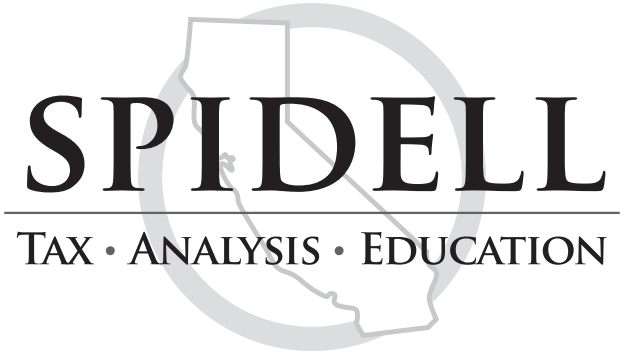
Health Insurance: Update for HRAs, 2% Shareholders, and More



www.caltax.com | E-mail: CPE@spidell.com | Phone: 714-776-7850 | Fax: 714-776-9906

HEALTH INSURANCE: UPDATE FOR HRAS, 2% SHAREHOLDERS, AND MORE

Course objectives: This course will provide an update of health insurance and health reimbursement arrangements (HRAs) subsequent to the passage of the 21st Century Cures Act in December 2016. Topics addressed include: eligible HRA reimbursements; HRA eligibility; the ACA's effect on HRAs; Notice 2015-17; self-employed taxpayers; partnerships and LLCs; 2% S corporation shareholders; attribution rules; Medicare; and much more.

After completing this course, you will be able to:

- Determine the tax treatment for reimbursements from an S corporation to a 2% shareholder for individual health insurance
- Recall how COBRA coverage affects HRA reimbursements
- Identify the limitations imposed by the 21st Century Cures Act for small businesses and HRAs
- Recall how and where sole proprietors report health insurance benefits
- Identify who should purchase a Medigap policy

Category: Taxes

Recommended CPE Hours: CPAs — 1 Tax
EAs/CRTPs — 1 Federal Update

Level: Basic

Prerequisite: None

Advanced Preparation: No advanced preparation is required.

Expiration Date: February 2018

Table of Contents

INTRODUCTION TO THIS WEBINAR

We receive many questions from practitioners about the proper reporting of fringe benefits, specifically health insurance and health reimbursement arrangements (HRAs) as they apply to small business owners, and with the passage of the 21st Century Cures Act in December 2016, the topic has become even more popular.

This webinar will cover the 21st Century Cures Act and the revised HRA rules, including:

- Eligible HRA reimbursements;
- Eligibility to participate in an HRA;
- Tax reporting for employees covered under HRAs and how they compare to self-employed health insurance; and
- We will use an employee fringe benefit comparison chart to help you explain the rules to your clients and provide a discussion of Medicare options and issues.

HEALTH REIMBURSEMENT ARRANGEMENTS — HOW WE GOT TO WHERE WE ARE

DEFINING HRAs

An HRA is an arrangement that:

- Is paid for solely by an employer and not through an employee salary reduction election or otherwise under an IRC §125 cafeteria plan;
- Reimburses an employee for medical care expenses incurred by the employee, his or her spouse, or dependents; and
- Provides reimbursement up to a maximum dollar amount for a coverage period. Any unused portion at the end of a coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods.
  (Notice 2002-45)

DEDUCTION FOR EMPLOYER

Revenue Ruling 61-146 provides that reimbursements to an employee for the employee's share of out-of-pocket medical expenses and/or premiums for medical insurance are treated as contributions by an employer to a health plan. Therefore, they are deductible by the employer and excluded from the employee's income, much like the direct payments by the employer to the insurance company.

INCOME EXCLUSION FOR EMPLOYEE

HRA coverage and reimbursements of medical care expenses are also generally excluded from the employee's gross income. (IRC §§105, 106; Rev. Rul. 61-146) To be eligible for the income exclusion, employees must substantiate qualifying medical expenses to their employer. (Rev. Rul. 61-146) Later, we will discuss an exception —2% shareholders of S corporations.

If an HRA provides a reimbursement for an amount paid to an employee for health insurance that has already been excluded from gross income, then payments made by the HRA are included in the employee's gross income. (Rev. Rul. 2002-3)

Example of HRA reimbursement

Tom and Gwen are married. Tom works for Smallco, and Gwen works for Bigco. Smallco has an HRA and will reimburse Tom for medical expenses, including health insurance, up to $4,500 per year. Tom and Gwen participate in Bigco's group health plan.

If Gwen participates in Bigco's health plan by salary reductions through its IRC §125 cafeteria plan (pretax), then Tom's HRA cannot reimburse Tom for his wife's salary reductions because Gwen is already receiving a pretax benefit; otherwise Tom and Gwen would receive a double benefit.

However, Tom's HRA could still reimburse Tom for any of Gwen's (or his) out-of-pocket medical expenses, such as co-pays, prescription drugs, etc., and still qualify for an income exclusion for Tom.

Eligible HRA reimbursements

HRA plans may provide reimbursement for any medical expenditures provided under IRC §213, so any medical expense available as an itemized deduction also qualifies for HRA reimbursements, including:

- Prescription drugs and insulin;
- Over-the-counter medicine and drugs, but only if prescribed by a doctor;
- Any amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease;
- Transportation that is essential for medical care;
- Long-term care services; and
- Health insurance (including Medicare).

Disqualifying payments

An HRA does not qualify for the income exclusion to an employee if any person has the right to receive cash or any other taxable or nontaxable benefit under the HRA other than the reimbursement of medical care expenses. (Notice 2002-45)

If any person has the right to receive cash, currently or for any future year, other than for the reimbursement of medical care expenses, then all distributions to all persons made from the HRA are included in gross income.

Example of disqualifying HRA payments

Tom, from the previous example, still works for Smallco. Smallco offers its health reimbursement arrangement as part of its IRC §125 cafeteria plan.

Cafeteria plans, by their very nature, permit employees to choose among at least one taxable benefit (such as cash) and one qualified benefit, including accident and health benefits. If Smallco's HRA plan meets all the requirements of an IRC §125 cafeteria plan, but allows an employee to receive cash instead of pretax HRA benefits, then the entire HRA offered by Smallco disqualifies for income exclusion to its employees.

HRA eligibility

Reimbursements from an HRA must be for medical care expenses for:

- Current and former employees;
- Their spouses;
- Their dependents; or
- The spouses and dependents of deceased employees.
  (Notice 2002-45)

HRAs may continue to reimburse former employees or retired employees even if the employee does not elect COBRA coverage.

Note that the term "employee" does not include a self-employed individual, discussed later. However, amounts reimbursed to bona fide employees, including an owner's spouse and dependents, are still excludable from the employee's gross income. (Rev. Rul. 71-588)

ENTER THE ACA

Until the Affordable Care Act (ACA) was passed, violation of the HRA rules simply meant that the benefits paid from the HRA to an employee were included in the employee's gross income. In that case, the benefits would be subject to income tax withholding as well as FICA and Medicare.

After passage of the ACA, the above rules still applied to HRAs; however, employers now face far more than back payroll taxes for violation of the HRA rules. Now, an employer that violates the HRA rules as they apply to the ACA also faces a $100 per day, per employee tax penalty ($36,500 per employee, per year). (IRC §4980D)

Many practitioners understood this to mean that HRAs were no longer permissible under the ACA and advised their clients to abandon them quickly. This was generally solid advice for many small business owners who offered HRAs as their only medical benefit to their employees. This was true because HRAs that weren't integrated with group insurance could easily result in penalties.

