Tax Implications of Federal Health Care Reform

Course #6790A/QAS6790A
Course Material
Tax Implications of Federal Health Care Reform
(Course #6790A/QAS6790A)

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This course provides a summary of health insurance changes made by the Affordable Care Act (ACA) and a description of the present-law rules with respect to the ACA revenue provisions and includes a discussion of implementation of these revenue provisions. The descriptions of the ACA revenue provisions are divided into three sections. Section I describes provisions in effect as of 2013; Section II describes provisions becoming effective in 2014; and Section III describes the one provision becoming effective in 2018.

The (ACA) made broad-based changes to the law with respect to health insurance coverage in the individual and group markets and the law with respect to group health plans as well as laws that apply to Medicare and Medicaid. The ACA also includes a significant number of changes to the Code, including the addition of new Code sections and the amendment of previously existing Code sections. Further, the ACA also included off-Code revenue provisions that impose certain industry fees.

The majority of the ACA revenue provisions are in effect as of 2013. However, several of the ACA revenue provisions, including the refundable premium assistance credit, the tax on individuals who fail to maintain minimum essential coverage, and the shared responsibility for employer regarding health coverage, become effective in 2014. These provisions are designed to become effective at the same time as when the most comprehensive of the changes to the individual and small group health insurance markets go into effect, including the establishment of American Health Benefit Exchanges (State-based exchanges for the sale of individual and small group health insurance plans), mandatory community rating in health insurance premiums, guaranteed issue for purchasers of individual health insurance plans, and a prohibition against preexisting condition limitations in health insurance plans. One of the ACA revenue provisions, which provides an excise tax on high cost employer-sponsored health coverage, does not become effective until 2018.

In the case of new Code provisions and the ACA revenue provisions creating new industry fees, this course describes the new provisions (reflecting post-enactment amendments, if any). In the case of pre-existing Code provisions amended by the ACA, this course describes the present law with respect to the relevant Code provision, as amended by the ACA. Other background with respect to a provision is included in the description to the extent needed to understand the present law with respect to that provision.

**UPDATE NOTE: Affordable Care Act Delayed Implementation**

On July 9, 2013, the Internal Revenue Service issued a formal notice (Notice 2013-45) that officially delays the employer mandate provisions of the Patient Protection and Affordable Care Act (ACA) for one year, and postpones the information reporting requirements. This extension gives larger employers (50 or more full-time employees or the equivalent in full- and part-time employees) an additional year to comply with the health care reform law. This transition relief through 2014 has no effect on the effective date or application of other ACA provisions.
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Requirements for group health plans

A group health plan is a plan, including a self-insured plan, of, or contributed to by, an employer or employee organization to provide health care to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Various requirements generally apply to group health plans, including limitations on exclusions on benefits for preexisting conditions, prohibition on discrimination against individuals based on health status or genetic information, guaranteed renewability of an employer’s participation in a multiemployer plan (generally a plan providing benefits under collective bargaining agreements to employees of two or more unrelated employers) or multiple-employer welfare arrangement (generally a plan providing benefits to employees of two or more unrelated employers, but not under collective bargaining agreements), specified benefits for mothers and newborns, mental health parity, and coverage for students on medical leave of absence from school. Compliance with these requirements is enforced through an excise tax.

Parallel requirements generally apply to group health plans of private employers under the Employee Retirement Income Security Act of 1974 (“ERISA”), to group health plans of State and local government employers under the Public Health Service Act (the “PHSA”), and to health insurance issued in connection with group health plans under ERISA and the PHSA. Some requirements apply also to individual health insurance under the PHSA.

Additional requirements under the ACA

Under the ACA, additional requirements apply to group health plans, generally effective for plan years beginning on or after September 23, 2010, six months after enactment of Patient Protection and Affordable Care Act (PPACA). Most of the PHSA requirements added by the ACA apply also to health insurance issued in connection with group health plans and to individual health insurance. The specifics of the new requirements under the ACA are contained in provisions of the PHSA and, subject to certain exceptions, apply under the Code and ERISA by cross-reference to the PHSA provisions.

The additional requirements under the ACA are:

- Required coverage of adult children up to age 26;
- Prohibition on preexisting condition exclusions for children under age 19;
- Required coverage of preventive health services with no cost-sharing (i.e., deductibles and co-pays);
• No lifetime limits or annual limits on essential health benefits (except, for years before 2014, restricted annual limits are permitted);

• Prohibition on discrimination under an insured group health plan in favor of highly compensated individuals;

• Additional choice of health care providers and access to certain services;

• Use of a uniform explanation of coverage and standardized definitions (commonly referred to as a summary of benefits and coverage or summary of benefits and coverage (SBC) and a uniform glossary);

• Required appeals process for benefit denials, including an internal appeal and external review;

• Prohibition on the recission of coverage, except in the case of fraud or intentional misrepresentation of material fact, and required advance notice of cancellation of coverage;

• Premium rebates for purchasers of health insurance (not self-insured coverage) unless a specified percentage of premiums is spent on health care and activities that improve health care quality (commonly referred to as medical loss ratio or “MLR” rebates); and Access to additional data about the particular health coverage, such as claims denials.

Under the ACA, a group health plan in which an individual was enrolled on March 23, 2010, the date of enactment of PPACA (a “grandfathered” plan) is excepted from the following new requirements: coverage of preventive health services with no cost-sharing, prohibition on discrimination under an insured plan in favor of highly compensated individuals, additional choice of health care providers and access to certain services, and required appeals process for benefit denials. In addition, until 2014, a grandfathered plan does not have to provide coverage to an adult child up to age 26 unless other employer-provided coverage is not available.

Implementation

Responsibility for the group health plan requirements is shared by three Departments (collectively, the “Departments”): Department of the Treasury (“Treasury”), specifically the IRS; Department of Health and Human Services (“HHS”), specifically the Center for Consumer Information & Insurance Oversight (“CCIIO”); and Department of Labor (“DOL”), specifically the Employee Benefits Security Administration (“EBSA”).

The Departments have issued extensive guidance on the ACA requirements, including regulations, notices, fact sheets, and questions and answers.
Chapter 2: Tax Treatment of Medical Care Expenses for Individuals

1. TAX TREATMENT FOR HEALTH COVERAGE FOR CHILDREN UNDER AGE 27

Exclusion for employer-provided health coverage

The Code generally provides that the value of employer-provided health coverage for employees (including former employees) and certain related individuals under an accident or health plan is excludible from gross income. In addition, any reimbursements under an employer-provided accident or health plan for medical care expenses for employees and certain related individuals generally are excluded from gross income. The exclusion applies both to health coverage in the case in which an employer directly pays the cost of employees’ medical expenses not covered by insurance (i.e., a self-insured plan) as well as in the case in which the employer purchases health insurance coverage for its employees.

Voluntary employee beneficiary associations and retiree medical accounts

Employer-provided health coverage (and medical reimbursements) may also be provided through a voluntary employee beneficiary association (“VEBA”). This is a tax-exempt entity providing for the payment of life, sickness, accident, or other benefits to members of the VEBA or certain related individuals. Further, a pension plan can establish a retiree medical account, which is a separate account to provide for the payment of benefits for sickness, accident, hospitalization, and medical expense of retired employees and certain related individuals if certain enumerated conditions are met. Amounts in such accounts used to reimburse medical care expenses or purchase health insurance coverage for retirees are also excluded from gross income.

Deduction for health insurance premiums by self-employed individuals

Subject to certain limitations provided under the Code, a self-employed individual (generally a sole proprietor or partner) is allowed to deduct as a trade or business expense the premiums for health insurance for the self-employed individual and certain related individuals.

Coverage of adult children under age 27

Prior to the enactment of ACA, the related individuals eligible for whom the exclusion for employer-provided health insurance coverage and reimbursement for medical expenses applied included only the employee’s spouse and dependents. These were also the related individuals who could receive health coverage under a VEBA or a retiree medical account, or for whom the cost of premiums was deductible by self-employed individuals. Generally, an employee’s (or self-employed individual’s) child is not a dependent if the child has attained age 19 as of the close of the taxable year (or if the child is a student and has attained age 24 as of the close of the taxable year). Further the child is required to meet certain other dependency requirements for the child to be a dependent.
Effective in March 30, 2010, ACA expanded the related individuals of an employee or self employed individual for whom the exclusion for employer-provided health coverage or deduction for health insurance premiums applies to include any children (of the employee or self-employed individual) who, as of the end of the taxable year, have not attained age 27. Further the exclusion or deduction applies without regard to whether the child meets any dependency requirement. Children include natural children, stepchildren, legally adopted children, individuals lawfully placed with the employee (or self-employed individual) for legal adoption, and eligible foster children (individuals placed with the employee (or self-employed individual) by an authorized placement agency or by judgment, decree, or order of any court of competent jurisdictions).

Implementation

On April 22, 2010, IRS issued Notice 2010-38 to provide guidance on the tax treatment of health coverage for children up to age 27 under the ACA. The Notice provides certain transition rules, including the time by which a cafeteria plan must be amended to reflect this expansion of related individuals.

2. DOLLAR LIMIT ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS

Arrangements to reimburse medical care expenses

Employers may provide health coverage in the form of an agreement to reimburse medical expenses of their employees (and certain related individuals), not reimbursed by a health insurance plan. Health coverage provided in the form of one of these arrangements and the actual reimbursements are excludible from gross income.

If, under such an arrangement, an employer specifies a dollar amount that is available for medical expense reimbursement and the arrangement does not provide for any salary reduction election by an employee under a cafeteria plan, as discussed below, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years. These arrangements are commonly called health reimbursement arrangements ("HRAs").

Health flexible spending arrangements under a cafeteria plan

An employer may include an arrangement to reimburse medical expenses through a salary reduction arrangement under a cafeteria plan. A cafeteria plan is a separate written plan of an employer under which all participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit (as defined below). If an employee receives a qualified benefit based on his or her election between the qualified benefit and a taxable benefit under a cafeteria plan, the qualified benefit generally is not includable in gross income.

A flexible spending arrangement for medical expenses under a cafeteria plan (commonly called a "health FSA") is an arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount of the salary reduction contributions made available for use in reimbursing the employee for his or her medical expenses. Health FSAs are subject to the general requirements for cafeteria plans, including a requirement that unused amounts remaining under a health FSA at the
end of a plan year generally must be forfeited by the employee (referred to as the “use-
or-lose rule”). A health FSA is permitted to allow a grace period not to exceed two and
one-half months immediately following the end of the plan year during which unused
amounts may be used. A health FSA can also include employer flex-credits, which are
nonelective employer contributions that the employer makes for every employee eligible
to participate in the employer’s cafeteria plan, to be used only for one or more excludible
qualified benefits (but not as cash or a taxable benefit).

**ACA limits salary reduction contributions under a health FSA**

For years before 2013, there is no annual limit on the dollar amount of salary reduction
that an employer may permit to be contributed to a health FSA under its cafeteria plan.
Beginning with 2013, the ACA imposes a limit on the annual amount of salary reduction
that an employee may elect to contribute to a health FSA under a cafeteria plan. The
annual limit is $2,500. This amount is adjusted for increases in the Consumer Price
Index for All Urban Consumers (CPI-U) for years after 2013, rounded down to the next
lowest multiple of $50.

**Implementation**

On May 30, 2010, IRS released Notice 2012-40 which provides guidance on the new
$2,500 annual limit. As explained in the notice, the $2,500 annual limit does not apply
amounts available for reimbursement of medical expenses that are not salary reduction
amount, such as flex credits or reimbursements under an HRA. The notice provides that
the annual limit applies to plan years for a cafeteria plan rather than taxable years and
first applies to plan years beginning in 2013. The notice makes clear that the annual limit
does not apply to amounts used for expenses incurred during any grace period for the
2012 plan year that occurs in 2013. The notice requests comments on whether the “use-
or-lose rule” should be modified in light of the new annual limit.

**3. NONDISCRIMINATION SAFE HARBOR FOR SIMPLE CAFETERIA PLANS**

**General rule**

Qualified benefits under a cafeteria plan are generally employer-provided benefits that
are not includable in gross income under a specific provision of the Code. Qualified
benefits include employer-provided health coverage, group-term life insurance coverage,
and benefits under a dependent care assistance program. Cafeteria plans and certain
qualified benefits (including group term life insurance, self-insured medical
reimbursement plans, and dependent care assistance programs) are subject to
nondiscrimination requirements to prevent discrimination in favor of highly compensated
individuals generally as to eligibility for benefits and as to actual contributions and
benefits provided. There are also rules to prevent the provision of disproportionate
benefits to key employees (within the meaning of section 416(i)) through a cafeteria
plan. Although the basic purpose of each of the nondiscrimination rules is the same, the
specific rules for satisfying the relevant nondiscrimination requirements, including the
definition of highly compensated individual, vary for cafeteria plans generally and for
each qualified benefit. An employer maintaining a cafeteria plan in which any highly
compensated individual participates must make sure that both the cafeteria plan and
each qualified benefit satisfies the relevant nondiscrimination requirements, as a failure
to satisfy the nondiscrimination rules generally results in a loss of the tax exclusion by
the highly compensated individuals.
ACA added a safe harbor plan design called a SIMPLE cafeteria plan

Effective for years beginning after December 31, 2010, ACA added a safe harbor plan design called a SIMPLE cafeteria plan for eligible small employers. An eligible small employer under the provision is, with respect to any year, an employer who employed an average of 100 or fewer employees on business days during either of the two preceding years. Under this safe harbor, an eligible small employer is provided with a safe harbor from the nondiscrimination requirements for cafeteria plans as well as from the nondiscrimination requirements for specified qualified benefits offered under a cafeteria plan, including group term life insurance, benefits under a self insured medical expense reimbursement plan, and benefits under a dependent care assistance program. Under the safe harbor, a SIMPLE cafeteria plan and the specified qualified benefits are treated as meeting the specified nondiscrimination rules. Requirements for SIMPLE cafeteria plans include (1) all employees (other than excludable employees) are eligible to participate, and each employee eligible to participate is able to elect any benefit available under the plan (subject to the terms and conditions applicable to all participants), and (2) the cafeteria plan provides for certain minimum employer contributions to each eligible non-highly compensated employee in addition to any salary reduction contributions made by the employee that is available for qualified benefit (other than a taxable benefit) offered under the plan.

The minimum contribution is permitted to be calculated under either the nonelective contribution method or the matching contribution method, but the same method must be used for calculating the minimum contribution for all non-highly compensated employees. The minimum contribution under the nonelective contribution method is an amount equal to a uniform percentage (not less than two percent) of each eligible employee’s compensation for the plan year, determined without regard to whether the employees makes any salary reduction contribution under the cafeteria plan. The minimum matching contribution is the lesser of 100 percent of the amount of the salary reduction contribution elected to be made by the employee for the plan year or six percent of the employee’s compensation for the plan year.

Implementation

The IRS has not as yet issued any formal guidance on this new safe harbor. The safe harbor has been referenced in relevant IRS Publications (e.g., Publication 15B, Employer’s Tax Guide to Fringe Benefits).

4. INCREASE IN TAX ON NONQUALIFIED DISTRIBUTIONS FROM HEALTH AND ARCHER MSAs

Health savings accounts

An individual with a high deductible health plan (and no other health plan other than a plan that provides certain permitted insurance or permitted coverage) may establish a health savings account (“HSA”). In general, HSAs provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, HSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents. Thus, earnings on amounts in HSAs are not taxable.
Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible by the individual. Contributions to an HSA are excludible from income and wages for employment tax purposes if made by the employer. For 2013, the maximum aggregate annual contribution that can be made to an HSA is $3,250 in the case of self-only coverage and $6,450 in the case of family coverage. The annual contribution limits are increased by $1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare. Distributions from an HSA that are used for qualified medical expenses are not includible in gross income.

**Archer MSA**

An Archer MSA is also a tax-exempt trust or custodial account to which tax-deductible contributions may be made by individuals with a high deductible health plan. Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. One of the main differences is that only self-employed individuals and employees of small employers are eligible to have an Archer MSA. After 2007, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had made Archer MSA contributions and employees who are employed by a participating employer.

**Additional tax for distributions not used for qualified medical expenses**

Distributions from an HSA or an Archer MSA that are not used for qualified medical expenses (“nonqualified distributions”) are includible in gross income and are subject to an additional tax. The additional tax on nonqualified distributions does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65). Prior to the ACA, the additional tax on nonqualified distributions from an HSA was 10 percent of the amount of the distribution and from an Archer MSA was 15 percent. For taxable years beginning after December 31, 2011, the ACA increased the additional tax on nonqualified distributions from both HSAs and Archer MSAs to 20 percent of the amount of the distribution.

**Implementation**

Internal Revenue Service (IRS) Forms and Publications, including Publication 969 (2012) and Form 8889 (2012) (and instructions) have been revised to reflect this increase in the additional tax for nonqualified distributions.

**5. CHANGE TO INDIVIDUAL ITEMIZED DEDUCTION FOR MEDICAL EXPENSES**

**General rule**

Expenses for medical care, not compensated for by insurance or otherwise, are deductible by an individual under the rules relating to itemized deductions to the extent the expenses exceed a threshold amount measured as a percentage adjusted gross income (“AGI”).
Change to the percentage threshold

Prior to the ACA, the threshold amount was 7.5 percent of AGI. Effective for taxable years beginning after December 31, 2012, the ACA increased the threshold amount to 10 percent of AGI. However, this increase in the percentage does not apply until taxable years beginning after December 31, 2016 with respect to a taxpayer if the taxpayer or the taxpayer’s spouse has attained age 65 before the close of the taxable year.

6. EXCLUSION OF OVER-THE-COUNTER DRUGS FROM THE DEFINITIONS OF MEDICAL CARE

General definition of medical care

For purposes of the exclusion for reimbursements under employer-provided health plans, and for distributions from HSAs (and Archer MSAs), used for qualified medical expenses, the definition of medical care is generally the same as the definition that applies for the itemized deduction for the cost of medical care. Medical care generally is defined for these purposes broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body. Medical care does not include toiletries or similar preparations (such as toothpaste, shaving lotion, shaving cream, etc.) nor does it include cosmetics (such as face creams, deodorants, hand lotions, etc., or any similar preparations used for ordinary cosmetic purposes).

Under an HRA or Health FSA, amounts available for reimbursement for medical care must be used exclusively for that purpose. The expense must also be substantiated before reimbursement. The IRS allows the use of debit cards issued to employees to satisfy these requirements if certain requirements are satisfied.

In contrast, distributions from an HSA are not required to be substantiated by the employer or a third party for the distributions to be excludible from income. Instead, the individual is the beneficial owner of his or her HSA, and thus the individual is required to maintain books and records with respect to the expense and claim the exclusion for a distribution from the HSA on their tax return. The determination of whether the distribution is for a qualified medical expense is subject to individual self-reporting and IRS enforcement.

ACA change to treatment of over-the-counter-medicine

Any amount paid during a taxable year for medicine or drugs is deductible as a medical expense only if the medicine or drug is a prescribed drug or insulin. The term prescribed drug means a drug or biological which requires a prescription of a physician for its use by an individual. Thus, any amount paid for medicine available without a prescription (“over-the-counter-medicine”) is not deductible as a medical expense, including any medicine prescribed or recommended by a physician.

Prior to the enactment of the ACA, the limitation (applicable to itemized deductions) with respect to over-the-counter-medicine did not apply to the exclusion for reimbursements under employer-provided health plans and for distributions from HSAs and Archer MSAs used for qualified medical expenses. Thus, for example, amounts paid from a Health FSA or HRA, or funds distributed from an HSA to reimburse a taxpayer for
nonprescription drugs, such as nonprescription aspirin, allergy medicine, antacids, or pain relievers, were excludable from income even though, if the taxpayer paid for such amounts directly (without such reimbursement), the expenses could not be taken into account in determining the itemized deduction for medical expenses.

For years beginning after December 31, 2010, the ACA changed the definition of medical care for purposes of the exclusion for reimbursements for medical care under employer-provided accident and health plans and for distributions from HSAs used for qualified medical expenses to require that over-the-counter-medicine (other than insulin) be prescribed by a physician in order for the medicine to be medical care for these purposes. Thus, under present law, a health FSA or an HRA is only permitted to reimburse an employee for the cost of over-the-counter-medicine if the medicine is prescribed by a physician and distributions from an HSA or Archer MSA used to purchase over-the-counter-medicine is not a qualified medical expense unless the medicine is prescribed by a physician.

Implementation

The IRS has issued Notice 2010-59 and Notice 2011-5, which provide rules for the use of health FSA and HRA debit card after the ACA change to the definition of medical care to exclude over-the-counter-medicine.

Over-the-Counter Medicines and Drugs FAQs

Q1. How are the rules changing for reimbursing the cost of over-the-counter medicines and drugs from health FSAs and HRAs?
A1. Section 9003 of the Affordable Care Act established a new uniform standard for medical expenses. Effective Jan. 1, 2011, distributions from health FSAs and HRAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.

Q2. How are the rules changing for distributions from HSAs and Archer MSAs that are used to reimburse the cost of over-the-counter medicines and drugs?
A2. In accordance with Section 9003 of the Affordable Care Act, only prescribed medicines or drugs (including over-the-counter medicines and drugs that are prescribed) and insulin (even if purchased without a prescription) will be considered qualifying medical expenses and subject to preferred tax treatment.

