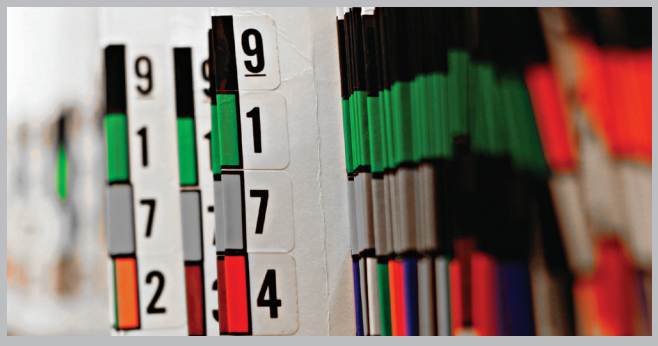
You can help expedite correct financial assistance and advance payments by promptly reporting any changes to your income or household size to the Marketplace.

Premium Reimbursement

Q: Can my employer reimburse me for health insurance premiums that I pay for an individual policy?

A: They can, but they will probably be subject to a nondeductible excise tax. The amount of the excise tax is steep: $100 per employee, per day, which amounts to $36,500 per year for each individual reimbursed under an arrangement. These arrangements are subject to the excise tax because they limit the amount of benefits to a maximum amount and do not provide for preventive services.

Under the ACA, group health plan annual and lifetime benefits cannot be limited and they must provide preventive services. This excise tax is imposed on the employer reimbursing the premium.



Tax-Advantaged Medical Benefits

Q: How have Health Flexible Spending Arrangements (FSA) contributions and Health Savings Account (HSA) distributions been affected by the ACA?

A: Annual contributions to a health FSA are limited to $2,550 (inflation adjusted) or the plan maximum, whichever is less, and there is a 20% penalty, up from 10%, on HSA funds applied to non-qualified medical expenses.

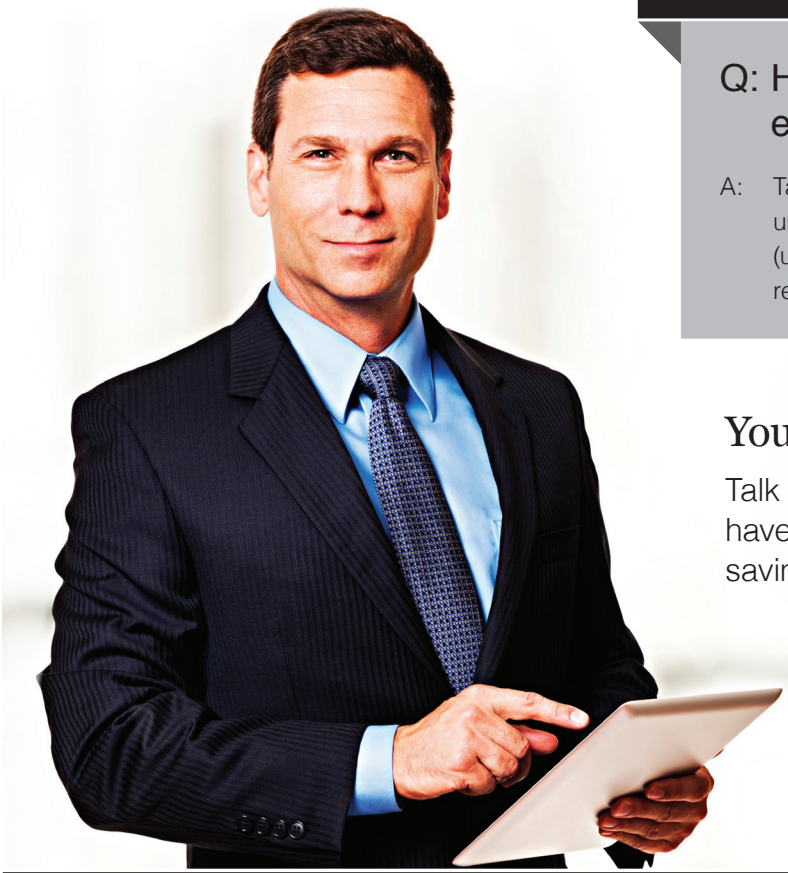
Q: Can distributions from HSAs or Archer Medical Savings Accounts (MSAs) be used to pay for over-the-counter medicines and drugs without a tax penalty?

A: With the exception of insulin, only prescription medicines and drugs are qualified medical expenses not subject to an additional 20% penalty tax.

Q: If FSA funds are used for co-pays and deductibles, are those expenses still reimbursable tax-free with Health FSA funds?

A: Funds used for co-pays and deductibles still are reimbursable tax-free from a Health FSA and a Health Reimbursement Arrangement (HRA).

Medical Deductions



Q: How have deductions for medical expenses been affected by the ACA?

A: Taxpayers under 65 years of age can only deduct unreimbursed medical/dental expenses that exceed 10% (up from 7.5%) of adjusted gross income. The deduction remains 7.5% through 2016 if age 65 or older.

Your CPA Can Help

Talk to your CPA about any concerns you may have about the ACA or ways to maximize tax savings for medical costs.

CPA