However, HRAs were still permitted under the ACA. The problem was that there were some changes that encompassed new ACA requirements, so most existing plans did not qualify if new language wasn't included. Since the initial enactment of the ACA provisions, additional guidance has been released to clarify these rules.

SUBSEQUENT ACA GUIDANCE

NOTICE 2013-54: GUIDANCE ON THE ACA'S EFFECT ON HRAs

Notice 2013-54 states that HRAs that cover more than one employee are considered "group health plans" and are subject to the requirements of the ACA, including:

- Prohibition on annual and lifetime limits;
- Prohibition on rescissions;
- Prohibition on cost sharing for preventive services;
- Coverage of adult children;
- Patient protections regarding choice of doctor and other services;
- Prohibition on excluding preexisting conditions; and
- No waiting periods over 90 days.

Many of these requirements can be met by HRAs. However, by their very nature, health reimbursement plans cannot meet some of the requirements, including prohibitions on annual limits and preventive care rules.

However, simply offering an HRA is not a violation of the ACA. Generally, if an HRA is integrated with a group health plan and the group health plan standing on its own meets all the ACA's requirements, then there is no $100 per day penalty under IRC §4980D because the combined benefit of the group plan and the integrated HRA satisfy the ACA's requirements.

This meant that an employer without a group health plan could not offer an HRA and reimburse employees for health insurance plans purchased on the open market. The 21st Century Cures Act (discussed below) eases this rule.

HRAs that are offered to only one employee do not violate the ACA and are thus not subject to the IRC §4980D $100 per day, per employee penalty, regardless of what they reimburse. Keep in mind that health plans disallow discrimination, so an owner/employee cannot simply create an HRA for himself only (and exclude other employees) if it would create discriminatory treatment.

NOTICE 2015-17: ADDITIONAL GUIDANCE AND TRANSITION RELIEF

Notice 2015-17 provided relief from the $100 per day penalties, but only for employers that are not applicable large employers (those with fewer than 50 full-time equivalent employees) and only through June 30, 2015.

Relief for S corporations made indefinite

Notice 2008-1 provides that if an S corporation pays for or reimburses premiums for individual health insurance covering a 2% shareholder, the payment or reimbursement is included in the shareholder's income, but the 2% shareholder-employee may deduct the premiums as an above-the-line deduction (as self-employed health insurance). (IRC §162(l))

Notice 2015-17 provides that until further guidance is issued (and to this date, no additional guidance has been issued), S corporation shareholders may continue to rely on Notice 2008-1. Additionally, if an employee is covered under a reimbursement arrangement with family coverage and another employee is covered by that same coverage as a spouse or dependent of the first employee, then the arrangement is considered to cover only one employee. Thus, if an S corporation has, as its sole shareholder-employees, a husband and wife, it is not subject to Notice 2013-54 because the husband and wife are deemed a single employee, and single employee plans are not considered group health plans. Notice 2015-17 stresses that it does not apply to employees of S corporations who are not 2% shareholders.

Practice Pointer

It is possible that a 2% shareholder would be allowed both an above-the-line deduction for self-employed health insurance pursuant to IRC §162(l) as well as a premium tax credit under IRC §36B. The IRS issued Revenue Procedure 2014-41 to provide taxpayers with calculation methods that resolve the circular relationship between IRC §162(l) and the §36B premium tax credit.

Be sure to review Revenue Procedure 2014-41 if you have clients that fall into this small group.

Medicare premium reimbursement for active employees

An arrangement under which an employer reimburses (or pays directly) some or all of Medicare Part B or Part D premiums for employees constitutes an employer payment plan, and if the arrangement covers more than one active employee, then it is a group health plan subject to penalties for noncompliance of ACA requirements. (Notice 2015-17)

HRAs cannot be integrated with Medicare coverage because Medicare coverage is not defined as a group health plan under the ACA. However, an employer payment plan that pays for or reimburses Medicare Part B or D premiums is considered to be integrated with another group health plan offered by the employer for purposes of the annual dollar limit prohibition and the preventive service requirements if:

- The employer offers a group health plan (other than the HRA) to the employee that does not consist solely of excepted benefits and offers coverage providing minimum value;
- The employee participating in the employer payment plan is actually enrolled in Medicare Parts A and B;
- The employer payment plan is available only to employees who are enrolled in Medicare Part A, B, or D, and
- The employer payment plan is limited to reimbursement of Medicare Part B or D premiums and excepted benefits, including Medigap premiums.

HRAs can reimburse Medicare for active employees so long as the HRA plan is integrated with an ACA-compliant plan offered to other employees.

WHAT IS STILL ALLOWED

There are still two categories of arrangements that remain permissible:

- HIPAA-excepted arrangements; and
- Fully integrated arrangements.

HIPAA-excepted arrangements

Generally, HIPAA-excepted benefits include retiree-only plans and plans that cover only dental and vision. Therefore, an employer that does not offer an ACA-compliant health insurance plan to its employees can offer an HRA that offers just HIPAA-excepted benefits to its employees without violating Notice 2013-54.

> ***Example of HIPAA-excepted plan***
>
> Sean Stone, a sole proprietor, does not offer his employees an ACA-compliant health insurance plan. Sean may establish an HRA for his employees that covers only dental and vision. Payments from this plan are excludable from the employees' wages because it does not pay other medical expenses provided under a HIPPA plan.

Fully integrated arrangements

An HRA will qualify if it is integrated with a qualified health plan (QHP) that is ACA-compliant.

However, an HRA cannot be integrated with individual market coverage or an employer plan that provides coverage through individual policies.

Comment

If the employer provides a QHP, then the requirements of a group health plan under the ACA are met. This opens the door for a reimbursement arrangement because even though the arrangement is a group health plan, by being integrated with the QHP, it is *part* of a group health plan in which the requirements have been met.

Allowable Reimbursement Arrangements	
No minimum value: limited reimbursement	**Minimum value: open-ended reimbursement**
QHP must be offered with more than HIPAA-excepted benefits	QHP must be offered providing minimum value
Employee must actually be enrolled in QHP	Employee must be actually enrolled in QHP
HRA reimburses only: • Copayments and deductibles; • Premiums under QHP; and • Medical expenses that are not essential health benefits (i.e., dental and vision)	Arrangement may reimburse any medical expense covered in IRC §213(d)

21st CENTURY CURES ACT

The 21st Century Cures Act (the Act) was signed into law on December 13, 2016, and exempts certain employers who operate HRAs from penalties imposed by the ACA. (HRA 34: The 21st Century Cures Act)

HR 34 amends the Internal Revenue Code to allow qualified HRAs to operate for small businesses without penalty. The rules require adherence to certain limits, including:

- Funding solely by employer contributions, no salary reduction contributions;
- Benefits capped at $4,950 per year ($10,000 for families);
- Proration of benefits for partial years; and
- Notification and reporting requirements.

Small businesses are those that are not "applicable large employers." Therefore, qualifying businesses are generally those with fewer than 50 employees. The Act allows employers without group plans to reimburse premiums for individual plans without being subject to ACA penalties.