Q3. How do I prove that I have purchased an over-the-counter medicine or drug with a prescription so that I can get reimbursed from my employer's health FSA or an HRA?
A3. If your employer's health FSA or HRA reimburses these expenses, you would provide the prescription (or a copy of the prescription or another item showing that a prescription for the item has been issued) and the customer receipt (or similar third-party documentation showing the date of the sale and the amount of the charge). For example, documentation could consist of a customer receipt issued by a pharmacy that reflects the date of sale and the amount of the charge, along with a copy of the prescription; or it could consist of a customer receipt that identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase and an Rx number.
Q4. How does this change affect over-the-counter medical devices and supplies?
A4. The new rule does not apply to items for medical care that are not medicines or drugs. Thus, equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits will still qualify for reimbursement by a health FSA or HRA if purchased after Dec. 31, 2010, and a distribution from an HSA or Archer MSA for the cost of such items will still be tax-free, regardless of whether the items are purchased using a prescription.

Q5. Will I need a prescription to use my health FSA, HRA, HSA or Archer MSA funds for insulin purchases after Dec. 31, 2010?
A5. No. You can continue to use your health FSA, HRA, HSA or Archer MSA funds to purchase insulin without a prescription after Dec. 31, 2010.

Q6. I use health FSA funds for my co-pays and deductibles. Will I still be able to reimburse those expenses with health FSA funds after Dec. 31, 2010?
A6. Yes. Co-pays and deductibles continue to be reimbursable from a health FSA after Dec. 31, 2010. Similarly, funds from an HRA can continue to be used for these expenses and a distribution from an HSA or Archer MSA for these purposes will be tax-free.

Q7. My company gives me two extra months beyond the end of the year to submit claims for health FSA expenses incurred during the year. What happens if I purchase over-the-counter medicines or drugs without a prescription in 2010 but do not submit the claim for those expenses until January 2011? Will they qualify for reimbursement?
A7. Yes. The new restriction on plan reimbursements for the cost of over-the-counter medicines or drugs applies only to purchases that are made after 2010.

Q8. My company’s health FSA includes a provision for a grace period, so that if I don’t spend all of the money in my health FSA by Dec. 31 in a given year, I can still use the amount left in my health FSA at the end of the year to reimburse expenses I incur during the first 2½ months of the following year. If I buy over-the-counter medicines or drugs without a prescription during the 2½ month grace period of 2011, can I still use the amount left in my health FSA at the end of 2010 to reimburse those expenses?
A8. No. The change applies to purchases made on or after Jan. 1, 2011. Thus, even if your employer’s plan includes the 2½ month grace period provision, the cost of over-the-counter medicines and drugs purchased without a prescription during the first 2½ months of 2011 will not be eligible to be reimbursed by a health FSA.

Q9. If my health FSA or HRA issues a debit card that I use to pay for over-the-counter medicines or drugs, will I still be able to use the card to purchase over-the-counter medicines or drugs after Dec. 31, 2010?
A9. Generally, yes, if you have a prescription for the medicine or drug. For expenses incurred in 2010, you may continue to use an FSA or HRA debit card to purchase over-the-counter medicines or drugs (whether or not you have a prescription) at pharmacies and from mail order and web-based vendors that sell prescription drugs. Starting after Jan. 15, 2011, you may continue to use an FSA or HRA debit card to purchase over-the-counter medicines or drugs at these vendors, so long as you obtain a prescription for the medicine or drug, the prescription is presented to the pharmacist, and the medication is dispensed by the pharmacist and given an Rx number.
Q10. The ACA removed over-the-counter medicines and drugs from the list of reimbursable qualified medical items if purchased without a prescription. If you have an HSA, Archer MSA, health FSA, or HRA, how will the change in the law affect reporting on Form W-2? Do the reimbursements for items that are not qualified medical expenses need to be included as taxable wages on employees’ Forms W-2?

A10. If you have an HSA or an Archer MSA, distributions for expenses that are not qualifying medical expenses (including over-the-counter medicines and drugs purchased without a prescription) will be included in your gross income and subject to an additional tax of 20%. The income tax and additional tax are reported on Form 8889 for an HSA distribution and on Form 8853 for an Archer MSA distribution. You complete these forms and attach them to your Form 1040 when you file your income tax return. Distributions from an HSA or an Archer MSA are not included as taxable wages and do not affect your Form W-2.

7. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS

Present law generally provides that gross income includes all income from whatever source derived. Exclusions from income are provided, however, for certain health care benefits.

Exclusion from income for specified Indian tribe health care benefits

Under ACA, Indian tribe members are not taxed on (that is, may “exclude” from gross income) the value of any qualified Indian health care benefit. The exclusion applies to the value of: (1) health services or benefits provided or purchased by the Indian Health Service (“IHS”), either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the IHS; (2) medical care (in the form of provided or purchased medical care services, accident or health insurance or an arrangement having the same effect, or amounts paid directly or indirectly, to reimburse the member for expenses incurred for medical care) provided by an Indian tribe or tribal organization to a member of an Indian tribe, including the member’s spouse or dependents; (3) accident or health plan coverage (or an arrangement having the same effect) provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, including the member’s spouse or dependents; and (4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for the programs and services provided by the Federal government to Indian tribes or Indians.
Implementation

After enactment, the IRS published, as part of its Tax Information for Indian Tribal Governments, a document entitled “Frequently Asked Questions” (FAQs) about new Section 139D.” This FAQs document contains answers to ten questions such as whether parents who are members of an Indian tribe and who are divorced, separated, or living apart can treat their child as a dependent of both parents for purposes of section 139D. The IRS answered that question in the affirmative in the FAQs document and in a Chief Counsel Advice Memorandum. In other guidance, the IRS concluded, based on its interpretation of the term “medical care,” that payments from an Indian tribe to a tribal member for the purchase of nonprescription drugs (i.e., over-the-counter) are not excludable payments under section 139D.
1. CREDIT FOR SMALL EMPLOYER HEALTH INSURANCE EXPENSES

In general

The ACA provides a tax credit for an eligible small employer for nonelective contributions to purchase health insurance for its employees. An eligible small employer for this purpose generally is an employer with no more than 25 full-time equivalent employees (“FTEs”) during the employer’s taxable year, whose average annual wages do not exceed $50,000. However, the full amount of the credit is available only to an employer with 10 or fewer FTEs whose average annual wages do not exceed $25,000.

An employer’s FTEs are calculated by dividing the total hours worked by all employees during the employer’s tax year (up to 2,080 for any employee) by 2,080 (and rounding down to the nearest whole number of FTEs). Average annual wages are determined by dividing the total wages paid by the employer by the number of FTEs (and rounding down to the nearest $1,000).

For purposes of the credit, the employer is determined by applying the aggregation rules for controlled groups, groups under common control, and affiliated service groups. In addition, for purposes of the credit, the term “employee” includes a leased employee, i.e., an individual who is not an employee of the employer, who provides services to the employer pursuant to an agreement between the employer and another person (a “leasing organization”) and under the primary direction or control of the employer, and who has performed such services on a substantially full-time basis for at least one year.

Self-employed individuals (including partners and sole proprietors), two-percent shareholders of an S corporation, and five-percent owners of the employer are not employees for purposes of the credit with the result that they are disregarded in determining number of FTEs, average annual wages, and nonelective contributions for employees’ health insurance. Family members of these individuals and any member of the individual’s household who is a dependent for tax purposes are also not employees for purposes of the credit. In addition, the hours of service worked by and wages paid to a seasonal worker of an employer are not taken into account in determining number of FTEs and average annual wages unless the worker works for the employer on more than 120 days during the taxable year.

The employer contributions must be provided under an arrangement that requires the eligible small employer to make, on behalf of each employee who enrolls in qualifying health insurance offered by the employer, a nonelective contribution equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualifying health insurance (described below).

The credit is available only to offset actual tax liability and is claimed on the employer’s tax return. The credit is a general business credit and generally can be carried back for one year and carried forward for 20 years. The credit is available for tax liability under the alternative minimum tax. The dollar amount of the credit reduces the amount of employer contributions the employer may deduct as a business expense.
Years credit available and qualifying health insurance

An initial credit is available for any taxable year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage as defined for purposes of the group health plan requirements under the Code, which is generally health insurance coverage offered by an insurance company licensed under State law.

For taxable years beginning after 2013, the credit is available only for nonelective contributions for premiums for qualified health plans offered by the employer through an American Health Benefit Exchange and is available for a maximum credit period of two consecutive taxable years beginning with the first taxable year in which the employer (or any predecessor) offers one or more qualified health plans to its employees through an American Health Benefit Exchange. The maximum two-year credit period does not take into account any taxable years beginning before 2014.

Calculation of credit amount

Only nonelective contributions by the employer are taken into account in calculating the credit. The credit is equal to the lesser of the following two amounts multiplied by an applicable credit percentage: (1) the amount of contributions the employer made on behalf of the employees during the taxable year for the qualifying health insurance and (2) the amount of contributions the employer would have made during the taxable year if each employee with the qualifying health insurance had enrolled in insurance with a benchmark premium (as described below). As discussed above, the credit is available only if nonelective contributions are a uniform percentage of at least 50 percent of the premium cost of the qualifying health insurance.

For the first phase of the credit (taxable years beginning in 2010, 2011, 2012, or 2013), the applicable credit percentage is generally 35 percent, and the benchmark premium is the average premium for the small group market (i.e., insurance coverage provided by small employers) in the employer’s State, as determined by the Secretary of Health and Human Services (“HHS”). For taxable years beginning after 2013, the applicable credit percentage is generally 50 percent, and the benchmark premium is the average premium for the small group market in the rating area in which the employee enrolls for coverage, as determined by the Secretary of HHS.

The credit is reduced for an employer with between 10 and 25 FTEs (“FTE phase-out”). The credit is also reduced for an employer for whom the average annual wages per FTE is between $25,000 and $50,000 (“average annual wages phase-out”). For an employer with both more than 10 FTEs and average annual wages in excess of $25,000, the reduction is the sum of the amount of the two reductions.

Tax-exempt organizations

For tax-exempt organizations, the applicable credit percentage during the first phase of the credit (taxable years beginning in 2010, 2011, 2012, or 2013) is limited to 25 percent and the applicable credit percentage during the second phase (taxable years beginning after 2013) is limited to 35 percent. In addition, instead of a general business credit, the credit is a refundable credit limited to the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.
Implementation

Guidance relating to the credit in effect for years before 2014 is provided by Notice 2010-44 (issued May 17, 2010) and Notice 2010-82 (issued Dec. 2, 2010).

Notices 2010-44 and 2010-82 address the following:

- Employers to which the credit is available; for example, the credit is generally not available to tax-exempt organizations that are not tax-exempt under section 501(c), but may be available to an employer that is not engaged in a trade or business, such as a household employer;

- Determination of the employees taken into account for purposes of the credit; for example, business owners and family members are generally not taken into account;

- Clarification that, while leased employees are taken into account in determining a small employer’s FTEs and average annual wages, premiums for health insurance coverage paid by a leasing organization (rather than the small employer) are not taken into account in computing the small employer’s credit;

- Determination of the number of hours of service performed by employees, specifically (1) an employee’s hours of service include hours for which an employee is paid or entitled to payment for the performance of services or for vacation, holidays, or other leave, and (2) several methods are available to an employer for determining an employee’s hours of service, including hours for which paid or a number of hours equivalent to days or weeks worked;

- Types of coverage for which the credit is available; for example, the credit generally is not available for self-insured coverage (other than under a church plan subject to the Church Plan Parity and Entanglement Prevention Act of 1999) but may be available for coverage under a multiemployer plan;

- Determination of employer-paid premiums taken into account in calculating the credit, including the effect of State credits and State Subsidies for health insurance;

- Options for determining whether an employer makes a uniform nonelective contribution of at least 50 percent of the premium cost of the employees’ health insurance; for example, an employer may pay the same amount of premiums for employees enrolled in different levels of coverage (such as self-only and family) or, if offering more than one plan, may designate a “reference” plan (provided certain conditions are met), the premiums for which can be used to measure the amount of employer contributions needed to satisfy the uniform percentage requirement under all plans; and

- Calculation of the credit, including the phase-outs.
2. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W-2

W-2 reporting

Every employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. The statement, made on the Form W-2, must be provided to each employee by January 31 of the succeeding year.

ACA adds requirement to report cost of employer-sponsored health coverage

Effective for taxable year beginning after December 31, 2010, the ACA added the cost of employer-sponsored health coverage as an item of information required to report on each employee’s annual Form W-2. If an employee enrolls in employer-sponsored health insurance coverage under multiple plans, the employer must disclose the aggregate cost of all such health coverage (excluding any salary reduction contribution to a health FSA). For example, if an employee enrolls in employer-sponsored health coverage under a major medical plan and an HRA, the employer is required to report the total cost of the combination of both of these health plans. For this purpose, employers generally use the same cost for all similarly situated employees receiving the same category of coverage (such as single or family health insurance coverage).

To determine the cost of employer-sponsored health coverage, the employer calculates the applicable premiums for the taxable year for the employee under the rules for Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, including the special rule for self-insured plans. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan would be required to calculate separate premiums for individual and family coverage for this purpose.

Table 3.1 W-2 Reporting of Employer-Sponsored Health Coverage

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<th>Coverage Type</th>
<th>Form W-2, Box 12, Code DD</th>
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<tr>
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<td>Report</td>
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<tr>
<td>Major medical</td>
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<tr>
<td>Dental or vision plan not integrated into another medical or health plan</td>
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<tr>
<td>Dental or vision plan which gives the choice of declining or electing and paying an additional premium</td>
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<td>Health Flexible Spending Arrangement (FSA) funded solely by salary-reduction amounts</td>
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<tr>
<td>Health FSA value for the plan year in excess of employee’s cafeteria plan salary reductions for all qualified benefits</td>
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<tr>
<td>Health Reimbursement Arrangement (HRA) contributions</td>
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<td>Health Savings Arrangement (HSA) contributions (employer or employee)</td>
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<td>Archer Medical Savings Account (Archer MSA) contributions (employer or employee)</td>
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<td>Hospital indemnity or specified illness (insured or self-funded), paid on after-tax basis</td>
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<tr>
<td>Hospital indemnity or specified illness (insured or self-funded), paid through salary reduction (pre-tax) or by employer</td>
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<td>Employee Assistance Plan (EAP) providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
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<td>On-site medical clinics providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
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<tr>
<td>Wellness programs providing applicable employer-sponsored healthcare coverage</td>
<td>Required if employer charges a COBRA premium</td>
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<td>Multi-employer plans</td>
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<td>Domestic partner coverage included in gross income</td>
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<td>Governmental plans providing coverage primarily for members of the military and their families</td>
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<td>Federally recognized Indian tribal government plans and plans of tribally charted corporations wholly owned by a federally recognized Indian tribal government</td>
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<td>Self-funded plans not subject to Federal COBRA</td>
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<td>Accident or disability income</td>
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<td>Liability insurance</td>
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<td>Supplemental liability insurance</td>
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<td>Provisions Affecting the Tax Treatment of Employers</td>
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<td>----------------------------------------------------</td>
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<td>Workers' compensation</td>
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<td>Automobile medical payment insurance</td>
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<td>Credit-only insurance</td>
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<td>Excess reimbursement to highly compensated individual, included in gross income</td>
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<tr>
<td>Payment/reimbursement of health insurance premiums for 2% shareholder-employee, included in gross income</td>
<td>X</td>
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<td>Other Situations</td>
<td>Report</td>
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<td>Employers required to file fewer than 250 Forms W-2 for the preceding calendar year (determined without application of any entity aggregation rules for related employers)</td>
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<tr>
<td>Forms W-2 furnished to employees who terminate before the end of a calendar year and request, in writing, a Form W-2 before the end of that year</td>
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<tr>
<td>Forms W-2 provided by third-party sick-pay provider to employees of other employers</td>
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</table>

**Implementation**

Notice 2012-9 provides guidance on this reporting requirement. For the 2011 tax year, reporting of the cost of employer sponsored coverage tax year was voluntary. The guidance in the notices is only applicable for 2012 and later. However, employers who voluntarily reported the cost for 2011 are permitted to rely on the guidance.

Notice 2012-9 provides detailed question and answer guidance on the information required to be included on the Form W-2, employers subject to the requirement, the completion of the W-2, the coverage required to be included in the cost, and the calculation of the cost. The notice provides relief from the reporting requirement in certain situations. For example, in the case of 2012 Forms W-2 (and later years unless and until further guidance is issued), the notice provides that an employer is not subject to the reporting requirement if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year. As another example, the notice provides that an employer that contributes to the cost of health coverage provided under a multiemployer plan is not required to report that cost on the Form W-2.
Chapter 4: Other Provisions Affecting the Tax Treatment of Individuals

1. ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH INCOME TAXPAYERS

Social Security and hospital insurance taxes

The Federal Insurance Contributions Act ("FICA") imposes tax on employers and employees based on the amount of wages (as defined for FICA purposes) paid to an employee during the year. The tax imposed on the employer and on the employee is each composed of two parts: (1) the Social Security or old age, survivors, and disability insurance ("OASDI") tax equal to 6.2 percent of covered wages up to the taxable wage base ($113,700 for 2013); and (2) the Medicare or hospital insurance ("HI") tax equal to 1.45 percent of all covered wages. The employee portion of the FICA tax generally must be withheld and remitted to the Federal government by the employer. If the employer fails to withhold the employee portion, the employer is generally liable for the amount that should have been withheld.

Instead of FICA taxes, railroad employers and employees are subject, under the Railroad Retirement Tax Act ("RRTA"), to taxes equivalent to the OASDI and HI taxes under FICA with respect to compensation as defined for RRTA purposes ("RRTA compensation"). The employee portion of RRTA taxes generally must be withheld from an employee’s RRTA compensation and remitted to the Federal government by the employer.

As a parallel to FICA and RRTA taxes, the Self-Employment Contributions Act ("SECA") imposes tax on the self-employment income of self-employed individuals. The rate of the OASDI portion of SECA tax is equal to the combined employee and employer OASDI FICA tax rates (12.4 percent) and applies to self-employment income up to the FICA taxable wage base (reduced by FICA wages, if any). Similarly, the rate of the HI portion of SECA tax is the same as the combined employer and employee HI rates (2.9 percent) and applies to all self-employment income.

Additional Medicare or HI tax

Under the ACA, effective for remuneration received and taxable years beginning after December 31, 2012, an additional HI tax of 0.9 percent is imposed on employees and self-employed individuals with FICA wages, RRTA compensation or self-employment income exceeding a threshold amount.

The employee portion of the HI tax under FICA and RRTA (not the employer portion) is increased by an additional tax of 0.9 percent on wages received in excess of the threshold amount. The threshold amount is $250,000 in the case of a joint return, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case. Thus, unlike the general 1.45 percent HI tax on wages, which is based only on an employee’s wages, in the case of a joint return, the additional HI tax is based on the combined wages of an employee and the employee’s spouse.
The employer is required to withhold the additional HI tax from an employee’s wages and RRTA compensation only to the extent wages or compensation paid to the employee by the employer exceeds $200,000. The employer’s withholding obligation does not depend on the amount of the employee’s ultimate liability for the additional HI tax, if any. That is, the amount required to be withheld may be more or less than the employee’s ultimate liability. If the employee’s liability is more than the amount withheld, the employee must pay the additional amount. For example, if an employee and spouse filing a joint return each receive wages of $175,000, for a total of $350,000, their employers are not required to withhold the additional HI tax. Instead, the employee and spouse must pay the additional HI tax on $100,000 ($350,000 total wages minus $250,000 threshold amount). If the employee’s liability is less than the amount withheld, the employee may claim a refund.

The additional HI tax applies also to self-employment income in excess of the threshold amount. As in the case of the additional HI tax for employees, the threshold amount for the additional SECA HI tax is $250,000 in the case of a joint return, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case. The threshold amount is reduced (but not below zero) by the amount of wages taken into account in determining the individual’s additional FICA HI tax, if any. Thus, only a single threshold amount applies for an individual (or individual and spouse) with both FICA wages and self-employment income.

**Implementation**

The IRS issued proposed regulations on the additional 0.9 percent HI tax on December 5, 2012, and has posted Questions and Answers about the additional 0.9 percent HI tax on its website. The regulations are effective for tax periods beginning after final regulations are issued.

The proposed regulations and Questions and Answers address the following topics:

- Applicability of the additional tax to all wages, including noncash fringe benefits and tips;
- Required employer withholding of the additional HI tax from FICA wages or RRTA compensation, including in specific situations, such as third-party sick pay, predecessor-successor employers, and agents under approved Forms 2678, Employer Appointment of Agent;
- Coordination of an employee’s requested income tax withholding and estimated tax payments with the employee’s expected total tax liability;
- Applicability of separate threshold amounts for an individual (or an individual and spouse) with RRTA compensation as well as FICA wages or self-employment income;
- Procedures for individuals to report and pay the additional HI tax and to claim a refund if the additional HI tax withheld by an employer exceeds the amount owed by the employee, using Form 1040, Individual Income Tax Return; and
• Correction and filing procedures if an employer withholds more or less than the required HI tax amount.

Additional Medicare or HI Tax FAQs

Q1. What wages are subject to Additional Medicare Tax?
A1. All wages that are currently subject to Medicare Tax are subject to Additional Medicare Tax if they are paid in excess of the applicable threshold for an individual’s filing status.

Q2. What Railroad Retirement Tax Act (RRTA) compensation is subject to Additional Medicare Tax?
A2. All RRTA compensation that is currently subject to Medicare Tax is subject to Additional Medicare Tax if it is paid in excess of the applicable threshold for an individual’s filing status.

Q3. Are nonresident aliens and U.S. citizens living abroad subject to Additional Medicare Tax?
A3. There are no special rules for nonresident aliens and U.S. citizens living abroad for purposes of this provision. Wages, other compensation, and self-employment income that are subject to Medicare tax will also be subject to Additional Medicare Tax if in excess of the applicable threshold.

Q4. Can I request additional withholding specifically for Additional Medicare Tax?
A4. No. However, if you anticipate liability for Additional Medicare Tax, you may request that your employer withhold an additional amount of income tax withholding on Form W-4. The additional income tax withholding will be applied against your taxes shown on your individual income tax return (Form 1040), including any Additional Medicare Tax liability.

Q5. Will I need to make estimated tax payments for Additional Medicare Tax?
A5. If you anticipate that you will owe Additional Medicare Tax but will not satisfy the liability through Additional Medicare Tax withholding and did not request additional income tax withholding using Form W-4, you may need to make estimated tax payments. You should consider your estimated total tax liability in light of your wages, other compensation, and self-employment income, and the applicable threshold for your filing status when determining whether estimated tax payments are necessary.

Q6. Does an individual who makes estimated tax payments to pay an expected liability for Additional Medicare Tax need to identify the payments as specifically for this tax?
A6. No. An individual cannot designate any estimated payments specifically for Additional Medicare Tax. Any estimated tax payments that an individual makes will apply to any and all tax liabilities on the individual income tax return (Form 1040), including any Additional Medicare Tax liability.
Q7. Will individuals calculate Additional Medicare Tax liability on their income tax returns?
A7. Yes. Individuals liable for Additional Medicare Tax will calculate Additional Medicare Tax liability on their individual income tax returns (Form 1040). Individuals will also report Additional Medicare Tax withheld by their employers on their individual tax returns. Any Additional Medicare Tax withheld by an employer will be applied against all taxes shown on an individual’s income tax return, including any Additional Medicare Tax liability.

Q8. Will an individual owe Additional Medicare Tax on all wages, compensation, and/or self-employment income or just the wages, compensation, and/or self-employment income in excess of the threshold for the individual’s filing status?
A8. An individual will owe Additional Medicare Tax on wages, compensation, and/or self-employment income (and that of the individual’s spouse if married filing jointly) that exceed the applicable threshold for the individual’s filing status. For married persons filing jointly the threshold is $250,000, for married persons filing separately the threshold is $125,000, and for all others the threshold is $200,000.

Q9. If my employer withholds Additional Medicare Tax from my wages in excess of $200,000, but I won’t owe the tax because my spouse and I file a joint return and we won’t meet the $250,000 threshold for joint filers, can I ask my employer to stop withholding Additional Medicare Tax?
A9. No. Your employer must withhold Additional Medicare Tax on wages it pays to you in excess of $200,000 in a calendar year. Your employer cannot honor a request to cease withholding Additional Medicare Tax if it is required to withhold it. You will claim credit for any withheld Additional Medicare Tax against the total tax liability shown on your individual income tax return (Form 1040).

Q10. What should I do if I have two jobs and neither employer withholds Additional Medicare Tax, but the sum of my wages exceeds the threshold at which I will owe the tax?
A10. If you anticipate that you will owe Additional Medicare Tax but will not satisfy the liability through Additional Medicare Tax withholding (for example, because you will not be paid wages in excess of $200,000 in a calendar year by an employer), you should make estimated tax payments and/or request additional income tax withholding using Form W-4.

Q11. Are wages that are not paid in cash, such as fringe benefits, subject to Additional Medicare Tax?
A11: Yes, the value of taxable wages not paid in cash, such as noncash fringe benefits, are subject to Additional Medicare Tax, if, in combination with other wages, they exceed the individual’s applicable threshold. Noncash wages are subject to Additional Medicare Tax withholding, if, in combination with other wages paid by the employer, they exceed the $200,000 withholding threshold.
Q12. Are tips subject to Additional Medicare Tax?
A12. Yes, tips are subject to Additional Medicare Tax, if, in combination with other wages, they exceed the individual’s applicable threshold. Tips are subject to Additional Medicare Tax withholding, if, in combination with other wages paid by the employer, they exceed the $200,000 withholding threshold.

Q13. How do individuals calculate Additional Medicare Tax if they have compensation subject to RRTA taxes and wages subject to FICA tax?
A13. Compensation subject to RRTA taxes and wages subject to FICA tax are not combined to determine Additional Medicare Tax liability. The threshold applicable to an individual’s filing status is applied separately to each of these categories of income. Example: J and K, are married and file jointly. J has $190,000 in wages subject to Medicare tax and K has $150,000 in compensation subject to RRTA taxes. J and K do not combine their wages and RRTA compensation to determine whether they are in excess of the $250,000 threshold for a joint return. J and K are not liable to pay Additional Medicare Tax because J’s wages are not in excess of the $250,000 threshold and K’s RRTA compensation is not in excess of the $250,000 threshold.

Q14. Will I also owe net investment income tax on my income that is subject to Additional Medicare Tax?
A14. No. The new tax imposed by section 1411 on an individual’s net investment income is not applicable to FICA wages, RRTA compensation, or self-employment income. Thus, an individual will not owe net investment income tax on these categories of income, regardless of the taxpayer’s filing status. See more information on the Net Investment Income Tax.

Q15. Is an employer liable for Additional Medicare Tax even if it does not withhold it from an employee’s wages?
A15. An employer that does not deduct and withhold Additional Medicare Tax as required is liable for the tax unless the tax that it failed to withhold from the employee’s wages is paid by the employee. Even if not liable for the tax, an employer that does not meet its withholding, deposit, reporting, and payment responsibilities for Additional Medicare Tax may be subject to all applicable penalties.

Q16. Is an employer required to notify an employee when it begins withholding Additional Medicare Tax?
A16. No. There is no requirement that an employer notify its employee.

Q17. Is there an “employer match” for Additional Medicare Tax (as there is with the regular Medicare tax)?
A17. No. There is no employer match for Additional Medicare Tax.

Q18. May an employee request additional withholding specifically for Additional Medicare Tax?
A18. No. However, an employee who anticipates liability for Additional Medicare Tax may request that his or her employer withhold an additional amount of income tax withholding on Form W-4. This additional income tax withholding will be applied against all taxes shown on the individual’s income tax return (Form 1040), including any Additional Medicare Tax liability.
2. TAX ON NET INVESTMENT INCOME FOR HIGH INCOME TAXPAYERS

Section 1411 imposes a tax with respect to unearned income on certain high-income individuals, estates and trusts. In the case of an individual, the tax is 3.8 percent of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount.

The threshold amount is $250,000 in the case of a joint return or surviving spouse, $125,000 in the case of a married individual filing a separate return, and $200,000 in any other case.

Modified adjusted gross income is adjusted gross income increased by the amount excluded from income as foreign earned income under section 911(a)(1) (net of the deductions and exclusions disallowed with respect to the foreign earned income).

In the case of an estate or trust, the tax is 3.8 percent of the lesser of undistributed net investment income or the excess of adjusted gross income (as defined in section 67(e)) over the dollar amount at which the highest income tax bracket applicable to an estate or trust begins.

The tax does not apply to a nonresident alien or to a trust all the unexpired interests in which are devoted to charitable purposes. The tax also does not apply to a trust that is exempt from tax under section 501 or a charitable remainder trust exempt from tax under section 664.

The tax is subject to the individual estimated tax provisions. The tax is not deductible in computing any tax imposed by subtitle A of the Internal Revenue Code (relating to income taxes).

Net investment income

Net investment income is investment income reduced by the deductions properly allocable to such income.

Investment income is the sum of (i) gross income from interest, dividends, annuities, royalties, and rents (other than income derived from any trade or business to which the tax does not apply), (ii) other gross income derived from any business to which the tax applies, and (iii) net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business to which the tax does not apply.

In the case of a trade or business, the tax applies if the trade or business is a passive activity with respect to the taxpayer or the trade or business consists of trading financial instruments or commodities (as defined in section 475(e)(2)). The tax does not apply to other trades or businesses conducted by a sole proprietor, partnership, or S corporation.

In the case of the disposition of a partnership interest or stock in an S corporation, gain or loss is taken into account only to the extent gain or loss would be taken into account by the partner or shareholder if the entity had sold all its properties for fair market value immediately before the disposition. Thus, only net gain or loss attributable to property held by the entity which is not property attributable to an active trade or business is taken into account.
Income, gain, or loss on working capital is not treated as derived from a trade or business. Investment income does not include distributions from a qualified retirement plan or amounts subject to SECA tax.

**Implementation**

On November 30, 2012, the Treasury Department issued proposed regulations concerning the tax imposed by section 1411 ("Proposed Regulations"). The Proposed Regulations are largely intended to be effective for taxable years beginning after December 31, 2013. Treasury stated that taxpayers may rely on the Proposed Regulations for purposes of compliance with section 1411 until the effective date of the final regulations. A public hearing on the Proposed Regulations has been scheduled for Tuesday, April 2, 2013.

The Proposed Regulations provide guidance on the following topics: (1) general operating rules applicable to section 1411; (2) rules applicable to individuals; (3) rules applicable to trusts and estates; (4) rules for defining net investment income; (5) rules for net investment income derived from trades or businesses that are passive activities or trading in financial instruments or commodities; (6) rules for gross income and net gain on the investment of working capital; (7) rules for dispositions of interests in partnerships and S corporations; (8) rules for distributions from certain qualified plans; (9) rules for items taken into account in determining self-employment income; and (10) rules with respect to controlled foreign corporations and passive foreign investment companies.

The following discussion is not intended to be a complete description of the Proposed Regulations, but rather is meant only to highlight certain aspects of the Proposed Regulations taxpayers may find useful or informative.

**General operating rules**

The Proposed Regulations provide that, except as otherwise provided, principles and rules established in chapter 1 of the Internal Revenue Code will be used in determining the tax under section 1411. Accordingly, the preamble to the Proposed Regulations provides that gain that is not recognized under chapter 1 for a taxable year is not recognized that year for purposes of section 1411 (for example, gain that is either deferred or excluded under sections 453, 1031, 1033, or 121). Similarly, the Proposed Regulations provide that all references to an individual’s adjusted gross income shall be treated as references to adjusted gross income (as defined in section 62), and that all references to an estate’s or trust’s adjusted gross income shall be treated as references to adjusted gross income (as defined in section 67).

**Application to individuals**

The Proposed Regulations state that the tax imposed under section 1411(a)(1) applies to any citizen or resident of the United States (within the meaning of section 7701(a)(30)(A)). In the case of a U.S. citizen or resident who is married to a nonresident alien individual, the spouses will be treated as married filing separately for purposes of section 1411, with the U.S. citizen being subject to the married filing separate threshold amount of $125,000. Married taxpayers who elect to have both spouses treated as residents of the United States for purposes of chapters 1 and 24 of the Code pursuant to section 6013(g) may also elect to be so treated for purposes of chapter 2A (relating to
the tax imposed by section 1411). The effect of such an election is to include the combined income of the U.S. citizen or resident spouse and the nonresident spouse in the section 1411(a)(1) calculation, and to apply the threshold amount for a taxpayer making a joint return (i.e., $250,000).

Application to trusts and estates

The Proposed Regulations provide that section 1411 applies to all estates and trusts that are subject to the provisions of part I of subchapter J of chapter 1 of subtitle A of the Code. The preamble of the Proposed Regulations explains that the effect of this rule is to exclude from the application of section 1411 certain business trusts, as well as certain state law trusts that are subject to specific taxation regimes in chapter 1 other than part I of subchapter J. Additionally, the Proposed Regulations state that the following trusts are excluded from the application of section 1411: (1) a trust all of the unexpired interests in which are devoted to one or more of the purposes described in section 170(c)(2)(B) (relating to religious, charitable, scientific, literary or educational purposes, etc.); (2) a trust exempt from tax under section 501; (3) a charitable remainder trust described in section 664; (4) any other trust, fund, or account that is statutorily exempt from taxes imposed in subtitle A; (5) a trust, or a portion thereof, that is treated as a grantor trust (but see below with respect to specific rules applicable to grantor trusts); and (6) a foreign trust (except as provided below).

The Proposed Regulations provide specific guidance related to grantor trusts, electing small business trusts, charitable remainder trusts, foreign estates and trusts, and bankruptcy estates.

Definition of net investment income

Net investment income includes, in part, gross income from interest, dividends, annuities, royalties and rents. However, such income is excluded from net investment income if it is derived in the ordinary course of a trade or business not described in section 1411(c)(2) (a trade or business that is either a passive activity to the taxpayer or the business of trading in financial instruments or commodities).

The Proposed Regulations provide rules for determining whether gross income is derived in a trade or business that qualifies for the exclusion from the tax levied under section 1411 (i.e., rules to determine whether that the trade or business is neither a passive activity to the taxpayer nor the business of trading in financial instruments or commodities), rules determining whether there has been a disposition of property under section 1411, and the treatment of properly allocable deductions for purposes of reducing items of gross income and net gain.

Exception for dispositions of interests in partnerships and S corporations

Section 1411(c)(4)(A) provides that, in the case of a disposition of an interest in a partnership or S corporation, gain from such disposition shall be taken into account under section 1411(c)(1)(A)(iii) only to the extent of the net gain which would be so taken into account by the transferor under section 1411(c)(1)(A)(iii) if all property of the partnership or S corporation were sold for fair market value immediately before the disposition of such interest.
The Proposed Regulations provide that the exception applies only to the disposition of interests in partnerships or S corporations if a) the partnership or S corporation is engaged in one or more trades or businesses (within the meaning of section 162), and at least one of its trades or businesses is not trading in financial instruments or commodities; and b) with respect to the partnership or S corporation interest disposed of, the transferor is engaged in at least one trade or business that is not a passive activity with respect to the transferor. The Proposed Regulations provide detailed rules pertaining to the calculation of the amount excluded in the event of such a sale.

Controlled foreign corporations and passive foreign investment companies

Generally, income with respect to investments in foreign corporations is included in the calculation of net investment income for section 1411 purposes. Such income includes dividend and gains derived with respect to the stock of a controlled foreign corporation (“CFC”) or a passive foreign investment company (“PFIC”). The Proposed Regulations provide rules addressing the treatment of amounts required to be included in income by United States shareholders of CFCs and PFICs under sections 951(a), 1296(a) and 1293(a).

Under subpart F of the Code, a United States shareholder of a CFC is required to include certain amounts in income currently under section 951(a). Such amounts are not treated as dividends under general tax principles, unless otherwise provided by the Code. Similar inclusions are required, and similar treatment is applied, for a shareholder of a PFIC if the person makes a qualified electing fund election under section 1295 with respect to the PFIC. Because these inclusions are not considered dividends, and thus are not included in the definition of net investment income under section 1411(c)(1)(A)(ii), unless an election is made (described below), the Proposed Regulations provide that such inclusions are not subject to the tax imposed by section 1411. However, the Proposed Regulations provide that when a subsequent distribution of an amount previously included in the shareholder’s income (by virtue of the sections 951(a), 1296(a), or 1293(a)), such a distribution is considered to be a dividend for chapter 2A purposes. Thus, although such a distribution is excluded from income tax, it nonetheless constitutes gross income from dividends for purposes of section 1411(c)(1)(A)(i).

The preamble to the Proposed Regulations discusses the potential administrative burden to taxpayers associated with the rules described above. As an attempt to eliminate a great deal of this complexity, the Proposed Regulations allow individuals, estates, and trusts to make an election to include inclusions under sections 951 and 1293 in net investment income in the same manner and in the same taxable year as such amounts are included in income for chapter 1 purposes. If such an election is made, any section 959(d) or section 1293(c) distributions that are not treated as dividends for chapter 1 purposes are not treated as dividends for section 1411 purposes, and thus would not be included in net investment income for section 1411 purposes. A separate computation of basis for section 1411 purposes would not be required.
Net Investment Income Tax FAQs

Basics of the Net Investment Income Tax

Q1. When does the Net Investment Income Tax take effect?
A1. The Net Investment Income Tax goes into effect on Jan. 1, 2013. The NIIT will affect income tax returns of individuals, estates and trusts for their first tax year beginning on (or after) Jan. 1, 2013. It will not affect income tax returns for the 2012 taxable year that will be filed in 2013.

Who Owes the Net Investment Income Tax

Q2. What individuals are subject to the Net Investment Income Tax?
A2. Individuals will owe the tax if they have Net Investment Income and also have modified adjusted gross income over the following thresholds:

<table>
<thead>
<tr>
<th>Filing Status</th>
<th>Threshold Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married filing jointly</td>
<td>$250,000</td>
</tr>
<tr>
<td>Married filing separately</td>
<td>$125,000</td>
</tr>
<tr>
<td>Single</td>
<td>$200,000</td>
</tr>
<tr>
<td>Head of household (w/ qualifying person)</td>
<td>$200,000</td>
</tr>
<tr>
<td>Qualifying widow(er) with dependent child</td>
<td>$250,000</td>
</tr>
</tbody>
</table>

Taxpayers should be aware that these threshold amounts are not indexed for inflation. If you are an individual that is exempt from Medicare taxes, you still may be subject to the Net Investment Income Tax if you have Net Investment Income and also have modified adjusted gross income over the applicable thresholds.

Q3. What individuals are not subject to the Net Investment Income Tax?
A3. Nonresident Aliens (NRAs) are not subject to the Net Investment Income Tax. If an NRA is married to a U.S. citizen or resident and has made, or is planning to make, an election under Internal Revenue Code (IRC) section 6013(g) to be treated as a resident alien for purposes of filing as Married Filing Jointly, the proposed regulations provide these couples special rules and a corresponding IRC section 6013(g) election for the NIIT.

Q4. What Estates and Trusts are subject to the Net Investment Income Tax?
A4. Estates and Trusts will be subject to the Net Investment Income Tax if they have undistributed Net Investment Income and also have adjusted gross income over the dollar amount at which the highest tax bracket for an estate or trust begins for such taxable year (for tax year 2012, this threshold amount is $11,650). There are special computational rules for certain unique types of trusts, such as Charitable Remainder Trusts and Electing Small Business Trusts, which can be found in the proposed regulations.

Q5. What Trusts are not subject to the Net Investment Income Tax?
A5. The following trusts are not subject to the Net Investment Income Tax: Trusts that are exempt from income taxes imposed by Subtitle A of the Internal Revenue Code (e.g., charitable trusts and qualified retirement plan trusts exempt from tax under IRC section 501, and Charitable Remainder Trusts exempt from tax under IRC section 664).
• A trust in which all of the unexpired interests are devoted to one or more of the purposes described in IRC section 170(c)(2)(B);

• Trusts that are classified as “grantor trusts” under IRC sections 671-679; and

• Trusts that are not classified as “trusts” for federal income tax purposes (e.g., Real Estate Investment Trusts and Common Trust Funds).

What Is Included in Net Investment Income

Q6. What is included in Net Investment Income?
A6. In general, investment income includes, but is not limited to: interest, dividends, capital gains, rental and royalty income, non-qualified annuities, income from businesses involved in trading of financial instruments or commodities, and businesses that are passive activities to the taxpayer (within the meaning of IRC section 469). To calculate your Net Investment Income, your investment income is reduced by certain expenses properly allocable to the income.

Q7. What are some common types of income that are not Net Investment Income?

Q8. What kinds of gains are included in Net Investment Income?
A8. To the extent that gains are not otherwise offset by capital losses, the following gains are common examples of items taken into account in computing Net Investment Income:

• Gains from the sale of stocks, bonds, and mutual funds;

• Capital gain distributions from mutual funds;

• Gain from the sale of investment real estate (including gain from the sale of a second home that is not a primary residence); and

• Gains from the sale of interests in partnerships and S corporations (to the extent you were a passive owner).

Q9. Does this tax apply to gain on the sale of a personal residence?
A9. The Net Investment Income Tax will not apply to any amount of gain that is excluded from gross income for regular income tax purposes. The pre-existing statutory exclusion in IRC section 121 exempts the first $250,000 ($500,000 in the case of a married couple) of gain recognized on the sale of a principal residence from gross income for regular income tax purposes and, thus, from the NIIT.
Example 1: A, a single filer, earns $210,000 in wages and sells his principal residence that he has owned and resided in for the last 10 years for $420,000. A’s cost basis in the home is $200,000. A’s realized gain on the sale is $220,000. Under IRC section 121, A may exclude up to $250,000 of gain on the sale. Because this gain is excluded for regular income tax purposes, it is also excluded for purposes of determining Net Investment Income. In this example, the Net Investment Income Tax does not apply to the gain from the sale of A’s home.

Example 2: B and C, a married couple filing jointly, sell their principal residence that they have owned and resided in for the last 10 years for $1.3 million. B and C’s cost basis in the home is $700,000. B and C’s realized gain on the sale is $600,000. The recognized gain subject to regular income taxes is $100,000 ($600,000 realized gain less the $500,000 IRC section 121 exclusion). B and C have $125,000 of other Net Investment Income, which brings B and C’s total Net Investment Income to $225,000. B and C’s modified adjusted gross income is $300,000 and exceeds the threshold amount of $250,000 by $50,000. B and C are subject to NIIT on the lesser of $225,000 (B’s Net Investment Income) or $50,000 (the amount B and C’s modified adjusted gross income exceeds the $250,000 married filing jointly threshold). B and C owe Net Investment Income Tax of $1,900 ($50,000 × 3.8%).

Example 3: D, a single filer, earns $45,000 in wages and sells her principal residence that she has owned and resided in for the last 10 years for $1 million. D’s cost basis in the home is $600,000. D’s realized gain on the sale is $400,000. The recognized gain subject to regular income taxes is $150,000 ($400,000 realized gain less the $250,000 IRC section 121 exclusion), which is also Net Investment Income. D’s modified adjusted gross income is $195,000. Since D’s modified adjusted gross income is below the threshold amount of $200,000, D does not owe any Net Investment Income Tax.