The employee must provide documentation to the employer to prove that the employee used the funds to purchase health insurance that provides minimum essential coverage.

In addition, the employee is not eligible for a premium tax credit for any month in which the employee is a participant in a qualifying HRA.

However, an HRA that is integrated with a qualified group plan still can't reimburse insurance premiums for an individual employee's separately purchased health insurance plan.

Example of allowable HRA premium reimbursement

Timco has 25 employees and does not offer group health insurance. Timco does offer an HRA that meets the requirements of the 21st Century Cures Act and reimburses employees for individual insurance policy premiums.

Timco's HRA plan can reimburse its employees for health insurance coverage they purchase on an exchange marketplace. However, the employees are ineligible for the premium tax credit for any month in which they are covered by Timco's HRA.

Example of disallowed HRA premium reimbursement

Joyco has 25 employees and offers ACA-compliant group health coverage to its employees and an HRA that meets the requirements of the 21st Century Cures Act.

Lisa decides she does not like the group health coverage offered by Joyco, so she purchases her own individual policy on an exchange marketplace. Joyco's HRA can't reimburse Lisa for her premiums.

RETROACTIVE PENALTY RELIEF

HR 34 retroactively extends the relief provided to small businesses in Notice 2015-17 to any plan year beginning on or before December 31, 2016. The provisions of the bill are effective to years beginning after December 31, 2016.

CAN'T MIX AND MATCH

One provision of HR 34 is that an employer cannot provide a qualifying cash-for-insurance HRA to any employee if the employer provides health coverage to even one employee. This caused alarm among small employers who thought this provision meant that an employer may no longer provide health coverage and have an HRA. This is not the case. Notice 2013-54 still applies, and an employer may provide health insurance and have either an arrangement providing only excepted benefits or a fully integrated arrangement.

This provision only means that an employer cannot provide health insurance to some employees and a cash-for-insurance HRA to other employees.

Example of mix and match

Jay is the sole shareholder of J. Co., a C corporation. J. Co. has 20 employees and offers an ACA-compliant health plan. Jay cannot offer an HRA only for himself that reimburses him for health insurance he purchases outside of the health plan J. Co. offers to its employees.

REVIEW QUESTIONS

Under the NASBA-AICPA self-study standards, self-study sponsors are required to present review questions intermittently throughout each self-study course. Additionally, feedback must be given to the course participant in the form of answers to the review questions and the reason why answers are correct or incorrect.

To obtain the maximum benefit from this course, we recommend that you complete each of the following questions, and then compare your answers with the solutions that immediately follow. *These questions and related suggested solutions are not part of the final examination and will not be graded by the sponsor.*

1. Details of HRAs are correctly described in which of the following?

    a) Reimbursements to an employee from an employer for out-of-pocket medical expenses are deductible to the employer
    b) Reimbursements to an employee from an employer for out-of-pocket medical expenses must be included in the employee's gross income
    c) Both over-the-counter and prescription drugs always qualify for HRA reimbursements
    d) Employees must elect COBRA coverage in order to continue to receive reimbursements if they retire or otherwise leave the company

2. What is true of Notice 2015-17, and what guidance did it provide to businesses?

    a) The notice provided relief from the $100 per day, per employee penalties for all employers
    b) Reimbursements from an S corporation to a 2% shareholder for individual health insurance are not included in the shareholder's income
    c) The provisions of Notice 2015-17 apply to all employees of S corporations
    d) If an employee is covered under an HRA with family coverage, and another employee is also covered by the same arrangement as a spouse or dependent, the arrangement is considered to cover just one employee

3. What is an accurate feature of the 21st Century Cures Act?

    a) It applies to small businesses with fewer than 100 employees
    b) Employees may still be eligible for a premium tax credit while participating in the employer's HRA
    c) An employer cannot provide health insurance to some employees and an HRA that offers cash for insurance to others
    d) An HRA that is integrated with a qualified group plan may reimburse insurance premiums for an employee's health insurance plan that was purchased separately

SOLUTIONS TO REVIEW QUESTIONS

Under the NASBA-AICPA self-study standards, self-study sponsors are required to present review questions intermittently throughout each self-study course. Additionally, feedback must be given to the course participant in the form of answers to the review questions and the reason why answers are correct or incorrect.

To obtain the maximum benefit from this course, we recommend that you complete each of the following questions, and then compare your answers with the solutions that immediately follow. *These questions and related suggested solutions are not part of the final examination and will not be graded by the sponsor.*

1. Details of HRAs are correctly described in which of the following? **(Page 1)**

    a) Correct. Such reimbursements are considered contributions by the employer to the employee's health plan.
    b) Incorrect. They are typically not included in the employee's gross income unless the reimbursement is for an amount that was already excluded.
    c) Incorrect. Over-the-counter medication will only qualify if prescribed by a physician.
    d) Incorrect. Reimbursements for an HRA may continue even without a COBRA election.

2. What is true of Notice 2015-17, and what guidance did it provide to businesses? **(Page 4)**

    a) Incorrect. The notice specifically applied to employers who were not applicable large employers.
    b) Incorrect. Such reimbursements are included in shareholder income and may be deducted as an above-the-line deduction.
    c) Incorrect. The notice does not apply to employees who are not 2% shareholders.
    d) Correct. For example, a husband and wife who are the only shareholder-employees of an S corporation are considered one employee.

3. What is an accurate feature of the 21st Century Cures Act? **(Page 7)**

    a) Incorrect. The Act applies to businesses that are not applicable large employers, which means the small businesses must employ fewer than 50 employees.
    b) Incorrect. The employee is not eligible for a PTC in any month they are participating in an HRA.
    c) Correct. The Act states that an employer cannot provide a cash-for-insurance HRA to any employee if the employer provides health coverage to even one employee, although the employer is able to offer health insurance and still have an arrangement providing excepted benefits or a fully integrated arrangement.
    d) Incorrect. In the case of an integrated arrangement, the HRA cannot reimburse an individual for their separately purchased plan.

SELF-EMPLOYED HEALTH INSURANCE

DEFINING SELF-EMPLOYED TAXPAYERS

Self-employed individuals may deduct the cost of health insurance for themselves, their spouse, dependents, and their children who are under age 27 as of the end of the year. (IRC §§162(l)(1), 401(c))

Self-employed individuals are generally defined as those:

- With earned income during the taxable year (IRC §401(c)(1)(B));
- From a trade or business in which personal services of the taxpayer are a material income-producing factor (IRC §401(c)(2)(A)(i)); and
- Who are not employees of another. (IRC §3121(d))

Individuals who would be defined as self-employed but for the fact that their trade or business did not have any net profits for the year are also deemed to be self-employed.

Self-employed taxpayers include:

- Sole proprietors and farmers who report their profit and loss from business on Schedule C or F of Form 1040;
- Partners;
- LLC members (treated as partners for income tax reporting); and
- Shareholders of S corporations that own (or are treated as owning) more than 2% of an S corporation's stock.

SOLE PROPRIETORS AND FARMERS

Sole proprietors and farmers who report their profit and loss from business on Schedule C or F deduct their self-employed health insurance as an above-the-line deduction on page 1 of Form 1040.

The above-the-line deduction cannot exceed the sum of self-employment income, less the deductible part of the taxpayer's self-employment tax. If the health insurance deduction is limited due to insufficient self-employment income, then the excess is reported as a medical expense on Schedule A, Itemized Deductions, and subject to AGI limitations.