Q10. Does Net Investment Income include interest, dividends and capital gains of my children that I report on my Form 1040 using Form 8814?
A10. The amounts of Net Investment Income that are included on your Form 1040 by reason of Form 8814 are included in calculating your Net Investment Income. However, the calculation of your Net Investment Income does not include (a) amounts excluded from your Form 1040 due to the threshold amounts on Form 8814 and (b) amounts attributable to Alaska Permanent Fund Dividends.

Q11. What investment expenses are deductible in computing NII?
A11. In order to arrive at Net Investment Income, Gross Investment Income is reduced by deductions that are properly allocable to items of Gross Investment Income. Examples of properly allocable deductions include investment interest expense, investment advisory and brokerage fees, expenses related to rental and royalty income, and state and local income taxes properly allocable to items included in Net Investment Income.
Q12. Will I have to pay both the 3.8% Net Investment Income Tax and the additional 0.9% Medicare tax?
A12. You may be subject to both taxes, but not on the same type of income. The 0.9% Additional Medicare Tax applies to individuals’ wages, compensation and self-employment income over certain thresholds, but it does not apply to income items included in Net Investment Income. See more information on the Additional Medicare Tax.

How the Net Investment Income Tax Is Reported and Paid

Q13. If I am subject to the Net Investment Income Tax, how will I report and pay the tax?
A13. For individuals, the tax will be reported on, and paid with, the Form 1040. For Estates and Trusts, the tax will be reported on, and paid with, the Form 1041.

Q14. Is the Net Investment Income Tax subject to the estimated tax provisions?
A14. The Net Investment Income Tax is subject to the estimated tax provisions. Individuals, estates, and trusts that expect to be subject to the tax in 2013 or thereafter should adjust their income tax withholding or estimated payments to account for the tax increase in order to avoid underpayment penalties.

Q15. Does the tax have to be withheld from wages?
A15. No, but you may request that additional income tax be withheld from your wages.

Examples of the Calculation of the Net Investment Income Tax

Q16. How does a Single taxpayer with income less than the statutory threshold calculate the Net Investment Income Tax?
A16. Taxpayer, a single filer, has wages of $180,000 and $15,000 of dividends and capital gains. Taxpayer’s modified adjusted gross income is $195,000, which is less than the $200,000 statutory threshold. Taxpayer is not subject to the Net Investment Income Tax.

Q17. How does a Single taxpayer with income greater than the statutory threshold calculate the Net Investment Income Tax?
A17. Taxpayer, a single filer, has $180,000 of wages. Taxpayer also received $90,000 from a passive partnership interest, which is considered Net Investment Income. Taxpayer’s modified adjusted gross income is $270,000. Taxpayer’s modified adjusted gross income exceeds the threshold of $200,000 for single taxpayers by $70,000. Taxpayer’s Net Investment Income is $90,000. The Net Investment Income Tax is based on the lesser of $70,000 (the amount that Taxpayer’s modified adjusted gross income exceeds the $200,000 threshold) or $90,000 (Taxpayer’s Net Investment Income). Taxpayer owes NIIT of $2,660 ($70,000 x 3.8%).
Additional Information

Q18. The proposed regulations are proposed to be effective for tax years beginning after Dec. 31, 2013, but Net Investment Income Tax goes into effect on Jan. 1, 2013. May I rely on the regulations for guidance on the Net Investment Income Tax during 2013?

A18. Taxpayers may rely on the proposed regulations for purposes of compliance with section 1411 until the effective date of the final regulations. To the extent the proposed regulations provide taxpayers with the ability to make an election, taxpayers may make the election provided that the election is made in the manner described in the proposed regulation. Any election made in reliance on the proposed regulations will be in effect for the year of the election, and will remain in effect for subsequent taxable years. However, if final regulations provide for the same or a similar election, taxpayers who opt not to make an election in reliance on the proposed regulations will not be precluded from making that election pursuant to the final regulations.

3. EXCLUSION FOR ASSISTANCE PROVIDED TO PARTICIPANTS IN STATE STUDENT LOAN REPAYMENT PROGRAMS FOR CERTAIN HEALTH PROFESSIONALS

In general

Gross income generally includes the discharge of indebtedness of the taxpayer. Under an exception to this general rule, gross income does not include any amount from the forgiveness (in whole or in part) of certain student loans, provided that the forgiveness is contingent on the student’s working for a certain period of time in certain professions for any of a broad class of employers.

Student loans eligible for this special rule are those made to an individual attending an educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its education activities are regularly carried on. Loan proceeds may be used for tuition and required fees, and room and board expenses. The loan must be made by (1) the United States (or an instrumentality or agency thereof), (2) a State (or any political subdivision thereof), (3) certain tax-exempt public benefit corporations that control a State, county, or municipal hospital and whose employees have been deemed to be public employees under State law, or (4) an educational organization that originally received the funds from which the loan was made from the United States, a State, or a tax-exempt public benefit corporation.

In addition, an individual’s gross income does not include amounts from the forgiveness of loans made by educational organizations (and certain tax-exempt organizations in the case of refinancing loans) out of private, nongovernmental funds if the proceeds of such loans are used to pay costs of attendance at an educational institution or to refinance any outstanding student loans (not just loans made by educational organizations) and the student is not employed by the lender organization. In the case of such loans made or refinanced by educational organizations (or refinancing loans made by certain tax-exempt organizations), cancellation of the student loan must be contingent upon the student working in an occupation or area with unmet needs and such work must be performed for, or under the direction of, a tax-exempt charitable organization or a governmental entity.
Finally, an individual’s gross income does not include any loan repayment amount received under the National Health Service Corps loan repayment program or certain State loan repayment programs.

The ACA modifies the gross income exclusion for amounts received under the National Health Service Corps loan repayment program or certain State loan repayment programs to include any amount received by an individual under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas (as determined by the State).

The provision added by the ACA is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

**Implementation**

The IRS released IR-2010-74 on June 16, 2010 to provide guidance for health care professionals who received student loan relief under state programs that reward those who work in underserved communities. The IRS informed health care professionals participating in these programs who had reported income from repaid or forgiven loan amounts on their 2009 returns, possibly after receiving a Form W-2, Wage and Tax Statement, or Form 1099, that they may be due refunds.

The IRS advised those who had already filed their tax returns that they may exclude eligible amounts by filing Form 1040X, Amended U.S. Individual Income Tax Return, and by writing “Excluded student loan amount under 2010 Health Care Act” in the Explanation of Changes box. The guidance provided that health care professionals may request an employer or other issuer to provide a Form W-2c, Corrected Wage and Tax Statement, or 1099 and may attach the corrected form to the Form 1040X. However, the Form 1040X may also be filed without attaching a corrected form.

The guidance also provided that an individual whose employer withheld and paid taxes under the Federal Insurance Contributions Act (FICA) on payments covered under the new exclusion may request that the employer seek a refund of withheld FICA on the employee’s behalf. And because employers also pay a portion of the FICA tax, the employer also may be entitled to a refund.
Assignment 1 – Review Questions

The following questions are designed to ensure that you have a complete understanding of the information presented in the assignment. They do not need to be submitted in order to receive CPE credit. They are included as an additional tool to enhance your learning experience.

We recommend that you answer each review question and then compare your response to the suggested solution before answering the final exam questions related to this assignment.

1. What changes did the ACA make to preexisting condition exclusions to group health plans effective on or after September 23, 2010:
   a) it prohibits preexisting condition exclusions for children under the age of 19
   b) it prohibits preexisting condition exclusions for children under the age of 27
   c) it prohibits all preexisting condition exclusions
   d) it does not make any changes to preexisting condition exclusions

2. The ACA expanded the classification of “related individuals” for whom the exclusion for employer-provided health coverage and reimbursement for medical expenses applies to include:
   a) the employee’s spouse
   b) the employee’s dependents
   c) the employee’s children who are in college
   d) any children of the employee who is not 27 years old by the end of the taxable year

3. The maximum aggregate annual contribution that a 55 year-old can make to a self-only coverage HSA is:
   a) $3,250
   b) $4,250
   c) $6,450
   d) $7,450

4. Which of the following falls under the category of “medical care”:
   a) toothpaste
   b) deodorant
   c) birth control
   d) face cream
5. In order to be eligible for the tax credit for small employer health insurance expenses, among other requirements, the organization must:

   a) employ no more than 25 full-time equivalent employees
   b) employ no more than 50 full-time equivalent employees
   c) be a health insurance company
   d) have an annual revenue of no more than $2.2 million dollars

6. Which of the following would be subject to the net investment income tax:

   a) Eric, whose income is subject to the Additional Medicare Tax
   b) Olivia, whose trust is classified as a “grantor trust”
   c) Sam, who is a nonresident alien
   d) Jill, a single woman who has net investment income and modified adjusted gross income of $270,000
Assignment 1 – Solutions and Suggested Responses

1. A: Correct. The Affordable Care Act did prohibit preexisting condition exclusions for children under the age of 19.

   B: Incorrect. The ACA eliminated preexisting condition exclusions for children under the age of 19, not 27.

   C: Incorrect. Preexisting condition exclusions were not totally eliminated under the ACA.

   D: Incorrect. One of the additional requirements under the ACA was the elimination of preexisting condition exclusions for children under the age of 19.

   (See pages 1 to 2 of the course material.)

2. A: Incorrect. Spouses were already included in the related individuals eligible for coverage prior to the enactment of the ACA.

   B: Incorrect. Prior to the enactment of the ACA, dependents were already included as eligible related individuals.

   C: Incorrect. The factor that makes children eligible for coverage is not a matter of whether or not they are in college, but their age. If a child is in college but 28 years old, he or she would not be eligible for coverage as a related individual.

   D: Correct. The ACA expanded the related individuals of an employee eligible for coverage to include any children who are under the age of 27 as of the end of the taxable year.

   (See pages 3 to 4 of the course material.)

3. A: Incorrect. The maximum annual contribution that someone under the age of 55 can make to a self-only HSA is $3,250, but at age 55, a catch-up contribution is permitted.

   B: Correct. This is the maximum permitted, which includes the $1,000 catch-up contribution.

   C: Incorrect. An individual can only contribute a maximum of $3,250 to a self-only HSA, if under 55, but the limit is raised to $6,450 for family coverage.

   D: Incorrect. This is the maximum contribution to an HSA for family coverage if over 55.

   (See page 7 of the course material.)
4. A: Incorrect. “Medical care” does not include toiletries, and toothpaste is considered a toiletry.

B: Incorrect. Deodorant is a toiletry and does not fall under the category of “medical care.”

C: Correct. “Medical care” is described as those items used for the purposes of diagnosis, cure, mitigation, and treatment or prevention of disease or for the purpose of affecting any structure of the body, and birth control meets the requirements of this definition.

D: Incorrect. Face cream is not considered for the use of “medical care” as is it a toiletry item.

(See page 8 of the course material.)

5. A: Correct. To qualify for a tax credit for small employer insurance expenses, the company can have no more than 25 full-time employees.

B: Incorrect. The company can have no more than 25 full-time employees to be eligible for the tax credit.

C: Incorrect. The tax credit for small employer health insurance expenses does not only apply to companies in the health care industry.

D: Incorrect. There are no limitations on the annual revenue of a company that would either permit or prevent a company from being eligible for the tax credit for small employer health insurance expenses.

(See page 13 of the course material.)

6. A: Incorrect. Eric would not be subject to the net investment income tax. Income that is subject to the Additional Medicare Tax will not be subject to the net investment income tax.

B: Incorrect. Trusts classified as “grantor trusts” are not subject to the net investment income tax.

C: Incorrect. The net investment income tax is not applicable to nonresident aliens, so Sam would not have to pay the tax.

D: Correct. The threshold for a single individual is $250,000, so Jill would be required to pay the net investment income tax since she has net investment income and her modified adjusted gross income exceeds $250,000.

(See pages 28 to 31 of the course material.)
Chapter 5: Other Changes in Business Deductions and Credits

1. LIMITATION ON DEDUCTION FOR REMUNERATION PAID BY HEALTH INSURANCE PROVIDERS

Million dollar limit on deductible compensation for publicly held corporations

An employer generally may deduct reasonable compensation for personal services as an ordinary and necessary business expense. Section 162(m) limits the otherwise allowable deduction for compensation paid or accrued with respect to a very limited group of executives of a publicly held corporation to no more than $1 million per year for each executive. The deduction limitation applies when the deduction would otherwise be taken. Unless specifically excluded, the deduction limitation applies to all remuneration for services, including cash and the cash value of all remuneration (including benefits) paid in a medium other than cash.

The following types of compensation are specifically not taken into account: (1) remuneration payable on a commission basis; (2) remuneration payable solely on account of the attainment of one or more performance goals if certain outside director and shareholder approval requirements are met ("performance-based compensation"); (3) payments to a tax-qualified retirement plan (including salary reduction contributions); and (4) amounts that are excludable from the executive’s gross income (such as employer-provided health benefits and miscellaneous fringe benefits). Remuneration also does not include compensation for which a deduction is allowable after a covered employee ceases to be a covered employee. Thus, for example, the deduction limitation does not apply to compensation for services performed while an individual is a covered executive that is otherwise subject to the deduction limitation (e.g., is not performance-based compensation) to the extent that the compensation is only deductible for taxable years after the covered executive terminates employment with the corporation, such as in the case of nonqualified deferred compensation only payable after termination of employment.

ACA change to the deduction for remuneration paid by health insurance providers

The ACA limits the deduction allowable for remuneration which is attributable to services performed by an applicable individual for a covered health insurance provider during a taxable year to remuneration not in excess of $500,000. There are no exceptions for performance-based or commission-based remuneration. The limitation applies to remuneration otherwise deductible for taxable years after 2012 with respect to services performed after 2009.

Applicable individuals

Applicable individuals include all officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of a covered health insurance provider. Thus, in contrast to the general rules under section 162(m), the limitation on the deductibility of remuneration from a covered health insurance provider is not limited to a small group of covered executives but generally applies to remuneration of all employees and service providers.
Covered insurance provider

An insurance provider is a covered health insurance provider under section 162(m)(6) if at least 25 percent of the insurance provider’s gross premium income from health business is derived from health insurance plans that provide minimum essential coverage within the meaning of section 5000A.

Deduction of compensation for services for a year otherwise deductible in a subsequent year

This $500,000 deduction limitation applies without regard to whether remuneration is otherwise deductible for a taxable year or for a subsequent taxable year. In the case of remuneration that relates to services that an applicable individual performs during a taxable year but that is not deductible until a later year, such as nonqualified deferred compensation, the unused portion (if any) of the $500,000 limit for the year is carried forward until the year in which the compensation is otherwise deductible, and the remaining unused limit is then applied to the compensation. In the case of services performed during taxable years beginning after December 31, 2009 but before January 1, 2013, the deduction limit does not limit the amount of compensation for such services deductible for taxable years beginning before January 1, 2013. However, any amount deductible for taxable years before 2013 as remuneration for services during any of those years is taken into account in determining whether the remuneration for such services otherwise deductible for taxable years after 2012 exceeds the $500,000 limit.

Implementation

On December 22, 2010, the IRS released Notice 2011-02 which provides guidance on this $500,000 limitation on the deduction for remuneration paid by health insurance providers.

Notice 2011-02 provides that applicable individual for purposes of this deduction limitation does not include an independent contractor with respect to whom a compensation arrangement would not be subject to the requirement for nonqualified deferred compensation under section 409A (generally independent contractors providing substantial services to multiple unrelated customers). Notice 2011-02 also provides a de minimis rule under which an insurance provider is not a covered insurance provider if the premiums received from providing minimum essential coverage are less than 2 percent of the insurance provider’s gross revenue for the taxable year.

2. REPEAL OF DEDUCTION FOR EXPENSES RELATED TO FEDERAL SUBSIDIES FOR RETIREE PRESCRIPTION DRUG PLANS

Exclusion for retiree prescription drug plan subsidies and deduction for plan expenses

Sponsors of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of HHS with respect to a portion of each qualified covered retiree’s gross covered prescription drug costs (“qualified retiree prescription drug plan subsidy”). A qualified retiree prescription drug plan is employment-based retiree health coverage that has an actuarial value at least as great as the Medicare Part D standard plan for the risk pool and that meets certain other disclosure and recordkeeping requirements.
These qualified retiree prescription drug plan subsidies are excludable from the plan sponsor’s gross income for the purposes of regular income tax and alternative minimum tax.

In general, no deduction is allowed under any provision of the Code for any expense or amount that would otherwise be allowable as a deduction if such expense or amount is allocable to a class or classes of exempt income. Thus, expenses incurred with respect to the subsidies excluded from income under section 139A would generally not be deductible. However, before the ACA, the exclusion for the qualified retiree prescription drug plan subsidy specifically provided that the exclusion was not taken into account in determining a deduction with respect to covered retiree prescription drug expenses taken into account in determining the subsidy payment. Therefore, a taxpayer could claim a deduction for covered retiree prescription drug expenses incurred notwithstanding that the taxpayer excludes from income qualified retiree prescription drug plan subsidies allocable to such expenses.

Effective for taxable years beginning after December 31, 2012, the ACA eliminates the rule that the exclusion for subsidy payments is not taken into account in determining a deduction with respect to retiree prescription drug expenses. Thus, the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of excludable subsidy payments received.

Implementation

The IRS has posted on its website Frequently Asked Questions about the change in the deduction rule, including examples of how the change applies in various situations.

3. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH ORGANIZATIONS

In general

A property and casualty insurance company is subject to tax on its taxable income, generally defined as its gross income less allowable deductions (sec. 832). For this purpose, gross income includes underwriting income and investment income, as well as other items. Underwriting income is the premiums earned on insurance contracts during the year, less losses incurred and expenses incurred. The amount of losses incurred is determined by taking into account the discounted unpaid losses. Premiums earned during the year is determined by taking into account a 20-percent reduction in the otherwise allowable deduction, intended to represent the allocable portion of expenses incurred in generating the unearned premiums (sec. 832(b)(4)(B)).

Present law provides that an organization described in sections 501(c)(3) or (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance (sec. 501(m)). When this rule was enacted in 1986, special rules were provided under section 833 for Blue Cross and Blue Shield organizations providing health insurance that (1) were in existence on August 16, 1986; (2) were determined at any time to be tax-exempt under a determination that had not been revoked; and (3) were tax-exempt for the last taxable year beginning before January 1, 1987 (when the present-law rule became effective), provided that no material change occurred in the structure or operations of the organizations after August 16, 1986, and before the close of 1986 or any subsequent taxable year. Any other organization is
eligible for section 833 treatment if it meets six requirements set forth in section 833(c): (1) substantially all of its activities involve providing health insurance; (2) at least 10 percent of its health insurance is provided to individuals and small groups (not taking into account Medicare supplemental coverage); (3) it provides continuous full-year open enrollment for individuals and small groups; (4) for individuals, it provides full coverage of pre-existing conditions of high-risk individuals and coverage without regard to age, income, or employment of individuals under age 65; (5) at least 35 percent of its premiums are community rated; and (6) no part of its net earnings inures to the benefit of any private shareholder or individual.

Section 833 provides a deduction with respect to health business of such organizations. The deduction is equal to 25 percent of the sum of (1) claims incurred, and liabilities incurred under cost-plus contracts, for the taxable year, and (2) expenses incurred in connection with administration, adjustment, or settlement of claims or in connection with administration of cost-plus contracts during the taxable year, to the extent this sum exceeds the adjusted surplus at the beginning of the taxable year. Only health-related items are taken into account.

Section 833 provides an exception for such an organization from the application of the 20-percent reduction in the deduction for increases in unearned premiums that applies generally to property and casualty companies.

Section 833 provides that such an organization is taxable as a stock property and casualty insurer under the Federal income tax rules applicable to property and casualty insurers.

**ACA eligibility limitations**

The ACA limits eligibility for the rules of section 833 to those organizations meeting a medical loss ratio standard of 85 percent for the taxable year. An organization that does not meet the 85-percent standard is not allowed the 25-percent deduction and the exception from the 20-percent reduction in the unearned premium reserve deduction under section 833.

For this purpose, an organization’s medical loss ratio is determined as the percentage of total premium revenue expended on reimbursement for clinical services that are provided to enrollees under the organization’s policies during the taxable year, as reported under section 2718 of the PHSA.

It is intended that the medical loss ratio under this provision be determined on an organization-by-organization basis, not on an affiliated or other group basis, and that Treasury Department guidance be promulgated promptly to carry out the purposes of the provision.

**Implementation**

The IRS has provided transitional relief and interim guidance on the computation of a taxpayer’s medical loss ratio, the consequences of nonapplication of section 833, and rules relating to changes in accounting method. This transitional relief has been extended to any taxable year beginning in 2012 and the first taxable year beginning after December 31, 2012.
Chapter 6: Industry, Product, or Service Fees or Excise Taxes

1. ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS

In general

An annual fee is imposed on covered entities engaged in the business of manufacturing or importing branded prescription drugs for sale to any specified government program or pursuant to coverage under any such program. Fees collected are credited to the Medicare Part B trust fund.

The aggregate annual fee imposed on all covered entities is $2.5 billion for calendar year 2011, $2.8 billion for calendar years 2012 and 2013, $3 billion for calendar years 2014 through 2016, $4 billion for calendar year 2017, $4.1 billion for calendar year 2018, and $2.8 billion for calendar year 2019 and thereafter. The aggregate fee is apportioned among the covered entities each year based on their relative share of branded prescription drug sales taken into account during the previous calendar year.

A covered entity’s relative market share for a calendar year is the entity’s branded prescription drug sales taken into account during the preceding calendar year as a percentage of the aggregate branded prescription drug sales of all covered entities taken into account during the preceding calendar year. Sales taken into account during any calendar year with respect to a covered entity is: (1) zero percent of sales not more than $5 million; (2) 10 percent of sales over $5 million but not more than $125 million; (3) 40 percent of sales over $125 million but not more than $225 million; (4) 75 percent of sales over $225 million but not more than $400 million; and (5) 100 percent of sales over $400 million.

A covered entity is any manufacture or importer with gross receipts from branded prescription drug sales. All persons treated as a single employer under section 52(a) or (b) or under section 414(m) or 414(o) are treated as a single covered entity. In applying the single employer rules under 52(a) and (b), foreign corporations are not excluded. If more than one person is liable for payment of the fee, all such persons are jointly and severally liable for payment of such fee.

Branded prescription drug sales are sales of branded prescription drugs made to any specified government program, or pursuant to coverage under any such program. The term branded prescription drugs includes any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act and for which an application was submitted under section 351(a) of such Act. Branded prescription drug sales do not include sales of any drug or biological product with respect to which an orphan drug tax credit was allowed for any taxable year under section 45C. The exception for orphan drug sales does not apply to any drug or biological product after such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the rare disease or condition with respect to which the section 45C credit was allowed.
Specified government programs include: (1) the Medicare Part D program under part D of title XVIII of the Social Security Act; (2) the Medicare Part B program under part B of title XVIII of the Social Security Act; (3) the Medicaid program under title XIX of the Social Security Act; (4) any program under which branded prescription drugs are procured by the Department of Veterans Affairs; (5) any program under which branded prescription drugs are procured by the Department of Defense; or (6) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

For purposes of procedure and administration, the fees are treated in the same manner as those excise taxes identified in subtitle F, “Procedure and Administration” for which the only avenue for judicial review is a civil action for refund. Thus, the fees may be assessed and collected using the procedures in subtitle F without regard to the restrictions on assessment in section 6213.

The fee is required to be paid no later than an annual payment date determined by the Secretary of the Treasury, but in no event later than September 30th each calendar year.

For purposes of section 275, relating to the nondeductibility of specified taxes, the fee is considered to be a nondeductible tax described in section 275(a)(6).

**Implementation**

On November 29, 2010, the IRS released Notice 2010-71, which proposed an approach to implementing the annual fee on branded prescription drugs and requesting comments. The notice was modified and superseded by Notice 2011-9, released on January 14, 2011. On April 29, 2011, the IRS released Rev. Proc. 2011-24, establishing a process for covered entities to submit claimed errors in their preliminary fee calculations for consideration before the final fee calculations for 2011. On May 27, 2011, the IRS released Notice 2011-46, deferring the due date for submission of error reports and the last possible date for sending final fee calculations for 2011.

On August 15, 2011, the IRS and the Treasury Department issued temporary regulations describing the rules related to the annual fee imposed on branded prescription drugs and the actions to be taken before the September 30th due date of each year’s fee. The temporary regulations provide a general overview of the rules, an explanation of terms used in implementing the fee, and information requested from covered entities and provided by the agencies responsible for the specified government programs. The temporary regulations describe how the fee is calculated and provide for a subsequent adjustment. The temporary regulations provide for a notice of the preliminary fee calculation, a dispute resolution process to allow covered entities to submit error reports relating to the preliminary fee calculation, and a notice of the final fee calculation. Additionally, the temporary regulations explain how to pay the fee, how the fee is treated for tax purposes, and how to submit refund claims. The temporary regulations are generally consistent with the approach proposed in previous guidance.

The temporary regulations provide each covered entity the opportunity to provide information relevant to the determination of the fee by annually submitting Form 8947, “Report of Branded Prescription Drug Information.” The Form requests information including the National Drug Codes (“NDCs”) for branded prescription drugs that the covered entity sold to the specified government programs, Medicare and Medicaid rebate information, section 45C orphan drug information, members of controlled groups, and designated entity information.
The IRS compiles information collected from covered entities regarding NDCs and provides that information to the agencies responsible for the specified government programs. The agencies use this information to provide data related to NDCs purchased by each government program. The IRS uses this information to produce the fee determination each year. The temporary regulations clarify that the IRS will compute the fee for a covered entity based on the branded prescription drug sales data for each NDC reported by the agencies and any rebate data for each NDC reported by the covered entities. As proposed in previous guidance, the temporary regulations use the second calendar year preceding the fee year as the sales year for purposes of calculating the fee as the Centers for Medicare and Medicaid Services of the Department of Health and Human Services is unable to provide data for the preceding year within the necessary time frame. Accordingly, because the use of the second preceding year as the sales year, rather than the immediately preceding year, may affect the amount of the fee paid by a covered entity, the annual fee due in every year after 2011 will include an adjustment amount.

The IRS provides each covered entity with a notice of preliminary fee calculation each year that includes the covered entity’s preliminary fee calculation; the covered entity’s branded prescription drug sales, by NDC, for each program; the covered entity’s branded prescription drug sales taken into account; the aggregate branded prescription drug sales taken into account for all covered entities; a preliminary adjustment amount; and a reference to the fee dispute resolution process. Notice 2012-74 provides information for the 2013 fee year and specifies that the IRS will mail each covered entity’s preliminary fee calculation by April 1, 2013 and final fee calculation by August 31, 2013. The annual fee for 2013 is due by September 30, 2013.

2. EXCISE TAX ON CERTAIN MEDICAL DEVICES

In general

A 2.3-percent excise tax is imposed on the sale of medical devices by the manufacturer or importer. “Medical device” is defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (“FFDCA”). Section 201(h) defines “device” as an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component part or accessory which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

The tax does not apply to eyeglasses, contact lenses, hearing aids, or to other medical devices specified by the Treasury Department to be generally sold in retail establishments or over the Internet to individuals for their personal use. Examples of such items could be pregnancy test kits, diabetes testing supplies, denture adhesives, and certain bandages and tipped applicators.
The manufacturers’ excise tax exemptions for further manufacture and for export apply to the medical device excise tax; however exemptions for use as supplies for vessels or aircraft, and for sales to State or local governments, nonprofit educational organizations, and qualified blood collector organizations are not applicable.

**Implementation**

**In general**

On December 5, 2012, the IRS and the Treasury Department issued final regulations providing guidance on the excise tax imposed on the sale of medical devices.

The regulations provide that for purposes of the medical device excise tax, a device defined in section 201(h) of the FFDCA is a device that is listed as a device with the Food and Drug Administration (“FDA”) under section 510(j) of the FFDCA and 21 Code of Federal Regulations (CFR) 807, pursuant to FDA requirements.

The regulations provide a facts and circumstances approach to evaluating whether a medical device is of a type that is generally purchased by the general public at retail for individual use. A device is considered to be of a type generally purchased by the general public at retail for individual use if (1) the device is regularly available for purchase and use by individual consumers who are not medical professionals, and (2) the device’s design demonstrates that it is not primarily intended for use in a medical institution or office, or by medical professionals. The regulations provide a non-exclusive list of factors to be considered in determining whether a device is regularly available for purchase and use by individual consumers who are not medical professionals and a non-exclusive list of factors to be considered in determining whether the design of a device demonstrates that it is primarily intended for use in a medical institution or office, or by medical professionals, and therefore not intended for purchase and use by individual consumers. The regulations also include a safe harbor provision that identifies certain categories of medical devices that the IRS and the Treasury Department have determined fall within the retail exception.

Notice 2012-77 issued on December 5, 2012 provides interim guidance for determining price, the donation of taxable medical devices, the licensing of taxable medical devices, and the tax treatment of medical convenience kits. Additionally, the notice provides temporary penalty relief for the first three calendar quarters of 2013 related to the requirement to make semimonthly deposits of the medical device excise tax.

**Medical device convenience kits**

The regulations define a “kit” as a set of two or more articles packaged in a single bag, tray, or box for the convenience of the end user. If a kit is a listed device, then the use of other taxable medical devices in the assembly of the kit constitutes “further manufacture” within the meaning of section 4221(a)(1) by the person who produces the kit. Hospitals or medical institutions that produce kits for their own use are known as “self-kitters.” Self-kitters are exempt from the FDA’s registration and listing requirements. Therefore, under the definition of medical device in the regulations, a kit produced by a hospital or medical institution for its own use is not a taxable medical device.
Under the interim guidance provided in Notice 2012-77, a “convenience kit” is a set of two or more medical devices within the meaning of section 201(h) of the FFDCA that is enclosed in a single package, such as a bag, tray, or box, for the convenience of a health care professional or the end user. Until such time as the IRS and the Treasury Department issue further guidance, no tax is imposed on the sale of a domestically produced convenience kit that is a taxable medical device under section 4191 and section 48.4191-2(b) of the regulations. During the interim period, the sale of a taxable medical device that goes into a domestically-produced convenience kit will be subject to tax on its sale by the manufacturer or importer. Tax is imposed on the sale by an importer of a convenience kit that is a taxable medical device, but only on the portion of the importer’s sale price of the convenience kit that is properly allocable to the individual taxable medical devices included in the convenience kit.

Medical Device Excise Tax: Frequently Asked Questions

Q1. When does the tax go into effect?

Q2. Will individual consumers be subject to any reporting or recordkeeping requirements?
A2. Generally, no action is required by individual consumers. Because the tax is imposed upon the sale of a taxable medical device by the manufacturer or importer, the manufacturer or importer is responsible for reporting and paying the tax.

Q3. Who is the manufacturer for purposes of the medical device excise tax?
A3. Generally, with regard to the medical device excise tax, the manufacturer is the person who produces a taxable medical device from scrap, salvage or junk material, or from new or raw material, by processing, manipulating or changing the form of a device or by combining or assembling two or more devices.

Q4. Who is the importer for purposes of the medical device excise tax?
A4. Generally, with regard to the medical device excise tax, the importer of a taxable medical device is the person who brings the device into the United States from a source outside the United States, or withdraws the device from a customs-bonded warehouse for sale or use in the United States.

Q5. When is the Form 720 due?
A5. Like other manufacturers excise taxes, the medical device excise tax is reported on Form 720. Form 720 is filed quarterly. The first return to report the medical device excise tax will be due on April 30, 2013, for the quarterly period including January, February and March 2013. Quarterly return due dates are as follows:

<table>
<thead>
<tr>
<th>For the months:</th>
<th>Due by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan., Feb., Mar.</td>
<td>April 30</td>
</tr>
<tr>
<td>Apr., May, Jun.</td>
<td>July 31</td>
</tr>
</tbody>
</table>
Q6. Are tax deposits required for the medical device excise tax?
A6. Yes. Semi-monthly deposits will generally be required if tax liability exceeds $2,500 for the quarter. The first deposit of the medical device excise tax, covering the first 15 days of January 2013, will be due on Jan. 29, 2013. Notice 2012-77 provides transition relief from deposit penalties during the first three calendar quarters of 2013.

Q7. Has the IRS issued guidance on the medical device excise tax?
A7. Yes. The IRS and the Treasury Department issued final regulations on Dec. 5, 2012. The IRS and the Treasury Department issued Notice 2012-77 on Dec. 5, 2012, to provide interim guidance on certain issues related to the medical device excise tax.

Q8. What is a taxable medical device?
A8. In general, a taxable medical device is a device that is listed as a device with the Food and Drug Administration under section 510(j) of the Federal Food, Drug, and Cosmetic Act and 21 CFR part 807, unless the device falls within an exemption from the tax, such as the retail exemption.

Q9. Are there any exemptions to the medical device excise tax?
A9. Yes. There are specific statutory exemptions for eyeglasses, contact lenses, and hearing aids. There is also an exemption for other devices that are of a type that are generally purchased by the general public at retail for individual use (the retail exemption).

Q10. Do the regulations illustrate how the retail exemption facts and circumstances test should be applied?
A10. Yes. The regulations include examples that apply the facts and circumstances test to several types of medical devices. Based on the totality of the circumstances presented in the examples, the examples conclude that non-sterile absorbent tipped applicators, adhesive bandages, snake bite suction kits, denture adhesives, mechanical and powered wheelchairs, portable oxygen concentrators, and therapeutic AC powered adjustable home use beds are devices that fall within the retail exemption. Based on the totality of the circumstances presented in the examples, the examples also conclude that mobile x-ray systems, nonabsorbable silk sutures, and nuclear magnetic resonance imaging systems are not devices that fall within the retail exemption.

Q11. Is there a retail exemption safe harbor?
A11. Yes. The regulations identify certain categories of devices that qualify for the retail exemption so that manufacturers and importers do not have to apply the facts and circumstances test. Those categories are set forth in a safe harbor provision in § 48.4191-2(b)(2)(iii) of the regulations.

Q12. Are there any circumstances under which a taxable medical device can be sold tax-free?
A12. Yes. A manufacturer or importer of a taxable medical device may, in certain circumstances, sell a taxable medical device tax-free for use by the purchaser for further manufacture (or for resale by the purchaser to a second purchaser for further manufacture), or for export (or for resale for export). To make a tax-free sale for further manufacture or export, both parties to the sale must be registered with the IRS. Form 637, Application for Registration for Certain Excise Tax Activities, is used for the registration process.
3. STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE

The ACA requires the Secretary of Veterans Affairs to conduct a study on the effect (if any) of the fees assessed on manufacturers and importers of branded prescription drugs, manufacturers and importers of medical devices, and health insurance providers on (1) the cost of medical care provided to veterans and (2) veterans’ access to branded prescription drugs and medical devices.

The Secretary of Veterans Affairs will report the results of the study to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate no later than December 31, 2012.

On February 13, 2013, the Department of Veteran Affairs submitted a report to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate. The report concluded that the three studied provisions, the annual fee on branded prescription drugs, the medical device excise tax, and the annual fee on health insurance providers, have not yet had an observable impact on either the cost or medical care provided to veterans or veterans’ access to medical devices and branded prescription drugs.

4. EXCISE TAX ON INDOOR TANNING SERVICES

In general

A retail sales tax is imposed on indoor tanning services. The tax rate is 10 percent of the amount paid for such services. Consumers are liable for the tax, with service providers being responsible for collecting and remitting the tax to the Federal Government.

Indoor tanning services are services employing any electronic product designed to induce skin tanning and which incorporate one or more ultraviolet lamps with wavelengths in air between 200 and 400 nanometers. Taxable services do not include phototherapy services performed by a licensed medical professional.

Implementation

On June 11, 2010, the IRS and the Treasury Department published final and temporary regulations that provide guidance on the excise tax on tanning services. The regulations define phototherapy services, provide rules for determining the tax when the provider charges for other goods and services in addition to indoor tanning services or sells bundled services, and provide that liability for tax is imposed at the time it can reasonably be determined that payment is made specifically for indoor tanning services. Additionally, the regulations specify that a payment of a membership fee to a qualified physical fitness facility that includes access to indoor tanning services is not a payment for indoor tanning services and is not subject to the excise tax.

The regulations apply the existing excise tax procedural rules in 26 CFR part 40 to the excise tax on indoor tanning services. The provider reports the tax on Form 720 “Quarterly Federal Excise Tax Return.” The regulations do not require semimonthly deposits of tax; rather, full payment of the tax is due quarterly at the time Form 720 is filed.
5. FEES RELATED TO THE PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND

Patient-Centered Outcomes Research Trust Fund and fees

Trust fund

Under the ACA, a new trust fund is established in the Treasury of the United States, the Patient-Centered Outcomes Research Trust Fund (“PCORTF”), to carry out the provisions in the Act relating to comparative effectiveness research. The PCORTF is funded in part from fees imposed with respect to certain health insurance policies and self-insured health plans. The fees apply for policy years and plan years ending after September 30, 2012, and before October 1, 2019.

Fees for health insurance policies and self-insured health plans

In the case of a specified health insurance policy (a “specified policy”), the fee is $2 ($1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy. For policy years ending after September 30, 2014, the fee is increased to reflect increases in projected per capita National Health Expenditures, as published by Treasury. The issuer of the policy is liable for payment of the fee.

A specified policy generally includes any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States (including a possession), subject to an exception for certain types of coverage. A prepaid health coverage arrangement is treated as a specified policy, and the person agreeing to provide (or arrange for the provision of) coverage under the arrangement is treated as the issuer.

In the case of an applicable self-insured health plan (an “applicable self-insured plan”), the fee is $2 ($1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan. For plan years ending after September 30, 2014, the fee is increased to reflect increases in projected per capita National Health Expenditures, as published by Treasury. The plan sponsor is liable for payment of the fee. For purposes of the provision, the plan sponsor is (1) in the case of a single-employer plan, the employer; (2) in the case of a plan established or maintained by an employee organization, the employee organization; (3) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, a multiple employer welfare arrangement (“MEWA”), or a voluntary employees’ beneficiary association (“VEBA”), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan; and (4) in the case of a plan established or maintained by a rural electric cooperative or a rural telephone cooperative association, the cooperative or association.

An applicable self-insured plan is any plan providing accident or health coverage, any portion of which coverage is provided other than through an insurance policy, and the plan is established or maintained (1) by one or more employers for their employees or former employees; (2) by one or more employee organizations for their members or former members; (3) jointly by one or more employers and one or more employee...
organizations for employees or former employees; (4) by a VEBA; (5) by a business league, chamber of commerce, or similar tax-exempt organization; or (6) by a MEWA, a rural electric cooperative, or a rural telephone cooperative association.

Governmental entities are generally not exempt from the fees imposed under the provision. However, the fees are not imposed with respect to exempt governmental programs, including Medicare, Medicaid, SCHIP, any Federal medical care program (other than through insurance policies) for members of the Armed Forces, veterans, or members of Indian tribes.

No fees collected are to be covered over to a United States possession. The fees are treated as taxes for purposes of the Code’s procedure and administration rules.

Implementation

Notice 2011-35 (issued June 8, 2011) requested comments on issues relating to implementation of the fees on specified policies and applicable self-insured plans, including methods for determining the average number of lives covered under a policy or plan and the treatment of certain types of employer-provided coverage.

The IRS subsequently issued proposed regulations on the fees on April 17, 2012 and final regulations on December 6, 2012. Under the final regulations:

- Separate fees apply for coverage for the same individual under multiple specified insurance policies, multiple applicable self-insured plans, or a specified insurance policy and an applicable self-insured plan. However, in the case of an applicable self-insured plan that offers fully-insured and self-insured options, individuals covered solely by fully-insured options may be disregarded in determining the fee for the applicable self-insured plan. In addition, two or more self-insured arrangements of the same plan sponsor and with the same plan year may be treated as a single applicable self-insured plan.

- A specified policy or applicable self-insured plan includes a policy or plan providing COBRA continuation coverage or coverage only for former employees. A limited exception applies for certain health flexible spending arrangements (“health FSAs”) and health reimbursement arrangements (“HRAs”), and, if a plan sponsor’s only self-insured plan is a health FSA or HRA, the plan sponsor may treat each participant’s health FSA or HRA as covering a single life (without regard to spouses, dependents or other beneficiaries). A group policy issued to an employer and designed and issued specifically to cover primarily employees working and residing outside the United States is not a specified policy, and a self-insured plan designed specifically to cover such a group of employees is not an applicable self-insured plan.

- Two alternative methods are available for determining the number of covered lives under a specified policy or applicable self-insured plan, specifically an actual count method or snapshot method. Alternatively, a member months method or State form method (i.e., using a form filed with the issuer’s State of domicile) can be used with respect to a specified policy, or a Form 5500 method (based on the number of participants reported on the plan’s Form 5500, Annual Return/Report of Employee Benefit Plan) may be used with respect to an applicable self-insured plan.
Chapter 7: Tax-Exempt Organizations

1. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS

Tax exemption for hospitals, in general

Charitable organizations, i.e., organizations described in section 501(c)(3), generally are exempt from Federal income tax, are eligible to receive tax deductible contributions, have access to tax-exempt financing through State and local governments (described in more detail below), and generally are exempt from State and local taxes. A charitable organization must operate primarily in pursuit of one or more tax-exempt purposes constituting the basis of its tax exemption. The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.

The Code does not provide a per se exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and otherwise meets the requirements of section 501(c)(3). The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole. It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care.

Since 1969, the IRS has applied a “community benefit” standard for determining whether a hospital is charitable. According to Revenue Ruling 69-545, community benefit can include, for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees composed of representatives of the community; operating with an open medical staff policy, with privileges available to all qualifying physicians; providing charity care; and utilizing surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education and research. Beginning in 2009, hospitals generally are required to submit information on community benefit on their annual information returns filed with the IRS.

Additional requirements for section 501(c)(3) hospitals enacted as part of the ACA

In general

The ACA establishes new requirements applicable to section 501(c)(3) hospitals. The new requirements are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in section 501(c)(3). The requirements generally apply to any section 501(c)(3) organization that operates at least one hospital facility. For purposes of the provision, a hospital facility generally includes: (1) any facility that is, or is required to be, licensed, registered, or similarly recognized by a State as a hospital; and (2) any other facility or organization the Secretary of the Treasury (the “Secretary”), in consultation with the Secretary of HHS and after public comment, determines has the provision of hospital care as its principal purpose. To qualify for tax exemption under section 501(c)(3), an organization subject to the ACA provision is required to comply with the following requirements with respect to each hospital facility operated by such organization.
Community health needs assessment

Each hospital facility is required to conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment. The assessment may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more other organizations, including related organizations. The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues. The hospital must disclose in its annual information report to the IRS (i.e., Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources). Each hospital facility is required to make the assessment widely available. Failure to complete a community health needs assessment in any applicable three-year period results in a penalty on the organization equal to $50,000. For example, if a facility does not complete a community health needs assessment in taxable years one, two or three, it is subject to the penalty in year three. If it then fails to complete a community health needs assessment in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four). An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.