Example of Schedules C and F self-employed health insurance deduction

John is single and a jack of all trades. John has the following taxable income:

Income	Self-Employment?	Amount
Wages	No	$80,000
Consulting income (Schedule C)	Yes	$ 7,500
Capital gains	No	$ 500
Farm income (Schedule F)	Yes	$ 2,000
Total income		$90,000
Self-employment income		$ 9,500

John paid $12,000 during the year for health insurance premiums. The deductible part of John's self-employment tax is $671.

John's above-the-line deduction for self-employed health insurance cannot exceed his self-employment income, less the deductible part of his self-employment tax:

Self-employment income	$9,500
Self-employment tax deduction	($ 671)
Maximum deduction	$8,829

John paid $12,000 for his health insurance for the year, so the remainder of $3,171 ($12,000 - $8,829) is deducted on Schedule A as a medical expense.

PARTNERSHIPS AND LLCs

Entity-level reporting

When it comes to fringe benefits, partners and members of LLCs taxed as partnerships are not able to take advantage of deductible fringe benefits as they would if the business were a C corporation.

Partners/members cannot be employees of the partnerships/LLC. Accordingly, unless the enabling fringe benefit statute specifically allows partners to receive a given benefit on a tax-free basis, a partner/member is taxed on the value of any such benefits provided by the partnership.

Health insurance and benefits covered under accident and health plans are benefits that are taxed to partners/members, but HRAs are not. (IRC §§105, 106)

Revenue Ruling 91-26 discusses the taxation of fringe benefits to partners in partnerships, and the same rules will apply to LLCs taxed as partnerships. So, when a partnership/LLC pays accident and health insurance benefits for the individual partners/member, the payment should be accounted for in the following places:

- Form 1065, page 1, line 10 – Guaranteed payments;
- Form 1065, Schedules K and K-1, line 4 – Guaranteed payments;
- Form 1065, Schedule K, line 13d – Other deductions; and
- Form 1065, Schedule K-1, line 13M – Other deductions (amounts paid for medical insurance).

Partner/member's 1040

Partners/members report their health insurance deduction on Form 1040, page 1, as an above-the-line deduction and calculate any limitations in the same manner as sole proprietors and farmers, above.

Example of health insurance paid by an LLC

Dotcom, LLC has two members: Bill and Joan. Each member owns an equal 50% interest in the profits, losses, and capital of the LLC. Dotcom provides health insurance for all its employees and members. The health insurance for Bill and his family amounts to $5,000 per year. Dotcom has ordinary income of $20,000 for 2016 before accounting for payments of Bill's health insurance.

Bill's K-1 from Dotcom should show:

Ordinary income (line 1) ($20,000 - $5,000) × 50%	$7,500
Guaranteed payments (line 4)	$5,000
Other deductions (line 13M)	$5,000

Bill will include the entire $5,000 of medical insurance, treated as a guaranteed payment, in his income on Form 1040, but then he will also be able to deduct that same $5,000 on page 1 of his 1040 as an above-the-line deduction for self-employed health insurance.

Example of health insurance paid directly by partner

The facts are the same as the example immediately above, except Dotcom offers no form of health insurance. Bill purchases health insurance for himself and his family on an exchange marketplace.

Dotcom, LLC has no reporting requirements for Bill's health insurance. Bill may deduct the health insurance he purchases as an above-the-line deduction for self-employed health insurance as long as his self-employment income is greater than the health insurance premiums.

If Bill's health insurance premiums are more than his self-employment income, then the difference is reported as an itemized deduction on Schedule A subject to the medical expense AGI limitations.

2% S CORPORATION SHAREHOLDERS

For purposes of applying employee fringe benefit rules (including health insurance), S corporations are treated as partnerships, and S corporation shareholders are treated as partners if they own (or are treated as owning), on any day during the taxable year:

- More than 2% of the S corporation's outstanding stock; or
- More than 2% of the total combined voting power of the S corporation.
  (IRC §1372)

Attribution rules

Stock owned directly or indirectly by one taxpayer may be attributed to another taxpayer for purposes of determining the 2% shareholder rule.

Individuals (aka family attribution rules)

An individual is treated as owning the stock owned by or for:

- His spouse (other than a spouse who is legally separated from the individual under a decree of divorce or separate maintenance); and
- His children (natural or adopted), grandchildren, and parents.
  (IRC §318(a)(1))

Stock ownership is only attributed to one taxpayer removed from the stock's actual owner; otherwise it would be attributed in an endless chain reaction.

Example of attribution

Bill is married to Emma, and they have three daughters, Alison, Dawn, and Cindy. Bill, Alison, and Dawn own BAD Company, an S corporation. Bill owns 40% of the company's stock, Alison owns 35%, and Dawn owns 25%.

Through family attribution rules, each family member is deemed to own the following stock:

Family member	Deemed ownership	Explanation
Bill	100%	His own 40% plus the stock owned by Alison and Dawn
Emma	100%	Deemed to own the stock owned by her spouse, Bill, and daughters Alison and Dawn
Alison	75%	Her own 35% plus her dad's 40%
Dawn	65%	Her own 25% plus her dad's 40%
Cindy	40%	Deemed to own her dad's 40%

Family attribution rules do not apply to siblings, and stock ownership cannot be reattributed. In other words, Alison is not deemed to own the stock owned by Dawn, and Dawn's stock that is deemed owned by Bill is not then reattributed to Alison.

If Cindy is employed by BAD Company, then the 40% stock ownership attributed to her will subject her to the self-employment rules for fringe benefits pursuant to IRC §1372(a).

Entity-level reporting

Medical insurance benefits paid on behalf of a 2% shareholder are reported in the following places on Form 1120S:

- **Form 1120S, page 1, line 18:** Employee benefit programs;
- **Schedule K:** nothing reported on Schedule K; and
- **Schedule K-1, line 17V:** Other information.

The medical insurance benefits are also reported on the 2% shareholder-employee's Form W-2. The benefits are included on Form W-2, line 1, as gross wages, and are subject to income tax withholding but are excluded from boxes 3 and 5 because they are not subject to FICA or Medicare withholding. Additionally, the health insurance premiums are included in box 14, other information, on the 2% shareholder-employee's W-2.

Shareholder's 1040

For purposes of the earned income limitation, a more than 2% S corporation shareholder's wages from the S corporation are treated as that shareholder's earned income. Items reported on Form K-1, Shareholder's Share of Income, Deductions, Credits, etc., do not come into play in determining earned income for purposes of the self-employed health insurance deduction limitation.

A 2% shareholder-employee in an S corporation is entitled to deduct health insurance premiums as an above-the-line deduction if the plan providing medical care coverage for the 2% shareholder-employee is established by the S corporation. (IRC §162(l); Rev. Rul. 91-26) A plan providing medical care coverage for the 2% shareholder-employee in an S corporation is established by the S corporation if:

- The S corporation makes the premium payments in the current taxable year; or
- The 2% shareholder-employee makes the premium payments and furnishes proof of premium payment to the S corporation, and then the S corporation provides a reimbursement in the taxable year.

Example of 2% shareholder self-employed health insurance deduction

Amber is married with children and is the sole shareholder of Cutback, Inc., an S corporation. Cutback, Inc. has had some very lucrative years but has struggled to make a profit this year, so Amber has cut her salary and has relied on her spouse's income. Amber has the following taxable income:

Income	Self-Employment?	Amount
Cutback, Inc. wages	Yes*	$ 10,000
Spouses's wages from unrelated employment	No	$150,000
Interest income	No	$ 500
Capital gains	No	$ 5,000
Schedule K-1 ordinary income from Cutback, Inc.	No	$ 5,000
Total taxable income		$170,500
Self-employment income		$ 10,000

* Yes for self-employment health insurance deduction purposes, but not subject to the self-employment tax

Amber paid $12,000 during the year for family health insurance premiums through Cutback, Inc. Amber's wages are considered earned income for purposes of calculating the self-employed health insurance deduction but are not subject to self-employment tax, so the deductible part of Amber's self-employment tax is $0.

Amber's above-the-line deduction for self-employed health insurance cannot exceed her self-employment income, less the deductible part of her self-employment tax ($10,000 - $0 = $10,000). Amber paid $12,000 for her health insurance for the year, so the remainder of $2,000 ($12,000 - $10,000) is deducted on Schedule A as an itemized deduction for medical care.

Planning for S corporations

A properly organized health plan can save 2% S corporation shareholders up to 15.3% (the self-employment tax) on their out-of-pocket health care expenses.

Example of HRA and S corporation planning

Lily is married to Pat, has no dependents, and is the sole shareholder of Flower-Lily, Inc. (FL).

FL has 10 employees, including Lily and Pat. FL offers ACA-compliant health insurance as well as an HRA plan to its employees with the following characteristics:

- $4,950 for each employee ($10,000 families), funded fully with employer contributions;
- HRA benefits may be used for health insurance costs for an employee's family and out-of-pocket costs, but employees must provide documentation to FL to prove they used the funds for qualifying medical expenses and/or to purchase health insurance that provides minimum essential coverage.

As a 2% shareholder, Lily may participate in FL's health insurance plan but may not directly participate in the HRA plan because she is treated the same as a partner for fringe benefit purposes, and as previously discussed, partners may participate as employees in a health insurance plan but not an HRA plan.

However, even though Pat is deemed to be 2% shareholder through attribution rules, as a bona fide employee, Pat may participate in the HRA and qualify for FL's $10,000 limit on HRA reimbursements for families. In this way, Lily can indirectly participate in FL's HRA plan.

Under the HRA plan, Pat's benefits (up to $10,000 for the family plan) are not subject to FICA or Medicare, and thus the plan would save 15.3% combined between FL and Pat.

Comparison of LLC (Taxed as a Partnership), S Corporation, and C Corporation			
Issue	**LLC**	**S corporation**	**C corporation**
Compensation	Members are never employees. Managing and working members are subject to self-employment tax on guaranteed payments and ordinary income	Must take reasonable compensation as wages subject to payroll taxes; net income may be subject to self-employment tax for personal service corporation	Must take wages subject to payroll tax; reasonable compensation issues
Medical insurance and long-term care	Not deductible by LLC — above-the-line deduction for member	Included in wages of >2% shareholder — above-the-line deduction (see IRS Notice 2008-1)	Deductible from C corporation income — not included in W-2 provided insurance is nondiscriminatory (employees are covered)
Medical reimbursement plan	Not available to member	Not available to >2% shareholder	Deductible by C corporation — not included in W-2
Disability and life insurance	No deduction for disability or life insurance paid for LLC member	Disability not available to >2% shareholder; life insurance not available to S corporation shareholder	Disability and up to $50,000 in premiums deductible for shareholder if employees are covered

MEDICARE INSURANCE OPTIONS — OVERVIEW

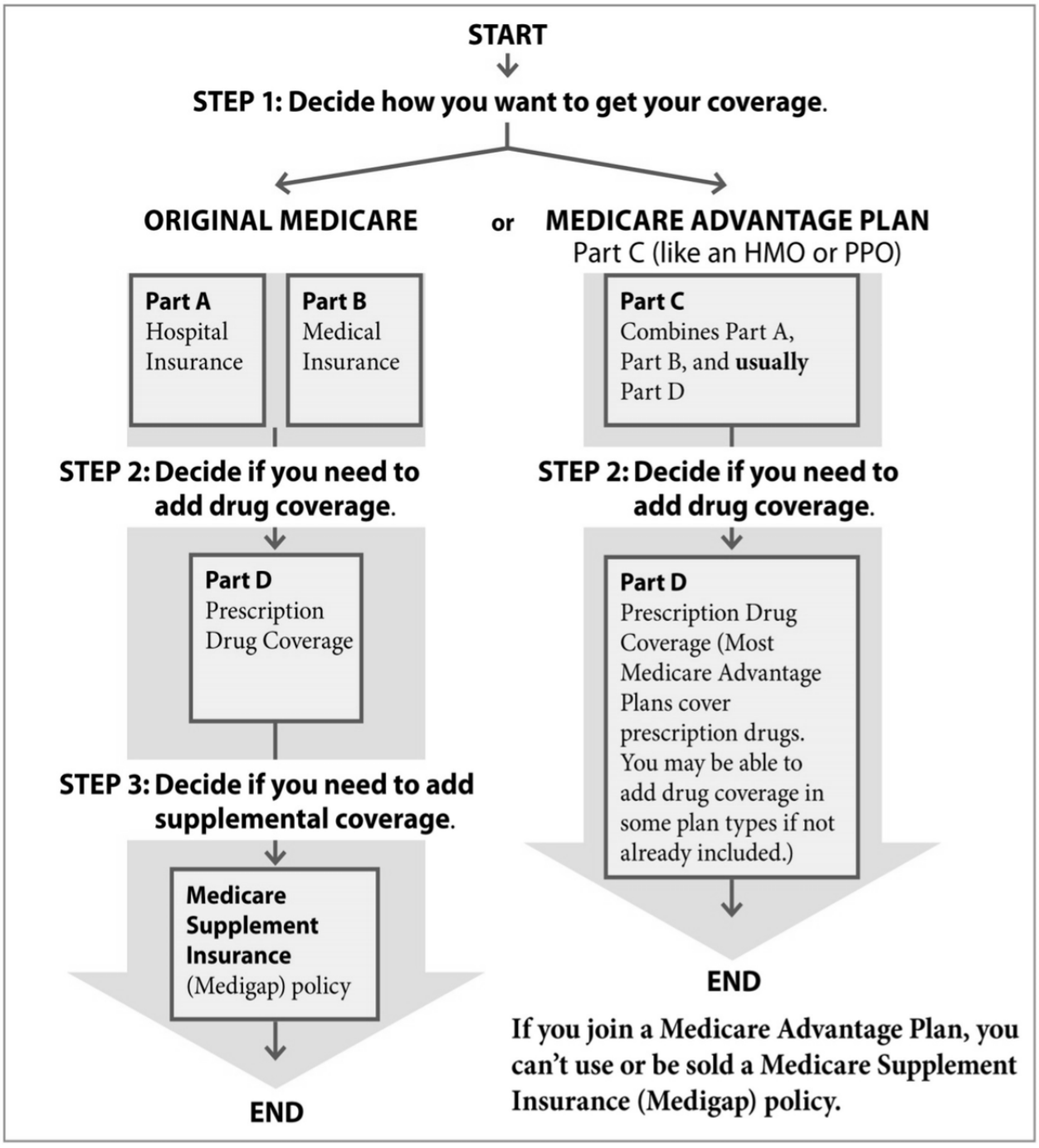
While the key age for Social Security is currently 66, the magic number for Medicare is age 65. Medicare is our country's health insurance program, and while it was signed into law in 1965 as an amendment to the Social Security Act, the program is now under the auspices of the U.S. Department of Health and Human Services.