Financial assistance policy

Each hospital facility is required to adopt, implement, and widely publicize a written financial assistance policy. The financial assistance policy must indicate the eligibility criteria for financial assistance and whether such assistance includes free or discounted care. For those eligible for discounted care, the policy must indicate the basis for calculating the amounts that will be billed to such patients. The policy must also indicate how to apply for such assistance. If a hospital does not have a separate billing and collections policy, the financial assistance policy must also indicate what actions the hospital may take in the event of non-response or non-payment, including collections action and reporting to credit rating agencies. Each hospital facility also is required to adopt and implement a policy to provide emergency medical treatment to individuals. The policy must prevent discrimination in the provision of emergency medical treatment, including denial of service, against those eligible for financial assistance under the facility’s financial assistance policy or those eligible for government assistance.

Limitation on charges

Each hospital facility is permitted to bill for emergency or other medically necessary care provided to individuals who qualify for financial assistance under the facility’s financial assistance policy no more than the amounts generally billed to individuals who have insurance covering such care. A hospital facility may not use gross charges (i.e., “chargemaster” rates) when billing individuals who qualify for financial assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.
Collection processes

Under the provision, a hospital facility (or its affiliates) may not undertake extraordinary collection actions (even if otherwise permitted by law) against an individual without first making reasonable efforts to determine whether the individual is eligible for assistance under the hospital’s financial assistance policy. Such extraordinary collection actions include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes. The Secretary is directed to issue guidance concerning what constitutes reasonable efforts to determine eligibility. It is intended that for this purpose, “reasonable efforts” include notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient’s bill, including invoices and telephone calls, before collection action or reporting to credit rating agencies is initiated.

Reporting and disclosure requirements

The Secretary or the Secretary’s delegate is required to review information about a hospital’s community benefit activities (currently reported on Form 990, Schedule H) at least once every three years. Each organization to which the ACA provision applies must file with its annual information return (i.e., Form 990) a copy of its audited financial statements (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statements).

The Secretary, in consultation with the Secretary of HHS, is required to submit annually a report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of means-tested government programs, and unreimbursed costs of non-means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals, as well as the costs incurred by private tax-exempt hospitals for community benefit activities. In addition, the Secretary, in consultation with the Secretary of HHS, must conduct a study of the trends in these amounts, and submit a report on such study to Congress not later than five years from date of enactment (March 23, 2010).

Effective Date

Except as provided below, the additional requirements for tax exempt hospitals enacted as part of the ACA are effective for taxable years beginning after the date of enactment (March 23, 2010). The community health needs assessment requirement is effective for taxable years beginning after the date which is two years after the date of enactment (March 23, 2010). The excise tax on failures to satisfy the community health needs assessment requirement is effective for failures occurring after the date of enactment (March 23, 2010).

Implementation

Guidance regarding new substantive requirements

On June 14, 2010, the IRS issued Notice 2010-39, soliciting comments on various aspects of the new requirements for charitable hospitals. On July 25, 2011, the IRS issued Notice 2011-52, describing the community health needs assessment (“CHNA”) requirements the Treasury Department and IRS anticipated would be included in
regulations and soliciting comments regarding the CHNA requirements. One purpose of the notice was to give guidance to organizations that chose to start conducting CHNAs in accordance with the new requirements prior to the effective date of the CHNA requirement (i.e., taxable years beginning after March 23, 2012). The notice provides that a hospital organization may rely on the anticipated regulatory provisions described in the notice for any CHNA made widely available to the public, and any implementation strategy adopted, on or before the date that is six months after the date further guidance regarding the CHNA requirements is issued.

On June 22, 2012, the IRS issued proposed regulations relating to the requirements for charitable hospitals, other than the CHNA requirements discussed in Notice 2011-52. The IRS requested comments on the proposed regulations by September 24, 2012. The regulations are proposed to apply for taxable years beginning on or after the date published in the Federal Register as final or temporary regulations, but taxpayers may rely on the proposed regulations until final or temporary regulations are issued. The temporary guidance regarding the CNHA requirement included in Notice 2011-52 remains in effect.

**Reporting requirements**

The annual information return for exempt organizations, i.e., Form 990, was redesigned for tax years beginning in 2008, and a new Schedule H for hospital organizations was added as part of the redesign. For tax years beginning in 2010, a new Section B was added to Part V of Schedule H, where hospitals would describe their compliance with the new ACA requirements on a facility-by-facility basis; the portions of Part V Section B relating to the CHNA requirements were optional for the 2010 and 2011 tax years. On July 5, 2011, the IRS issued Announcement 2011-37, which provided that the entirety of Part V Section B would be optional for the 2010 tax year.

**2. TAX EXEMPTION FOR CERTAIN MEMBER-RUN HEALTH INSURANCE ISSUERS**

**The Consumer Operated and Oriented Plan**

In general

The ACA authorized $6 billion in funding for, and instructs the Secretary of Health and Human Services (“HHS”) to establish, the Consumer Operated and Oriented Plan (the “program”) to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans. Federal funds are to be distributed as loans to assist with start-up costs and grants to assist in meeting State solvency requirements.

The Secretary of HHS must require any person receiving a loan or grant under the program to enter into an agreement with the Secretary of HHS requiring the recipient of funds to meet and continue to meet any requirement under the provision for being treated as a qualified nonprofit health insurance issuer, and any requirements to receive the loan or grant. The Section 1322 of PPACA adds new section 501(c)(29) to the Code and amends section 6033 of the agreement must prohibit the use of loan or grant funds for carrying on propaganda or otherwise attempting to influence legislation or for marketing.
If the Secretary of HHS determines that a grant or loan recipient failed to meet the requirements described in the preceding paragraph, and failed to correct such failure within a reasonable period from when the person first knew (or reasonably should have known) of such failure, then such person must repay the Secretary of HHS an amount equal to 110 percent of the aggregate amount of the loans and grants received under the program, plus interest on such amount for the period during which the loans or grants were outstanding. The Secretary of HHS must notify the Secretary of the Treasury of any determination of a failure that results in the termination of the grantee’s Federal tax-exempt status.

Qualified nonprofit health insurance issuers

A qualified nonprofit health insurance issuer is an organization that meets the following requirements:

- The organization is organized as a nonprofit, member corporation under State law;
- Substantially all of its activities consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans;
- None of the organization, a related entity, or a predecessor of either was a health insurance issuer as of July 16, 2009;
- The organization is not sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision;
- Governance of the organization is subject to a majority vote of its members;
- The organization’s governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference;
- The organization must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to its members, in accordance with regulations to be promulgated by the Secretary of HHS;
- Any profits made must be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to its members;
- The organization meets all other requirements that other issuers of qualified health plans are required to meet in any State in which it offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, rules on network adequacy, rate and form filing rules, and any applicable State premium assessments. Additionally, the organization must coordinate with certain other State insurance reforms under the Act; and
• The organization does not offer a health plan in a State until that State has in effect (or the Secretary of HHS has implemented for the State), the market reforms required by part A of title XXVII of the Public Health Service Act ("PHSA"), as amended by the Act.

Tax exemption for qualified nonprofit health insurance issuers

Under new section 501(c)(29) of the Code, an organization receiving a grant or loan under the program qualifies for exemption from Federal income tax under section 501(a) with respect to periods during which the organization is in compliance with the above-described requirements of the program and with the terms of any program grant or loan agreement to which such organization is a party. Such organizations also are subject to organizational and operational requirements applicable to certain section 501(c) organizations, including the prohibitions on private inurement and political activities, the limitation on lobbying activities, taxation of excess benefit transactions (section 4958), and taxation of unrelated business taxable income under section 511.

Program participants are required to file an application for exempt status with the IRS in such manner as the Secretary of the Treasury may require, and are subject to annual information reporting requirements. In addition, such an organization is required to disclose on its annual information return the amount of reserves required by each State in which it operates and the amount of reserves on hand.

Implementation

Establishment of CO-OP Program by HHS

In July 2011, the Department of Health and Human Services issued proposed regulations regarding establishment of the Consumer Operated and Oriented Plan ("CO-OP Program"), requesting comments on the proposed rule by September 16, 2011. In December 2011, the Department issued final regulations establishing the CO-OP Program, effective February 13, 2012. The final regulations describe eligibility standards for the CO-OP Program, establish terms for CO-OP loans, and provide basic standards organizations must meet to participate in the program and become a qualified nonprofit health insurance issuer.

As of December 21, 2012, 24 issuers offering coverage in 24 states had been awarded a cumulative total of $1.98 billion in CO-OP loans.

Guidance regarding applications for tax-exempt status

In early 2011, the IRS issued Notice 2011-23, describing the requirements for tax exemption under new section 501(c)(29) and stating that the IRS will not accept applications for exempt status until the IRS issues a revenue procedure describing the application process and the applicant has entered into the required agreement with the Secretary of HHS. In the notice, the Treasury Department and IRS requested comments regarding the application procedures, the effective date of an applicant’s tax-exempt status, and the need for further guidance regarding the new requirements.
In February 2012, the IRS issued Revenue Procedure 2012-11 outlining the procedures for issuing determination letters and rulings regarding tax-exempt status under new section 501(c)(29). The Revenue Procedure provides that a determination letter or ruling regarding section 501(c)(29) status generally is effective as of the later of the date of the organization’s formation or March 23, 2010 (the effective date of the ACA), provided certain requirements are met. The Revenue Procedure was issued in conjunction with temporary regulations and a notice of proposed rulemaking regarding the process for applying for exempt status under section 501(c)(29).

Rescission of certain appropriated but unobligated amounts

The Department of Defense and Full-Year Continuing Appropriations Act of 2011, reduced the total appropriation available for CO-OP loans by $2.2 billion, to $3.8 billion.

The American Taxpayer Relief Act of 2012 (“ATRA”) requires the Secretary of HHS to establish a fund to be used to provide assistance and oversight to qualified nonprofit health insurance issuers that had been awarded loans or grants under the CO-OP Program prior to the date of enactment of ATRA (January 2, 2013). ATRA requires the transfer of 10 percent of the unobligated balance of sums appropriated for the CO-OP Program to the above-described fund. ATRA rescinds the remaining 90 percent of such appropriated but unobligated amounts.

3. TAX EXEMPTION FOR ENTITIES ESTABLISHED PURSUANT TO TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL MARKET IN EACH STATE

Overview of ACA provision regarding transitional reinsurance entities

Establishment of transitional reinsurance entities

In general, issuers of health benefit plans that are offered in the individual market are required to contribute to a temporary reinsurance program for individual policies that is administered by a nonprofit reinsurance entity. Such contributions are to begin January 1, 2014, and continue for a 36-month period. Each State, no later than January 1, 2014, must adopt a reinsurance program based on a model regulation and must establish (or enter into a contract with) one or more applicable reinsurance entities to carry out the reinsurance program under the provision. For purposes of the provision, an applicable reinsurance entity is a not-for-profit organization (1) the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first three years of operation of an exchange for such markets within the State, and (2) the duties of which are to carry out the reinsurance program under the provision by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program. A State may have more than one applicable reinsurance entity to carry out the reinsurance program in the State, and two or more States may enter into agreements to allow a reinsurer to operate the reinsurance program in those States.

Tax exemption for transitional reinsurance entities

An applicable reinsurance entity established under the provision is exempt from Federal income tax. Notwithstanding an applicable reinsurance entity’s tax-exempt status, it is subject to tax on unrelated business taxable income under section 511 as if such entity were described in section 511(a)(2).
Implementation

The ACA provision is silent regarding the deductibility of contributions to a temporary reinsurance program. The IRS, however, has posted on its website responses to frequently asked questions regarding deductibility of such contributions. The responses provide that a contribution to a temporary reinsurance program by a health insurance issuer or a sponsor of a self-insured group health plan generally is deductible as an ordinary and necessary business expense.

Transitional Reinsurance Program FAQs

Section 1341 of the Affordable Care Act establishes a transitional Reinsurance Program to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. The statute requires all health insurance issuers and third-party administrators on behalf of self-insured group health plans to make contributions under this program to support payments to individual market issuers that cover high-cost individuals (payment-eligible issuers). Regulations proposed by the Department of Health and Human Services to implement the Reinsurance Program specify that self-insured group health plans are liable for the contributions, although a plan may utilize a third-party administrator or administrative-services-only contractor for transfer of the contributions.

The Department of Labor has advised that paying required contributions under the Reinsurance Program would constitute a permissible expense of the plan for purposes of Title I of the Employee Retirement Security Act (ERISA) because the payment is required by the plan under the Affordable Care Act as interpreted in the proposed rule issued by the Department of Health and Human Services.

Taxpayers generally may deduct ordinary and necessary business expenses, including most fees and taxes paid to the government. However, under the rules of the Internal Revenue Code, deductions for ordinary and necessary business expenses may be disallowed, limited, or deferred in some circumstances. For example, taxpayers that use inventories may be required to include these expenses in their inventory costs, while deductions for taxpayers that are insurance companies may be affected by rules under Subchapter L.

Reinsurance Program

Q1. How may a health insurance issuer treat the contributions under the Reinsurance Program?

A1. Health insurance issuers will be able to treat contributions under the Reinsurance Program as ordinary and necessary expenses paid or incurred in carrying on a trade or business, subject to any applicable disallowances or limitations, or as a reduction to taxable income as provided under Subchapter L.
Q2. May a sponsor of a self-insured group health plan treat contributions under the Reinsurance Program as ordinary and necessary business expenses?
A2. Yes. A sponsor of a self-insured group health plan that pays Reinsurance Program contributions may treat the contributions as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Code. This treatment applies whether the contributions are made directly or through a third-party administrator or administrative-services-only contractor. If a plan pays Reinsurance Program contributions directly or through a third-party administrator, as may happen, for example, in the case of a multiemployer plan or a plan funded through a voluntary employees’ beneficiary association, the employer or employers contributing to the plan would be permitted to deduct their contributions to the plan, subject to any generally applicable disallowances or limitations.
Chapter 8: Other Revenue Provisions

1. CODIFICATION OF ECONOMIC SUBSTANCE DOCTRINE AND IMPOSITION OF PENALTIES

The ACA clarifies and enhances the application of the so-called “economic substance” doctrine and imposes a stronger penalty regime on relevant transactions.

Prior to this codification, courts had developed and applied the economic substance doctrine, among others, to deny the tax benefits of a tax-motivated transaction, notwithstanding that the transaction may satisfy the literal requirements of a specific tax provision. However, there had been a lack of uniformity regarding the proper application of the economic substance doctrine. For example, some courts had applied a conjunctive test that requires a taxpayer to establish the presence of both economic substance (i.e., the objective component) and business purpose (i.e., the subjective component) in order for the transaction to survive judicial scrutiny. Other courts used a narrower approach to conclude that either a business purpose or economic substance is sufficient to respect the transaction. A third approach had regarded economic substance and business purpose as “simply more precise factors to consider” in determining whether a transaction has any practical economic effects other than the creation of tax benefits.

Also, prior to the ACA, no special penalty applied under prior law to any case involving a failure to satisfy the “economic substance” doctrine as such. Other penalties applied (and continue to apply) to various types of understatements, but each of these types of penalties can be avoided if the taxpayer has reasonable cause for the position taken on the return (with a heightened standard in the case of listed or reportable transactions) and the taxpayer acted in good faith.

The ACA provides that in the case of any transaction to which the economic substance doctrine is relevant, such transaction is treated as having economic substance only if (1) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer’s economic position, and (2) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction. The ACA also provides more specific rules for considering certain factors such as non-Federal tax business purpose and profit potential. The ACA further provides that the determination of whether the economic substance doctrine is relevant to a transaction is made in the same manner as if the provision had never been enacted.

In addition, the ACA imposes a new 20-percent penalty on transactions to which the economic substance doctrine is relevant, doubled to 40 percent if the taxpayer did not adequately disclose the relevant facts in its return. Unlike penalties in other situations, reasonable cause is not a defense to the new penalty.

Implementation

On September 13, 2010, the IRS issued a notice providing interim guidance regarding the codification of the economic substance doctrine and the related amendments to the penalties. The notice applies to transactions entered into on or after March 31, 2010. The notice generally reiterates the statutory language and provides guidance regarding
adequate disclosures for purposes of the new penalty regime that applies a 40 percent penalty (rather than 20 percent) on transactions that are not adequately disclosed. The notice also states that the Treasury Department and the IRS do not intend to issue general administrative guidance regarding the types of transactions to which the economic substance doctrine applies. In addition, the notice provides specific guidance concerning (i) the IRS’ continued reliance on relevant case law, (ii) the calculation of profit motive, (iii) the treatment of foreign taxes, and (iv) disclosure issues.

On September 14, 2010, the Large and Mid-Size Business Division of IRS (now the Large Business & International Division (LB&I)) issued a directive requiring that the appropriate Director of Field Operations (DFO) review and approve any proposal by examination to impose the codified economic substance doctrine and related penalty provisions.

On July 15, 2011, LB&I issued a second directive, which provides a series of inquiries that LB&I examiners and their managers must develop and analyze before seeking approval from the DFO to raise the codified economic substance doctrine. This directive also provides that until further guidance is issued, the related penalty provisions are limited to the application of the economic substance doctrine and may not be imposed due to the application of any other “similar rule of law” or judicial doctrine, e.g., step transaction doctrine, substance over form, or sham transaction.

On April 3, 2012, the IRS Office of Chief Counsel issued a notice providing (1) instructions regarding Counsel’s role during an examination that involves the application of the economic substance doctrine under the common law or the codified economic substance doctrine and related penalty provisions; (2) instructions for reviewing a statutory notice of deficiency or a notice of a final partnership administrative adjustment if a Business Operating Division concludes that a transaction lacks economic substance; and (3) coordination procedures for litigating the common law economic substance doctrine or the codified economic substance doctrine and related penalty provisions.

The Treasury Department and the IRS have included the issuance of guidance under section 7701(o) and section 6662(b)(6) as an item in their priority guidance plan for 2012-2013.

2. ELIMINATION OF UNINTENDED APPLICATION OF CELLULOSIC BIOFUEL PRODUCER CREDIT

Black liquor

The process for making paper produces a byproduct called black liquor, which has been used for decades by paper manufacturers as a fuel in the papermaking process. Black liquor is composed of water, lignin and the spent chemicals used to break down the wood. The amount of the biomass in black liquor varies. The portion of the black liquor that is not consumed as a fuel source for the paper mills is recycled back into the papermaking process. Black liquor has ash content (mineral and other inorganic matter) significantly above that of other fuels.

In an informal Chief Counsel Advice (“CCA”), the IRS concluded that black liquor is a liquid fuel from biomass and may qualify for the cellulosic biofuel producer credit.
**Cellulosic biofuel producer credit**

The “cellulosic biofuel producer credit” is a nonrefundable income tax credit for each gallon of qualified cellulosic fuel production of the producer for the taxable year. The amount of the credit is generally $1.01 per gallon.

“Qualified cellulosic biofuel production” is any cellulosic biofuel which is produced by the taxpayer and which is: (1) sold by the taxpayer to another person (a) for use by such other person in the production of a qualified cellulosic biofuel mixture in such person’s trade or business (other than casual off-farm production), (b) for use by such other person as a fuel in a trade or business, or (c) who sells such cellulosic biofuel at retail to another person and places such cellulosic biofuel in the fuel tank of such other person; or (2) used by the producer for any purpose described in (1)(a), (b), or (c).

Prior to the Health Care and Education Reconciliation Act of 2012 (HCERA) modifications, “cellulosic biofuel” meant any liquid fuel that (1) is produced in the United States and used as fuel in the United States, (2) is derived from any lignocellulosic or hemicellulosic matter that is available on a renewable or recurring basis, and (3) meets the registration requirements for fuels and fuel additives established by the Environmental Protection Agency (“EPA”) under section 211 of the Clean Air Act.

**Modification to the definition of cellulosic biofuel made by HCERA**

HCERA modified the cellulosic biofuel producer credit to exclude fuels with significant water, sediment, or ash content, such as black liquor. Consequently, credits are not available for these fuels. Specifically, the provision excluded from the definition of cellulosic biofuel any fuels that (1) are more than four percent (determined by weight) water and sediment in any combination, or (2) have an ash content of more than one percent (determined by weight).

Although the cellulosic biofuel producer credit was applicable to fuel sold or used on or after January 1, 2009, the HCERA modification was not retroactive to the date of enactment of the cellulosic biofuel producer credit. Instead, the provision is effective for fuels sold or used on or after January 1, 2010, leaving prior law in place for calendar year 2009.
Chapter 9: Disclosures to Carry Out the Reduction of Medicare Part D Subsidies for High Income Beneficiaries

Disclosures of return and return information in general

Section 6103 provides that returns and return information are confidential and may not be disclosed by the IRS, other Federal employees, State employees, and certain others having access to such information except as provided in the Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances. For example, section 6103 provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B premium subsidy adjustment.

Section 6103(p)(4) requires, as a condition of receiving returns and return information, that Federal and State agencies (and certain other recipients) provide safeguards as prescribed by the Secretary of the Treasury by regulation to be necessary or appropriate to protect the confidentiality of returns or return information. Unauthorized disclosure of a return or return information is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both, together with the costs of prosecution. The unauthorized inspection of a return or return information is punishable by a fine not exceeding $1,000 or imprisonment of not more than one year, or both, together with the costs of prosecution. An action for civil damages also may be brought for unauthorized disclosure or inspection.