Individuals should apply for Medicare from three months before their 65th birthday month to three months after — a seven-month period. If already receiving Social Security benefits, they will be automatically enrolled in Parts A and B upon turning age 65.

There are four parts to Medicare:

- **Part A:** hospital insurance;
- **Part B:** medical insurance;
- **Part C:** Medicare advantage plan; and
- **Part D:** prescription drug coverage.

The following is an excellent decision chart from the Medicare publication *Medicare & You* (2014). As shown on the chart, there are two options available to a Medicare recipient: Original Medicare (Parts A and B) and Medicare Advantage Plan (Part C), with the option of adding Part D in either scenario.



Source: *Medicare & You* (2014). Available at: www.medicare.gov/Pubs/pdf/10050.pdf

What's the Difference Between Parts A, B, C, and D?				
Part A	**Part B**	**Supplemental**	**Part C**	**Part D**
Hospital	Doctors and other medical expenses not covered by Part A; this plan is PPO insurance	Pays what A and B don't pay (amounts depent on policy); not required	PPO; replaces Part A, Part B, and elective supplement	Prescription drugs
No charge	Monthly charge billed through SSA	Monthly charge paid to insurance company	Monthly charge billed through SSA	Can pay for additional drug costs on the side

PART A

This is the hospital insurance portion of Original Medicare. If one chooses to purchase Part A, Part B must also be purchased. For those with limited income and assets, the state may help pay for Part A and/or Part B. Features include:

- Covers 80% of inpatient hospital care, skilled nursing, hospice, and home health care; and
- Free for most recipients — if they paid Medicare taxes while working (called "premium-free Part A").

PART B

This is the medical insurance portion of Original Medicare. It helps cover doctors' services, outpatient care, and other medical services not covered by Part A. Part B also covers some preventive services.

It involves a monthly premium — $109.00 per month for 2017 ($134.00 if you were not enrolled in 2016). The premium is higher for married recipients with AGI exceeding $170,000 or single recipients with AGI over $85,000.

If individuals do not enroll in Part B when first eligible, a late enrollment penalty of 10% will apply. The penalty is 10% for each full 12-month period after the initial enrollment period ends. For example, if a person's initial enrollment period ended September 30, 2013, and he waited until March 2016 to sign up for Part B, two full 12-month periods will have elapsed. Therefore the penalty would be 20% of his premium each year for the rest of his life.

An exception to the Part B late enrollment penalty is if one works past age 65 and is covered by medical insurance at work. This also applies to a spouse having work-provided medical insurance, covering both spouses. An individual has eight months from the date the covered worker stops working, or the date the coverage ends — whichever is earlier — to then apply for Part B penalty-free.

PART C

This is the Medicare Advantage (MA) Plan alternative to Parts A and B. It involves plans offered by private companies, approved by Medicare. Medicare pays a fixed amount for an individual's care every month to the selected company, and the recipient pays a monthly premium.

MA plans include managed care plans, PPO plans, and specialty plans. They provide all of one's Part A and Part B coverage and may even offer extra coverage, such as vision, hearing, dental, etc.

PART D

This is the Prescription Drug Coverage plan available to both Part A/B and Part C recipients. Drug plans are operated by insurance companies and other private companies approved by Medicare.

Part D is optional, and most Part C plans include it. While optional, there is also a penalty for late enrollment, not nearly as onerous as the Part B late penalty.

A monthly premium also applies to this plan, which varies based on level of coverage.

SUPPLEMENTAL

Because Medicare doesn't cover 100% of medical-related costs, some recipients opt to supplement their coverage with a second policy, sometimes referred to as Medigap. Medigap uses a virtual alphabet soup of plan alternatives: A, B, C, D, F, G, K L, M, and N.

All insurers offering Medigap coverage must offer identical coverage for each plan type; the only difference is cost. Therefore, shopping around is important.

It should be noted that with Medicare's Part C (Medicare Advantage Plans), Medigap is not needed, nor can it be sold to a Part C subscriber.

SHARED ELIGIBILITY

An individual must be eligible for Social Security in order to also be eligible for subsidized Medicare. Government employees are eligible if they paid the Medicare portion of the Social Security tax.

Individuals at least 65 years of age or disabled who are already receiving Social Security benefits are automatically enrolled in Medicare Parts A and B and have the option to opt out of Part B. If not receiving Social Security benefits by age 65, an individual should contact Medicare and discuss enrollment options and deadlines.

Comment

Everyone is eligible for Medicare, even without the requisite number of qualifying quarters of work. The difference is that anyone who doesn't have the qualifying quarters of work will have to pay higher premium costs in order to get coverage.

HOLD HARMLESS FOR MOST ENROLLEES

There is an increase in the basic Part B premium. However, because of the hold harmless provision, most enrollees will pay a small additional premium over 2016 even though basic premiums have increased more.

The hold harmless provision is intended to guarantee that Social Security beneficiaries see no reduction in their net check; that is, their Social Security premium after deduction for Part B premiums.

Since most beneficiaries have withholding of Medicare premiums, in most cases, it boils down to which year an individual first became a beneficiary.

DEDUCTING PREMIUMS FROM SOCIAL SECURITY PAYMENTS

Medicare premiums are generally deducted from Social Security payments, depending on the individual's situation. Requests to have the premium deducted takes about two months to go into effect, and so the first amount deducted will be two months' worth of premiums.

If the premium amount exceeds the amount of the Social Security payment, the premium will not be deducted from the payment, and the individual will need to pay the premium through some other means.

Not yet collecting Social Security

An individual not yet collecting Social Security benefits will not make quarterly payments to the Social Security Administration either.

Medicare will bill you for your coverage, and payment can be made in one of three ways:

- Medicare Easy Pay, a free service with deductions each month from a checking or savings account;
- Check or money order; or
- Credit card.

Premium assistance

Individuals who are receiving premium assistance will still have the full premium amount deducted from their Social Security payment, and then must get reimbursed by Medicare for the amount of extra assistance. Social Security cannot adjust the percentage of the premium that is withheld.

INFORMATION AND ASSISTANCE

SOCIAL SECURITY

- The SSA's website (www.socialsecurity.gov or www.ssa.gov) is an excellent source of information, including numerous publications;
- The National Committee to Preserve Social Security & Medicare (www.ncpssm.org) is a nonprofit organization. "Ask Mary Jane" at the bottom of the homepage — she will respond to questions submitted via the website; and
- Meet with a representative at SSA offices or via phone at (800) 772-1213.

MEDICARE

- The Medicare website (www.medicare.gov) is also an excellent source of information, including numerous publications, such as *Medicare & You*;
- Medicare assistance and information can be obtained countrywide via the Seniors Resource Guide (www.seniorsresourceguide.com); and
- California residents may obtain advice and information through the Health Insurance Counseling & Advocacy Program (HICAP), a division of California Health Advocates (www.calhealthadvocates.org). Program managers will give advice and information only; they will not make decisions for, nor enroll, clients.