Changes made by the ACA

The ACA expanded the Medicare Part B premium disclosure authority to cover the disclosure of return information relating to a taxpayer whose Medicare Part D premium may be subject to adjustment. Specifically, upon written request from the Commissioner of Social Security, the IRS may disclose the following limited return information of a taxpayer whose Medicare Part D premium subsidy, according to the records of the Secretary, may be subject to adjustment:

- Taxpayer identity information with respect to such taxpayer;
- The filing status of the taxpayer;
- The adjusted gross income of such taxpayer;
- The amounts excluded from such taxpayer’s gross income under sections 135 and 911 to the extent such information is available;
- The interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available;
- The amounts excluded from such taxpayer’s gross income by sections 931 and 933 to the extent such information is available;
• Such other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate that the amount of the Part D premium of the taxpayer may be subject to an adjustment and the amount of such adjustment; and

• The taxable year with respect to which the preceding information relates.

Officers, employees, and contractors of the Social Security Administration may use this return information only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any Medicare Part D premium subsidy adjustment.

For purposes of both the Medicare Part B premium subsidy adjustment and the Medicare Part D premium subsidy adjustment, the provision provides that the Social Security Administration may re-disclose only taxpayer identity and the amount of premium subsidy adjustment to officers and employees and contractors of the Centers for Medicare and Medicaid Services, and officers and employees of the Office of Personnel Management and the Railroad Retirement Board. This re-disclosure is permitted only to the extent necessary for the collection of the premium subsidy amount from the taxpayers under the jurisdiction of the respective agencies.

Further, the Social Security Administration may re-disclose the return information received under this provision to officers and employees of the Department of HHS to the extent necessary to resolve administrative appeals of the Part B and Part D subsidy adjustments and to officers and employees of the Department of Justice to the extent necessary for use in judicial proceedings related to establishing and collecting the appropriate amount of any Medicare Part B or Medicare Part D premium subsidy adjustments.

**Implementation**

The IRS and the Social Security Administration established a computer-matching program to implement the disclosure authority. The Social Security Administration has released three notices announcing the implementation and renewal of the matching program for the purpose of establishing the correct amount of Medicare Part B premium subsidy adjustments and Medicare prescription drug coverage premium increases under sections 1839(i) and 1860D-13(a)(7) of the Social Security Act (Act) (42 U.S.C. 1395r(i) and 1395w-113(a)(7)), as enacted by section 811 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and section 3308 of the Affordable Care Act of 2010.
Assignment 2 – Review Questions

The following questions are designed to ensure that you have a complete understanding of the information presented in the assignment. They do not need to be submitted in order to receive CPE credit. They are included as an additional tool to enhance your learning experience.

We recommend that you answer each review question and then compare your response to the suggested solution before answering the final exam questions related to this assignment.

1. The ACA changed the allowable deduction for remunerations paid by health insurance providers to be no more than:
   a) $200,000
   b) $250,000
   c) $500,000
   d) $750,000

2. The annual fee on branded prescription pharmaceutical manufacturers and importers for 2014-2016 will be:
   a) $2.5 billion
   b) $2.8 billion
   c) $3 billion
   d) $4.1 billion

3. Which of the following is subject to the excise tax on medical devices:
   a) eyeglasses
   b) hearing aids
   c) heart monitors
   d) diabetes testing supplies

4. Who does the medical device excise tax typically apply to:
   a) patients
   b) manufacturers and importers
   c) insurance providers
   d) everyone
5. In order for hospitals to qualify for tax exemptions under the additional requirements of the health care reform law:
   
   a) they must conduct a community health needs assessment at least once every taxable year
   b) they cannot use gross charges when billing individuals who qualify for financial assistance
   c) they must have a separate billing and collections policy
   d) they do not have to take any additional actions because every hospital is eligible for the tax exemption

6. The “cellulosic biofuel producer credit” is generally:
   
   a) $0.50 per gallon
   b) $1.01 per gallon
   c) $1.75 per gallon
   d) $2.00 per gallon
Assignment 2 – Solutions and Suggested Responses

1. A: Incorrect. The new allowable deduction for remunerations paid by health insurance providers is higher than $200,000.

   B: Incorrect. $250,000 is too low of an amount.

   **C: Correct.** The amount of allowable deduction for remunerations paid by health insurance providers can be no more than $500,000.

   D: Incorrect. $750,000 is too high of an amount.

   (See page 38 of the course material.)

2. A: Incorrect. The fees from the annual tax totaled $2.5 billion in 2011.

   B: Incorrect. $2.8 billion is the aggregate annual fee imposed on all entities engaged in the business of manufacturing or importing branded prescription drugs for 2012-2013.

   **C: Correct.** The annual fee for 2014-2016 is $3 billion.

   D: Incorrect. $4.1 billion will be the fee for 2018.

   (See page 42 of the course material.)

3. A: Incorrect. Eyeglasses are not subject to the medical device excise tax. There are certain medical devices, those sold in retail establishments or over the Internet for personal use, that the Treasury Department has specified as exempt from the medical excise tax.

   B: Incorrect. Hearing aids are an example of a medical device that the Treasury Department has specified as being exempt from the tax.

   **C: Correct.** Heart monitors are subject to the medical device excise tax.

   D: Incorrect. Diabetes testing supplies are not subject to the medical device excise tax.

   (See page 44 of the course material.)
4. A: Incorrect. Patients are not required to report or pay for the medical device excise tax.

   **B: Correct.** Manufacturers and importers are responsible for reporting and paying the medical device excise tax. This tax is due quarterly and should be reported on Form 720.

   C: Incorrect. The medical device excise tax does not apply to insurance providers.

   D: Incorrect. Only manufacturers and importers are typically required to report and pay the tax.

   (See page 46 of the course material.)

5. A: Incorrect. A hospital has to conduct a community health needs assessment at least once every three years, not once a year, in order to be eligible for the tax exemptions provided by the ACA.

   **B: Correct.** A hospital is not permitted to use “chargemaster” rates on individuals who qualify for financial assistance.

   C: Incorrect. It is not required that hospitals have a separate billing and collections policy; however, if they do not have one, their financial assistance policy has to be clear as to the actions that hospitals may take in the case of a non-response or non-payment.

   D: Incorrect. Not every hospital is eligible for the tax exemptions. Hospitals are required to comply with all of the additional requirements enacted as part of the ACA in order to be eligible for the tax exemptions.

   (See pages 52 to 53 of the course material.)

6. A: Incorrect. The cellulosic biofuel producer credit is higher than $0.50 per gallon.

   **B: Correct.** The nonrefundable income tax credit for each gallon of cellulosic biofuel production is $1.01 per gallon.

   C: Incorrect. The actual credit is $1.01, not $1.75 per gallon.

   D: Incorrect. $2.00 per gallon is higher than the actual cellulosic biofuel producer credit.

   (See pages 61 to 62 of the course material.)
Requirements

As discussed in Chapter 1, group health plans (i.e., plans providing employment-related health benefits) are subject to various requirements under the Code, ERISA and the PHSA.

In addition to the requirements applicable for plan years beginning on or after September 23, 2010, the ACA applies new requirements to group health plans (and, generally, to insurance issued in connection with group health plans and individual insurance) for plan years beginning on or after January 1, 2014. The ACA requirements applicable as of 2014 are:

- No annual limits on essential health benefits, no preexisting condition exclusions, and no waiting periods of more than 90 days;
- Guaranteed availability and renewability of coverage;
- Setting of premiums without regard to health status (commonly referred to as “community rating”) and provision of essential health benefits;
- Statutory standards for programs to promote health or prevent disease (commonly referred to as “wellness” programs);
- Consistent coverage for individuals participating in approved clinical trials; and
- Consistent treatment of health care providers.

Implementation

As discussed in Chapter 1, the Departments that share responsibility for these ACA requirements (i.e., Treasury, HHS and DOL) have issued extensive guidance with respect to these requirements, including regulations, notices, fact sheets, and questions and answers.
1. BACKGROUND ON AMERICAN HEALTH BENEFIT EXCHANGES

The ACA provides for the establishment of American Health Benefit Exchanges, through which individuals can purchase health insurance coverage beginning 2014. In general, an American Health Benefit Exchange is to be established for each State (referred to in HHS regulations as a “State Exchange”); however, an American Health Benefit Exchange may be established for two or more States (referred to in HHS regulations as a “regional Exchange”) or part of a State (referred to in HHS regulations as a “subsidiary Exchange”). In addition, HHS is to establish an American Health Benefit Exchange for any State that fails to do so (referred to in HHS regulations as a “Federally-facilitated Exchange”).

A health insurance plan offered through an American Health Benefit Exchange (a “qualified health plan”) must meet certain requirements, including offering certain specified benefits (“essential health benefits”).

As part of the process of enrollment in a qualified health plan, an individual may apply and be approved in advance for a premium assistance credit (discussed below). The individual must provide information on income, family size, and changes in marital or family status or income. Initial eligibility for the premium assistance credit is generally based on the individual’s income for the tax year ending two years prior to the enrollment period. If an individual is approved for a premium assistance credit, the Treasury pays the credit amount directly to the health plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the difference between the premium tax credit amount and the total premium charged for the plan. As part of the enrollment process, an individual may also apply and be approved for reduced cost sharing (discussed below).

2. PREMIUM ASSISTANCE CREDIT

In general

For taxable years ending after December 31, 2013, a refundable tax credit (the “premium assistance credit”) is provided for eligible individuals and families who purchase health insurance through an American Health Benefit Exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer (as discussed above), subsidizes the purchase of certain health insurance plans through an American Health Benefit Exchange.

The premium assistance credit is available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved who are not eligible for certain other health insurance. Household income is defined as the sum of: (1) the taxpayer’s modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining that taxpayer’s family size (but only if such individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded by section 911 (the exclusion from gross income for citizens or residents living abroad), (2) any tax-
exempt interest received or accrued during the tax year, and (3) an amount equal to the portion of the taxpayer’s social security benefits (as defined in section 86(d)) that is excluded from income under section 86 (that is, the amount of the taxpayer’s Social Security benefits that are excluded from gross income). To be eligible for the premium assistance credit, taxpayers who are married (within the meaning of section 7703) must file a joint return. Individuals who are listed as dependents on a tax return are ineligible for the premium assistance credit.

As described in Table 11.1 below, premium assistance credits are available on a sliding scale basis for individuals and families with household incomes between 100 and 400 percent of FPL to help subsidize the cost of private health insurance premiums. The premium assistance credit amount is determined based on the percentage of income the individual’s or family’s share of premiums represents, which rises from two percent of income for those at 100 percent of FPL for the family size involved to 9.5 percent of income for those at 400 percent of FPL for the family size involved. After 2014, the percentages of income are indexed to the excess of premium growth over income growth for the preceding calendar year. After 2018, if the aggregate amount of premium assistance credits and cost-sharing reductions (discussed below) exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year. For purposes of calculating family size, individuals who are not lawfully present in the United States are not included.

<table>
<thead>
<tr>
<th>Household income (expressed as a percent of FPL)</th>
<th>Initial premium</th>
<th>Final premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% up to 133%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>133% up to 150%</td>
<td>3.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>150% up to 200%</td>
<td>4.0%</td>
<td>6.3%</td>
</tr>
<tr>
<td>200% up to 250%</td>
<td>6.3%</td>
<td>8.05%</td>
</tr>
<tr>
<td>250% up to 300%</td>
<td>8.05%</td>
<td>9.5%</td>
</tr>
<tr>
<td>300% up to 400%</td>
<td>9.5%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>
The premium assistance credit amount is generally the lower of (1) the premium for the qualified health plan in which the individual or family enrolls, and (2) the premium for the second lowest cost silver plan in the rating area where the individual resides (referred to as a “benchmark plan”), reduced by the individual’s or family’s share of premiums.

**Minimum essential coverage and employer offer of health insurance coverage**

Generally, if an employee is offered minimum essential coverage in the group market, including employer-provided health insurance coverage, the individual is ineligible for the premium assistance credit for health insurance purchased through an American Health Benefit Exchange.

If an employee’s share of the premium for self-only employer-provided coverage exceeds 9.5 percent of an employee’s household income, so that the coverage is considered unaffordable, or the plan’s share of total allowed cost of provided benefits is less than 60 percent of such costs, so that the employer-provided coverage fails to provide required minimum value, the employee can be eligible for the premium assistance credit. Premium assistance tax credit eligibility requires that an employee decline enrollment in employer-offered coverage and satisfy the conditions for receiving a premium assistance tax credit through an American Health Benefit Exchange.

**Reconciliation**

An American Health Benefit Exchange is required to report certain information with respect to coverage provided to an individual, specifically, identifying information of the individual and others insured, the level of coverage provided, the total premium for the coverage without regard to any premium assistance credit or reduced cost-sharing, the aggregate amount of any advance premium assistance credit or reduced cost-sharing, any information provided to the Exchange (including any change of circumstances) necessary to determine eligibility for and the amount of a premium assistance credit, and any information necessary to determine whether an individual has received excess advance payments. This information must be reported to the Treasury and to the individual.

If the premium assistance credit received through advance payment exceeds the amount of premium assistance credit to which the taxpayer is entitled for the taxable year, the liability for the overpayment must be reflected on the taxpayer’s income tax return for the taxable year subject to a limitation on the amount of such liability. For persons with household income below 400 percent of FPL, the liability for the overpayment for a taxable year is limited to a specific dollar amount (the “applicable dollar amount”) as shown in Table 11.2 (one-half of the applicable dollar amount shown in Table 11.2 for unmarried individuals who are not surviving spouses or filing as heads of households).
Table 11.2. Reconciliation

<table>
<thead>
<tr>
<th>Household income (expressed as a percent of FPL)</th>
<th>Applicable dollar amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 200%</td>
<td>$600</td>
</tr>
<tr>
<td>At least 200% but less than 300%</td>
<td>$1,500</td>
</tr>
<tr>
<td>At least 300% but less than 400%</td>
<td>$2,500</td>
</tr>
</tbody>
</table>

If the premium assistance credit for a taxable year received through advance payment is less than the amount of the credit to which the taxpayer is entitled for the year, the shortfall in the credit is also reflected on the taxpayer’s tax return for the year.

**Implementation**

**Regulations**

The IRS issued proposed regulations relating to the premium assistance credit on August 17, 2011, and final regulations were issued May 23, 2012, and January 30, 2013. The final regulations:

Address the determination of family, family size (which may include individuals who are not subject to the requirement to have minimum essential coverage, discussed in Part II.C), and FPL applicable to the family (including situations involving residence in different States during the year);

- Address the determination of household income, including a special rule under which an individual or family whose household income is estimated at the time of enrollment to be between 100 percent and 400 percent of FPL does not become ineligible for the credit merely because actual household income is less than 100 percent of FPL;

- Apply the credit with respect to coverage under a qualified health plan purchased on an “Exchange,” defined by reference to the definition in HHS regulations, under which the term Exchange includes a State Exchange, a regional Exchange, a subsidiary Exchange and a Federally-facilitated Exchange;

- Specify when an individual is considered eligible for government-sponsored minimum essential coverage, and thus not eligible for the credit, including a period during which an individual can be eligible for the credit while establishing eligibility for government-sponsored minimum essential coverage;
• Specify that an individual is considered eligible for minimum essential coverage under a veterans’ health program only if actually enrolled in the program;

• With respect to employer-sponsored coverage, (1) specify that affordability for an employee’s family members is generally based on the premium for self-only coverage, (2) provide an affordability safe harbor, under which, if coverage for a plan year under an employer-sponsored plan is determined to be unaffordable at the time of enrollment in a qualified health plan for a period coinciding with the plan year, the determination will generally apply for the entire plan year, (3) specify that an employee or related individual is not treated as eligible for employer-sponsored coverage during a waiting period or as a result of automatic enrollment followed by termination of the coverage within a short period, (4) treat an individual related to an employee for whom the employee does not claim a personal exemption as eligible for employer-sponsored coverage only for periods that the individual is enrolled in the coverage, and (5) treat an individual as eligible for COBRA continuation coverage only for periods the individual is enrolled in the coverage;

• Address the determination of the premium for a benchmark plan, including (1) the ability to take multiple plans into account and to disregard qualified health plans that are not open to enrollment by an individual or family member, (2) adjustments for certain benefits, and (3) the allocation of premiums if members of more than one family (as defined for purposes of the credit) are covered by the same qualified health plan.

• Address reconciliation of the advance credit, including a taxpayer’s responsibility for the advance credit provided with respect to family members and situations in which a taxpayer’s marital status (or tax return filing status) changes during the year; and

• Specify the information that must be reported by an Exchange with respect to individuals enrolled in qualified health plans, including the premium for the benchmark plan used to determine eligibility for an advance credit.

Minimum value

On April 26, 2012, the IRS issued Notice 2012-31, addressing the determination of minimum value of coverage under an employer-sponsored health plan for purposes of whether an employee or family member who is eligible for the coverage may nonetheless be eligible for a premium assistance credit. To satisfy the minimum value requirement, the plan’s share of the total allowed costs of benefits provided under the plan must equal or exceed 60 percent of the costs. The notice describes potential approaches that could be used to determine whether an employer-provided coverage provides minimum value and requests public comments on issues relating to the determination of minimum value. The notice also states that the IRS plans to issue regulations relating to the determination of minimum value.

Since the issuance of Notice 2013-31, HHS issued final regulations addressing the determination of minimum value. The regulations provide methods for determining whether an employer-sponsored health plan provides minimum value, including use of a standard population developed by HHS for this use purpose to reflect the population covered by self-insured health plans.
3. REDUCED COST-SHARING

Under a qualified health plan, an individual’s or family’s share of costs (i.e., deductibles and other out-of-pocket expenses) under the plan (“cost-sharing”) cannot exceed a specified limit. Individuals with household incomes between 100 and 400 percent of FPL for the family size involved who are eligible for an advance premium assistance credit and who enroll in a silver level qualified health plan may be eligible for a subsidy to reduce their cost-sharing. The cost-sharing limit is generally reduced by two-thirds for individuals with household income of more than 100 but not more than 200 percent of FPL; by one-half for those between 201 and 300 percent of FPL; and by one-third for those between 301 and 400 percent of FPL.

The reduced cost-sharing is required to increase the plan’s share of total costs to (but not to more than) certain levels. This level is 94 percent for individuals with household income between 100 and 150 percent of FPL; 87 percent for those between 150 and 200 percent of FPL; and 73 percent for those between 201 and 250 percent of FPL. In addition, in the case of those between 251 and 400 percent of FPL, the reduced cost-sharing cannot increase the plan’s share of total costs to more than 70 percent.

HHS makes payments to the issuer of the qualified health plan in the amount of the reduced cost-sharing.

Implementation

The IRS is not responsible for implementation of the ACA provisions relating to reduced cost-sharing.

4. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS

Disclosure of return information in general

Section 6103 provides that returns and return information are confidential and may not be disclosed by the IRS, other Federal employees, State employees, and certain others having access to such information except as provided in the Internal Revenue Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances.

Section 6103(p)(4) requires, as a condition of receiving returns and return information, that Federal and State agencies (and certain other recipients) provide safeguards as prescribed by the Secretary of the Treasury by regulation to be necessary or appropriate to protect the confidentiality of returns or return information. Unauthorized disclosure of a return or return information is a felony punishable by a fine not exceeding $5,000 or imprisonment of not more than five years, or both, together with the costs of prosecution. The unauthorized inspection of a return or return information is punishable by a fine not exceeding $1,000 or imprisonment of not more than one year, or both, together with the costs of prosecution. An action for civil damages also may be brought for unauthorized disclosure or inspection.
Changes made by the ACA

As part of the application process to claim the cost-sharing reduction and the tax credit on an advance basis, individuals will submit information to an American Health Benefit Exchange ("Exchange").

The Department of HHS serves as the centralized verification agency for information submitted by individuals to the exchanges with respect to the reduction and the tax credit to the extent provided on an advance basis. The ACA provided the IRS with authority to disclose return information to substantiate the accuracy of income information that has been provided to HHS for eligibility determination.

Specifically, upon written request of the Secretary of HHS, the IRS is permitted to disclose the following return information of any taxpayer whose income is relevant in determining the amount of the tax credit or cost-sharing reduction, or eligibility for participation in the specified State health subsidy programs (i.e., a State Medicaid program under title XIX of the Social Security Act, a State’s children’s health insurance program under title XXI of such Act, or a basic health program under section 1331 of the Patient Protection and Affordable Care Act): (1) taxpayer identity; (2) the filing status of such taxpayer; (3) the number of individuals for which a deduction under section 151 (relating to personal exemptions) was allowed ("family size") (4) the modified adjusted gross income (“MAGI”) (as defined in sec. 36B of the Code) of such taxpayer, the taxpayer’s spouse and of any dependents who are required to file a tax return; (5) such other information as is prescribed by Treasury regulation as might indicate whether such taxpayer is eligible for the credit or subsidy (and the amount thereof); and (6) the taxable year with respect to which the preceding information relates, or if applicable, the fact that such information is not available. HHS is permitted to disclose to an exchange or its contractors, or to the State agency administering the health subsidy programs referenced above (and their contractors) any inconsistency between the information submitted and IRS records.

The disclosed return information may be used only for the purposes of, and only to the extent necessary in, establishing eligibility for participation in the exchange, verifying the appropriate amount of the tax credit, and cost-sharing subsidy, or eligibility for the specified State health subsidy programs.

Recipients of the confidential return information are subject to the safeguard protections and civil and criminal penalties for unauthorized disclosure and inspection. The IRS is required to make an accounting for all disclosures.