GLOSSARY OF ACA TERMS

Affordable coverage: A job-based health plan covering only the employee that costs 9.66% or less of the employee's household income. If a job-based plan is "affordable," and meets the "minimum value" standard, the taxpayer is not eligible for a premium tax credit if he/she buys a Marketplace insurance plan instead of the job-based health plan.

- The plan used to define affordability is the lowest priced "self-only" plan the employer offers — meaning a plan covering only the employee, not dependents. This is true even if the taxpayer is enrolled in a plan that covers more or covers dependents.
- The cost is the amount the employee would pay for the insurance, not the plan's total premium.
- The employee's total household income is used. Total household income includes income from everybody in the household who's required to file a tax return.

Annual limit: A cap on the benefits an insurance company will pay in a year while the taxpayer is enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After the annual limit is reached, the taxpayer must pay all associated heath care costs for the rest of the year.

Employer shared responsibility payment (ESRP): The ACA requires certain employers with at least 50 full-time employees (or equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the ACA or to make a tax payment called the ESRP.

Essential health benefits: A set of 10 categories of health services that must be covered under the ACA. These include doctor's services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

Lifetime limit: A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Minimum value: A standard of minimum coverage that applies to job-based health plans. If an employer's plan meets this standard and is considered "affordable," employees aren't eligible for a premium tax credit if they buy a Marketplace insurance plan instead.

A health plan meets the minimum value standard if both of these apply:

- It's designed to pay at least 60% of the total cost of medical services for a standard population; and
- Its benefits include substantial coverage of physician and inpatient hospital services.

Minimum essential coverage: Any insurance plan that meets the ACA's requirement for having health coverage. To avoid the penalty for not having insurance, a taxpayer must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage"). Examples of plans that qualify include: marketplace plans, job-based plans, Medicare, Medicaid, and CHIP.

Premium tax credit: A tax credit taxpayers can use to lower their monthly insurance payment (called a "premium") when they enroll in a plan through a marketplace. The tax credit is based on the income estimate and household information provided by the taxpayer on his/her marketplace application.

If the taxpayer's estimated income falls between 100% and 400% of the federal poverty level for their household size, then they qualify for a premium tax credit.

A taxpayer can use all, some, or none of his/her premium tax credit in advance (the advanced premium tax credit) to lower his/her monthly premium.

If the taxpayer uses more advance payments of the tax credit than he/she qualifies for base on their final yearly income, then the taxpayer must repay the difference when they file their federal income tax return. If the taxpayer uses less premium tax credit than they qualify for, then they will receive the difference as a refundable credit when they file their tax return.

Preventive services: Routine health care that includes screenings, check-ups, and patient counseling to prevent illness, disease, or other health problems.

Second-lowest cost silver plan (SLCSP): The second-lowest priced marketplace health insurance plan in the silver category that applies to the taxpayer. It may not be the plan the taxpayer enrolled in. The taxpayer needs to know his/her SLCSP premium to figure out his/her final premium tax credit. In most cases, the SLCSP premium is reported on Form 1095-A.

The Marketplace sends Form 1095-A to the taxpayer early in the year after someone in the household had a Marketplace health plan.

REVIEW QUESTIONS

Under the NASBA-AICPA self-study standards, self-study sponsors are required to present review questions intermittently throughout each self-study course. Additionally, feedback must be given to the course participant in the form of answers to the review questions and the reason why answers are correct or incorrect.

To obtain the maximum benefit from this course, we recommend that you complete each of the following questions, and then compare your answers with the solutions that immediately follow. *These questions and related suggested solutions are not part of the final examination and will not be graded by the sponsor.*

4. Which statement correctly identifies the tax treatment and reporting requirements of fringe benefits and HRAs for self-employed taxpayers?

    a) Self-employed individuals may deduct health insurance costs for themselves, their spouse, dependents, and children under age 18 as of the end of the year
    b) Sole proprietors and farmers using Schedule C or F to report business profit and loss deduct their health insurance as an above-the-line deduction on page 1 of Form 1040
    c) For partnerships and LLCs, HRAs and health insurance benefits are taxed to partners/members
    d) S corporations' medical insurance benefits are reported on a 2% shareholder-employee's Form W-2 and are subject to income tax withholding, as well as FICA and Medicare

5. What is an accurate feature of Medicare as outlined under Parts A, B, C, and D?

    a) Part A may be purchased alone
    b) Parts A and B are typically free as long as the individual paid Medicare taxes while they were working
    c) Part D, Prescription Drug Coverage, is not included with Parts A, B, or C, and must always be purchased separately
    d) Medicare Advantage plans involve private insurance companies that get paid by Medicare to cover a person's care every month

SOLUTIONS TO REVIEW QUESTIONS

Under the NASBA-AICPA self-study standards, self-study sponsors are required to present review questions intermittently throughout each self-study course. Additionally, feedback must be given to the course participant in the form of answers to the review questions and the reason why answers are correct or incorrect.

To obtain the maximum benefit from this course, we recommend that you complete each of the following questions, and then compare your answers with the solutions that immediately follow. *These questions and related suggested solutions are not part of the final examination and will not be graded by the sponsor.*

4. Which statement correctly identifies the tax treatment and reporting requirements of fringe benefits and HRAs for self-employed taxpayers? **(Page 8)**

    a) Incorrect. For insurance purposes, children are considered individuals under the age of 27.
    b) Correct. The above-the-line deduction cannot be more than the sum of all self-employment income, less whatever is deductible from the taxpayer's self-employment tax.
    c) Incorrect. Although health insurance benefits provided from a health plan are taxed to partners/members, HRAs are not.
    d) Incorrect. Medical insurance benefits are not subject to FICA and Medicare.

5. What is an accurate feature of Medicare as outlined under Parts A, B, C, and D? **(Page 16)**

    a) Incorrect. An individual who chooses Part A must also purchase Part B.
    b) Incorrect. Part A is free, but there is a fee of $109 per month to cover physician's services, outpatient care, and whatever else is not covered in Part A.
    c) Incorrect. Part D is frequently included in a Part C Medicare Advantage plan.
    d) Correct. The companies must be approved by Medicare, and the individual pays a monthly premium for a managed care plan, a PPO, or some type of specialty plan.

GLOSSARY

Above-the-line deduction: a deduction that is subtracted from income prior to calculating adjusted gross income in order to lower tax liability

Applicable large employer: a company with a minimum of 50 full-time employees or full-time equivalents. Under the Affordable Care Act, a full-time employee is one who works for at least 30 hours per week

COBRA: the Consolidated Omnibus Budget Reconciliation Act, under which individuals are entitled to continue to receive health benefits if they are fired or otherwise leave their job. Employers with 20 or more employees are required to give employees who are leaving the company the option of continuing their health coverage (including family coverage) for up to 18 months

FICA: Federal Insurance Contributions Act tax paid by both employers and employees to fund Social Security and Medicare

Fully integrated arrangement: an arrangement whereby HRAs are integrated with other health care coverage as part of a group health plan. The other parts of the plan alone comply with the requirements for coverage such that the limitations of the HRA do not violate the terms of the Affordable Care Act

Health reimbursement arrangement (HRA): an employer-funded, tax-advantaged employer health benefit plan from which employees are reimbursed tax-free for out-of-pocket medical expenses for themselves, their spouse, or dependents up to a specific dollar amount every year

HIPAA-excepted benefits: benefits that are not actually health coverage under the Health Insurance Portability and Accountability Act, such as accident or disability income insurance, or benefits that are offered separately and are not part of a health care plan, such as dental or vision care or retiree-only plans

Marketplace: a resource where individuals can review their health care options and enroll in coverage; also known as the health care exchange

Medicare: a national insurance program administered by the U.S. government for persons age 65 and over who have worked and paid into the system. It also provides health insurance to individuals with disabilities who are under age 65 and to persons with end stage renal disease or amyotrophic lateral sclerosis (Lou Gehrig's disease). It consists of Part A, the hospital portion of Original Medicare; Part B, the medical insurance portion of Original Medicare (doctor's services, outpatient care); Part C, Medicare Advantage (alternative to Parts A and B); and Part D, prescription drug coverage (optional)

Medicare Easy Pay: for individuals not yet collecting Social Security, a free service whereby deductions can be made each month from a checking or savings account

Medigap: Medicare supplemental insurance sold through private insurance companies to help cover health care costs that are not covered in Parts A and B

Minimum essential coverage (MEC): the minimum health care coverage required to avoid paying a penalty for not having insurance under the Affordable Care Act unless an exemption applies

Personal service corporation: a corporation that provides personal services to groups or individuals. The employee-owners must perform at least 20% of the personal services themselves and must own a minimum of 10% of the outstanding stock on the last day of the initial one-year testing period (the testing period for a tax year is typically the previous tax year)

Premium Tax Credit: a refundable credit that is advanced to eligible individuals of low or moderate income to assist them in purchasing health care through a health care exchange, also known as the Marketplace

Qualified health plan (QHP): a health plan that meets the benefits and cost sharing standards under the Affordable Care Act including minimum essential coverage

INDEX

HEALTH INSURANCE: UPDATE FOR HRAS, 2% SHAREHOLDERS, AND MORE

Course description and study guide

Course objectives: This course will provide an update of health insurance and health reimbursement arrangements (HRAs) subsequent to the passage of the 21st Century Cures Act in December 2016. Topics addressed include: eligible HRA reimbursements; HRA eligibility; the ACA's effect on HRAs; Notice 2015-17; self-employed taxpayers; partnerships and LLCs; 2% S corporation shareholders; attribution rules; Medicare; and much more.

Completion deadline and exam: This course, including the examination, must be completed within one year of the date of purchase. In addition, unless otherwise indicated, no correct or incorrect feedback for any exam question will be provided.

Category: Taxes

Recommended CPE Hours: CPAs — 1 Tax
EAs – 1 Federal Update
CRTPs — 1 Federal Update

Level: Basic

Prerequisite: None

Advanced Preparation: No advanced preparation is required.

Course qualification: Qualifies for QAS and NASBA Registry CPE credit based on a 50-minute per CPE hour measurement

CPE sponsor information: Spidell Publishing, Inc. (Registry ID: 104931)

Expiration Date: February 2018*

*Exam must be completed within one year of the date of purchase

Learning assignment and objectives

As a result of studying the assigned materials, you should be able to meet the objectives listed below.

Assignment:

At the start of the materials, participants should identify the following topics for study:

- Health reimbursement arrangements
- 21st Century Cures Act
- Self-employed health insurance
- Shared eligibility

Learning Objectives:

After completing this course, you will be able to:

- Determine the tax treatment for reimbursements from an S corporation to a 2% shareholder for individual health insurance
- Recall how COBRA coverage affects HRA reimbursements
- Identify the limitations imposed by the 21st Century Cures Act for small businesses and HRAs
- Recall how and where sole proprietors report health insurance benefits
- Identify who should purchase a Medigap policy

After studying the materials, please answer exam questions 1-5.

Course Evaluation for Spidell Publishing, Inc.

Program title: **Health Insurance: Update for HRAs, 2% Shareholders, and More**

If applicable, program instructor: _____

Program date: _____ Participant name (optional): _____

Instructions: Please comment on all of the following evaluation points for this program and assign a number grade, using a 1-5 scale, with 5 as the highest rating.

1. Were the stated learning objectives met? _____
2. If applicable, were prerequisite requirements appropriate and sufficient? _____
3. Were the program materials accurate? _____
4. Were program materials relevant, and did they contribute to the achievement of the learning objectives? _____
5. Was the time allotted to the learning activity appropriate? _____
6. If applicable, were the individual instructors knowledgeable and effective? _____
7. Were the facilities and/or technological equipment appropriate? _____
8. Were the handout and/or advanced preparation materials satisfactory? _____
9. Were the audio and visual materials effective? _____

IRS Course Number (if applicable): CRA7E-U-00262-16-S

TTP (CTEC) Course Number (if applicable): 1019-CE-0727

Date course completed: _____

Number of hours it took to complete the course: _____

SPIDELL
SPIDELL PUBLISHING, INC.®

Examination for Spidell's Health Insurance: Update for HRAs, 2% Shareholders, and More

PLEASE: Place the correct response for each question on the attached answer sheet and retain this examination for your records. If you purchased the online version, or would like to complete your exam online, please log-in to your SpidellCPE online account to submit your answers to the exam. 70% or more (4 of 5) correct responses are necessary to receive credit for this course. This course must be completed within one year of the date of purchase.

Final Exam Questions

1. What is a key element of a health reimbursement arrangement (HRA)?

   a) It must be paid through an employee salary reduction election
   b) It is for the employee only
   c) There is a maximum dollar amount for the arrangement during a coverage period
   d) Any unused portion of funds for a period of coverage cannot be carried forward to subsequent years

2. HR 34: The 21st Century Cures Act modifies the Internal Revenue Code to permit qualified HRAs to operate for small businesses without penalties within all but which of the following limits?

   a) Contributions may not include employee salary reductions
   b) Benefits are capped at $5,000 per year
   c) Benefits for partial years are prorated
   d) There are specific reporting requirements

3. For the purpose of applying employee fringe benefits, when determining the 2% shareholder rule, what is Jon's deemed ownership in the following example based on family attribution rules?
   Henry is married to Susan. Together they have three children: Jon, Liz, and Olivia. Henry, Jon, Liz, and Olivia own Flowers, Inc., an S corporation. Henry owns 45% of the company stock, Jon owns 25%, Liz owns 20%, and Olivia owns 10%.

   a) 25%
   b) 55%
   c) 100%
   d) 70%

4. When comparing insurance benefits for an LLC taxed as a partnership, an S corporation, or a C corporation, which of the following is correct?

   a) Medical insurance and long-term care is deductible by an LLC
   b) Medical insurance is deductible from C corporation income and included on employee's W-2s
   c) Medical reimbursement plans are not available to LLC members
   d) Medical reimbursement plans are available to all S corporation shareholders

5. What is true about Medicare?

   a) If a person is already receiving Social Security, they will automatically be enrolled in Medicare Parts A and B when they turn age 65
   b) The Medicare program is managed out of the Social Security Administration
   c) Individuals should apply for Medicare from three months before their 66th birthday to three months after
   d) Participants in a Medicare Advantage Plan should also buy a Medigap policy to supplement their coverage