Implementation

On March 27, 2012, the Secretary of HHS promulgated final regulations published in the Federal Register, limiting the information an individual needs to provide to an Exchange for purposes of income verification and allowing the Exchange to solicit information from the IRS through HHS with respect to the individual and his family members whose names and social security numbers, or adoption taxpayer identification numbers, are provided.
The Department of the Treasury published proposed regulations regarding this disclosure authority on April 30, 2012. The proposed regulations note that in some situations, the IRS will be unable to calculate MAGI. For example, for certain relevant taxpayers who receive nontaxable social security benefits, the IRS may not have complete information from which to determine the amount of those benefits. If the IRS has information indicating that a relevant taxpayer received nontaxable social security benefits, but is unable to determine the amount of those benefits, the IRS will provide the aggregate amount of the other components used to calculate the relevant taxpayer’s MAGI, as well as information indicating that the amount of nontaxable social security benefits must still be taken into account to determine MAGI. Similarly, where MAGI is not available, the IRS will disclose the adjusted gross income, as well as information indicating that the other components of MAGI must still be taken into account to determine MAGI. Because the ACA requires that Exchanges use alternative means of verifying income when IRS information is not available, the proposed regulations concluded that these explanatory items may assist the Exchange in determining eligibility.

The proposed regulations provide that where some or all of the items of return information is unavailable, the IRS will provide information indicating why the particular item is not available. For example, if the taxpayer filed a joint return with a spouse who is not on the Exchange application) the IRS will not disclose MAGI from the joint return because it cannot be properly allocated among the spouses. Instead, the IRS will disclose that a joint return was filed. The proposed regulations also allow the IRS to disclose that the taxpayer has been a victim of identity theft or has been reported deceased. This additional information would suggest to the Exchange to further verify the identity of the relevant taxpayer and the possible need to use alternate means of income verification.

The final regulations issued by HHS also provide that advance payments of the premium tax credit will not be permitted where the relevant taxpayer has received advance payments in the reference tax year and failed to file a return reconciling the advance payments with the actual premium tax credit. Therefore, the proposed Treasury regulations provide that the IRS will disclose to HHS that a relevant taxpayer who received an advance payment of a premium tax credit in the reference tax year did not file a return reconciling the advance payments with any premium tax credit available.
Chapter 12: Requirement to Maintain Minimum Essential Coverage

1. TAX ON INDIVIDUALS WITHOUT MINIMUM ESSENTIAL COVERAGE

Requirement to maintain coverage

Beginning January, 2014, individuals are required to be covered by a health plan that provides at least minimum essential coverage or be subject to a tax for failure to maintain the coverage. If an individual is a dependent of another taxpayer, the other taxpayer is liable for any tax for failure to maintain the required coverage with respect to the individual. The tax is imposed for any month that an individual does not have minimum essential coverage, unless the individual qualifies for an exemption for the month.

Minimum essential coverage

Minimum essential coverage includes government sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. Certain individuals present or residing outside of the United States and bona fide residents of possessions of the United States are deemed to maintain minimum essential coverage.

Government-sponsored programs that provide minimum essential coverage include Medicare, Medicaid, Children’s Health Insurance Program, coverage for members of the U.S. military, veterans health care, and health care for Peace Corps volunteers. Eligible employer-sponsored plans include: governmental plans, church plans, grandfathered plans and other group health plans offered in the small or large group market within a State. Minimum essential coverage does not include coverage that consists of certain excepted benefits. Other excepted benefits that do not constitute minimum essential coverage if offered under a separate policy, certificate or contract of insurance include long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance.

Tax on failure to maintain minimum essential coverage

The tax for failure to maintain minimum essential coverage for any calendar month on or after December 31, 2013 is calculated as one twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of the flat dollar amount or the excess income amount. The flat dollar amount is the lesser of sum of the individual annual dollar amounts for the members of the taxpayer’s family and 300 percent of adult individual dollar amount. The excess income amount is a specified percentage of the excess of the taxpayer’s household income for the taxable year over the threshold amount of income required for income tax return filing for that taxpayer. The total annual household payment may not exceed the national average annual premium for bronze level health plans offered through American Health Benefit Exchanges that year for the family size.
A taxpayer’s family includes the taxpayer (and taxpayer’s spouse for a married couple filing jointly) and taxpayer’s dependents, including, generally, any dependent eligible to be claimed on the taxpayer’s return. Household income is the sum of the modified adjusted gross incomes of the taxpayer and all individuals in the taxpayer’s family required to file a tax return for that year. Modified adjusted gross income means adjusted gross income increased by all tax- exempt interest and foreign earned income.

The tax is phased in over the first three years. The individual adult annual dollar amount is phased in as follows: $95 for 2014; $325 for 2015; and $695 in 2016. For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount. For years after 2016, the $695 amount is indexed to CPI-U, rounded to the next lowest multiple of $50. The specified percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015.

The tax is assessed in the same manner as an assessable penalty under the enforcement provisions of subtitle F of the Code. As a result, the tax is assessed without the need for a statutory notice of deficiency, issuance of which provides a taxpayer with a right to seek judicial review in the U.S. Tax Court prior to paying the tax. Although assessable and collectible under the Code, the IRS authority to use certain collection methods is limited. Specifically, the filing of notices of liens and levies otherwise authorized for collection of taxes does not apply to the collection of this tax. In addition, a taxpayer is not subject to criminal prosecution or penalties for non-compliance with the requirement to pay this tax. However, the authority to collect the tax by offset of refunds or credits is not limited by the provision.

**Individuals exempt from the health coverage requirement**

**Exemption based on status, religious beliefs, residence, or hardship**

Individuals are exempt from the requirement to maintain minimum essential coverage for months they are incarcerated, not legally present in the United States, or qualify for religious exemptions. To qualify for a religious exemption, the individual must be a member of a recognized religious sect exempting them from self-employment taxes and adhere to tenets of the sect. There is also an exemption for members of a health care sharing ministry. All members of Indian tribes are exempt from the requirement. The Secretary of HHS is authorized to grant an exemption from the requirement to an individual who has suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

**Exemption based on income level including affordability**

Taxpayers with income below the income tax filing threshold are also exempt from the tax for failure to maintain minimum essential coverage. An individual can also be exempt from the tax if the individual does not have access to affordable coverage. Coverage is affordable if the required contribution for coverage does not exceed eight percent of the taxpayer’s household income for the year. In years after 2014, the eight percent exemption is increased by the amount by which premium growth exceeds income growth.
For individuals not eligible for minimum essential coverage in the form of employer-sponsored coverage, the minimum required contribution is the premium for the lowest cost bronze plan in the American Health Benefit Exchange, reduced by the maximum amount of any premium assistance credit (determined as if the individual was covered for the entire taxable year). For individuals who are eligible for minimum essential coverage in the form of employer-sponsored coverage either by reason of being an employee or based on a relationship to an employee, the determination of whether coverage is affordable to the employee and any related individual generally is made by reference to the employee’s required contribution for the coverage.

**Three-month gap in coverage**

No tax is assessed for individuals who do not maintain health insurance for a period of three months or less during the taxable year. If an individual exceeds the three-month maximum during the taxable year, the tax for the full duration of the gap during the year is applied. If there are multiple gaps in coverage during a calendar year, the exemption from penalty applies only to the first such gap in coverage. The Secretary of the Treasury shall provide rules when a coverage gap includes months in multiple calendar years.

**Implementation**

Proposed Treasury regulations on the requirement to maintain minimum essential coverage and the tax for failure to satisfy the requirement were published on February 1, 2013. A public hearing on the proposed regulations is scheduled for May 29, 2013. The explanation of provisions in the preamble to the proposed regulations describes the interpretations of section 5000A being proposed. Some of those positions are described below.

The proposed regulations clarify that eligible employer-sponsored plans include self-insured health plans as well as plans providing insurance purchased from an insurance company by the employer in the group markets in the State.

The proposed regulations clarify that a taxpayer is liable for the tax imposed with respect to any individual for a month in a taxable year for which the taxpayer may claim a personal exemption deduction for the individual for that taxable year. Whether the taxpayer actually claims the individual as a dependent for the taxable year does not affect the taxpayer’s liability for the tax for the individual. The proposed regulations define the family to include all individuals for whom a taxpayer (including a spouse, if married filing jointly) is liable for the tax. The proposed regulations clarify that a taxpayer who qualifies for an exemption (from maintaining minimum essential coverage) remains liable for a tax payment imposed for a nonexempt dependent who does not have minimum essential coverage, and, if filing jointly, remains liable with the spouse for the spouse’s tax.

The proposed regulations clarify that an individual who is not a citizen or national of the United States is exempt for any month if the individual is not lawfully present in the United States in that month within the meaning of 45 CFR 155.20 (referring to lawful immigration status within the United States). In addition, under the proposed regulations, an individual who is not a citizen or national of the United States is treated as not lawfully present in the United States for any month in a taxable year if the individual is a nonresident alien as defined in section 7701(b)(1)(B) for that taxable year.
In determining whether an individual qualifies for an exemption because health coverage is not affordable based on the cost of the lowest cost bronze plan, under the proposed regulations, the plan is the lowest cost bronze plan that would cover all the individuals in the taxpayers family who are not exempt for another reason (such as a religious exemption). If the American Health Benefit Exchange does not offer a single bronze plan that would cover all the individual’s family, the premium for determining affordability is the sum of the premiums for the lowest cost bronze plans that in the aggregate cover all the individuals in the taxpayer’s family.

Under the proposed regulations, in the case of individuals who are eligible for coverage under an employer-sponsored plan because of their relationship to an employee and for whom a personal exemption deduction under section 151 is claimed on the employee’s Federal income tax return, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all such related individuals included in the employee’s family and not otherwise exempt. Under the proposed regulations, if an individual is eligible for coverage both as an employee of an employer offering health coverage and as an individual related to an employee of an employer offering coverage, the exemption is determined based on the required contribution the lowest cost self-only coverage under the plan of individual’s employer and not the employer of the related individual.

In determining gap months, if an employee is entitled to an exemption for any month or deemed to have coverage for a month, that month also is not counted as a gap month. The proposed regulations address coverage gaps straddling multiple taxable years including a rule for a gap that begins with the last two months of a taxable year. To provide taxpayers certainty when filing their Federal income tax returns, the proposed regulations provide that an individual who has a gap in coverage at the end of the taxable year for a period no longer than the last two months of a taxable year will be deemed to have a short gap exemption for those months if the coverage gap is the first to occur in that taxable year. The exemption applies for the last two months of the year regardless of whether the individual is covered during the first months of the of the following taxable year. The proposed regulations provide that, for any calendar month, an individual is treated as having minimum essential coverage if the individual is enrolled in and entitled to receive benefits under a program that is minimum essential coverage for at least one day during the month. Consistent with that approach, for purposes of determining when a three-month gap has occurred, the proposed regulation make clear that the months in the gap period only include whole months of no coverage. Finally, if an individual qualifies for an exemption for at least one day during any month, such as for being incarcerated, then the individual is treated as exempt for the entire month.

2. REPORTING OF HEALTH INSURANCE COVERAGE

In general

For calendar years beginning after 2013, the ACA requires insurers (including employers that self-insure) that provide minimum essential coverage to any individual during a calendar year to report certain health insurance coverage information to both the covered individual and to the IRS. In the case of coverage provided by a governmental unit, or any agency or instrumentality thereof, the reporting requirement applies to the person or employee who enters into the agreement to provide the health insurance coverage (or their designee).
The information required to be reported includes: (1) the name, address, and taxpayer identification number of the primary insured, and the name and taxpayer identification number of each other individual obtaining coverage under the health plan; (2) the dates during which the individual was covered under the plan during the calendar year; (3) whether the coverage is a qualified health plan offered through an American Health benefit Exchange; (4) the amount of any premium tax credit or cost-sharing reduction received by the individual with respect to such coverage; and (5) such other information as the Secretary may require.

To the extent health insurance coverage is provided through an employer-sponsored group health plan, the insurer is also required to report the name, address and employer identification number of the employer, the portion of the premium, if any, required to be paid by the employer, and any other information the Secretary may require to administer the new tax credit for eligible small employers.

The insurer is required to report the above information, along with the name, address and contact information of the reporting insurer, to the covered individual on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS.

An insurer who fails to comply with these new reporting requirements is subject to the penalties for failure to file an information return and failure to furnish payee statements, respectively.

The IRS is required, not later than June 30 of each year, in consultation with the Secretary of HHS, to provide annual notice to each individual who files an income tax return and who fails to enroll in minimum essential coverage. The notice is required to include information on the services available through the exchange operating in the individual’s State of residence.

**Implementation**

On April 26, 2012, the IRS issued Notice 2012-32 which requests comments concerning the reporting requirements for health insurance issuers, government agencies, employers that sponsor self-insured plans, and other persons that provide minimum essential coverage to an individual. Specifically the notice requests comments on issues to be addressed and lists a number of potential issues.
Chapter 13: Provisions Related to Employer Responsibility to Provide Health Coverage

1. SHARED RESPONSIBILITY FOR EMPLOYERS

General rule

Beginning for months after 2013, the ACA generally imposes an assessable payment on any applicable large employer if one or more of its full time employees is certified to the employer as having received a premium assistance credit or a cost-sharing reduction for health insurance. The amount of the assessable payment depends on whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under a group health plan sponsored by the employer. An employer that offers its full-time employees the opportunity to enroll in affordable minimum essential coverage that provides at least minimum value is not subject to the assessable payment. In this case, the employer’s full-time employees generally are not eligible for the premium assistance credit or cost-sharing reduction.

Applicable large employer

An employer is an applicable large employer with respect to any calendar year if it employed an average of at least 50 full-time employees and full-time equivalent employees during the preceding calendar year. An employer is not treated as employing more than 50 full-time employees if the employer’s workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year and the employees that cause the employer’s workforce to exceed 50 full-time employees are seasonal workers. In counting the number of employees for purposes of determining whether an employer is an applicable large employer, a full-time employee (meaning, for any month, an employee working an average of at least 30 hours or more each week) is counted as one employee and all other employees are counted on a pro-rated basis in accordance with regulations prescribed by the Secretary. The number of full-time equivalent employees that must be taken into account for purposes of determining whether the employer exceeds the threshold is equal to the aggregate number of hours worked by non-full-time employees for the month, divided by 120 (or such other number based on an average of 30 hours of service each week as the Secretary may prescribe in regulations).

Assessable payment for employers not offering minimum essential coverage

An applicable large employer who fails to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month is subject to the assessable payment if at least one of its full-time employees is certified to the employer as having enrolled in health insurance coverage with respect to which a premium tax credit or cost-sharing reduction is allowed or paid for such employee or employees.

The assessable payment for a month is equal to the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are receiving a premium assistance credit or cost-sharing reduction) multiplied by one-twelfth of $2,000. For example, in 2014, Employer A fails to offer
minimum essential coverage and has 100 full-time employees, ten of whom receive a premium assistance credit for the year. For each employee over the 30-employee threshold, the employer owes $2,000, for a total penalty of $140,000 ($2,000 multiplied by 70 (100-30)).

Assessable payment for employers offering minimum essential coverage

An applicable large employer that offers, for any month, its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan is subject to an assessable payment if any full-time employee is certified to the employer as having enrolled in health insurance coverage with respect to which a premium assistance credit or cost-sharing reduction is allowed or paid for such employee or employees. For each full-time employee receiving a premium tax credit or cost-sharing reduction for any month, the employer is required to pay an amount equal to one-twelfth of $3,000. The assessable payment for each employer for any month is capped at an amount equal to the number of full-time employees during the month (regardless of how many employees are receiving a premium assistance credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of $2,000.

For example, in 2014, Employer A offers health coverage and has 100 full-time employees, 20 of whom receive premium assistance credits for the year. For each employee receiving a tax credit, the employer owes $3,000, for a total penalty of $60,000. The maximum penalty for this employer is capped at the amount of the assessable payment that it would have been assessed for a failure to provide coverage, or $140,000 ($2,000 multiplied by 70 (100-30)). Since the calculated penalty of $60,000 is less than the maximum amount, Employer A pays the $60,000 calculated penalty.

Cost of living adjustments for assessable payments

For calendar years after 2014, the $3,000 and $2,000 dollar amounts are increased by the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary of HHS no later than October 1 of the preceding calendar year) exceeds the average per capita premium for 2013 (as determined by the Secretary of HHS), rounded down to the nearest $10.

Application of controlled-group rules

In determining whether an employer is an applicable large employer, all employees of the entities aggregated under the controlled-group rules of section 414(b), (c), (m), and (o) are treated as a single employer. If after applying this controlled-group test, the controlled group has at least 50 employees, then each entity in the controlled group is an applicable large employer even if any one entity by itself would not be an applicable large employer. Further, in the case of entities treated as a single employer under the provision, the 30-employee reduction in full-time employees is made from the total number of full-time employees employed by all members of the controlled group (i.e., only one 30-employee reduction is permitted per controlled group of employers) and is allocated among such entities in relation to the number of full-time employees employed by each entity.
Certification that an employee has received a premium assistance credit or a cost-sharing reduction

An employer must be notified by the Exchange if one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction because the employer does not provide minimal essential coverage through an employer-sponsored plan, or the employer does offer such coverage but it is not affordable or the plan’s share of the total allowed cost of benefits is less than 60 percent. The notice must include information about the employer’s potential liability for payments under section 4980H. The employer must also receive notification of the appeals process established for employers notified of potential liability for assessable payments. An employer is generally not entitled to information about its employees who qualify for the premium assistance credit or cost-sharing reductions; however, the appeals process must provide an employer the opportunity to access the data used to make the determination of an employee’s eligibility for a premium assistance credit or cost-sharing reduction, to the extent allowable by law.

Time for payment, deductibility of excise taxes, restrictions on assessment

The assessable payments are payable on an annual, monthly or other periodic basis as the Secretary of the Treasury may prescribe. The assessable payments are not deductible as a business expense. The restrictions on assessment under section 6213 are not applicable to the excise taxes imposed under the provision.

The Secretary is required to prescribe rules, regulations or guidance for the repayment of any assessable payment (including interest) if the payment is based on the allowance or payment of a premium assistance credit or cost-sharing reduction with respect to an employee that is subsequently disallowed and with respect to which the assessable payment would not have been required to have been made in the absence of the allowance or payment.

Implementation

Regulations and other guidance

Proposed Treasury regulations on this assessable payment were published in the Federal Register on January 2, 2013. A public hearing on the proposed regulations is scheduled for April 23, 2013. The explanation of provisions in the preamble to the proposed regulations describes the interpretations being proposed. Some of those interpretations are described below.

Prior to publishing the proposed regulations, the IRS and Treasury issued a series of notices describing positions being considered for the regulations and requesting comments for consideration in the development of the proposed regulations.

Definition of dependent

Under the proposed regulations, an employee’s dependents only include the employee’s children who have not attained age 26 and does not include the employee’s spouse or any other related individual (even if claimed as a dependent on the employee’s Federal income tax return for the year). However, as provided in the section 4980H and
explained under the proposed regulations, even though coverage must be offered to employees’ children under age 26, the payment does not apply merely because an employee’s child receives a premium assistance credit or cost-sharing reduction.

**Determination of an employee’s hours and full-time status**

**Hours of service**

The proposed regulations provide rules for determining hours worked both for employees paid on an hourly basis and those paid on a nonhourly basis. For employees paid on an hourly basis, an employer must calculate actual hours of service from records of hours worked and hours for which payment is made or due. For employees employed on a nonhourly basis, the proposed regulations provide methods of determining hours that use daily or weekly equivalencies unless use of an equivalency substantially understates an employee’s actual hours of service in a manner that would cause that employee not to be treated as full-time. The proposed regulations provide that, for example, an employer may not use a days-worked equivalency in the case of an employee who generally works three 10-hour days per week, because the equivalency would treat each day worked as 8 hours and substantially understate the employee’s actual hours of service as 24 hours of service per week, which would result in the employee being treated as not a full-time employee. Rather, the number of hours of service calculated using the days-worked or weeks-worked equivalency method must reflect generally the hours actually worked and the hours for which payment is made or due.

**Full-time status**

For ongoing employees, the proposed regulations provide that an applicable large employer has the option to determine each ongoing employee’s full-time status by looking back at a measurement period (a defined time period of not less than three but not more than 12 consecutive months, as chosen by the employer). If the employer determines that an employee was employed on average at least 30 hours of service per week during the measurement period, then the employer treats the employee as a full-time employee during a subsequent stability period, regardless of the employee’s number of hours of service during the stability period, so long as he or she remains an employee. For an employee whom the employer determines to be a full-time employee during the measurement period, the stability period generally would be a period that immediately followed the measurement period, the duration of which would be at least the greater of six consecutive calendar months or the length of the measurement period. If the employer determines that the employee did not work full-time during the measurement period, the employer would be permitted to treat the employee as not a full-time employee during the immediately following stability period (which may be no longer than the associated measurement period). The applicable large employer member, at its option, may also elect to add an administrative period between the measurement period and the stability period (subject to certain limitations) as part of this method.

The proposed regulations also describe the rules that apply for new employees, employees who have a change in employment status, or who work on and off, as well as other types of work schedules.
Controlled group rules

Other than treating each member of the controlled group as an applicable large employer, the controlled-group rules do not apply for purposes of determining whether an entity is liable for an assessable payment. For example, one entity in a controlled group may offer all its employees (and their dependents) the opportunity to enroll in minimum essential coverage. For that entity, the assessable payment will be based only on the employees (if any) employed by that entity that receive a premium assistance credit or cost-sharing reduction. That entity’s liability is not changed because another entity in the same controlled group does not offer minimum essential coverage to its employees (and their dependents).

Affordability safe harbors

As explained in Part II.B.2., an employee (and related individuals if applicable) are not eligible for a premium assistance credit or cost-sharing reduction if they are offered the opportunity to enroll in minimum essential coverage under an employer sponsored plan that is affordable and provides minimum value. The coverage is affordable for this purpose if the employee’s required contribution for the lowest cost self-only coverage under the employer’s health plan does not exceed 9.5 percent of the employee’s household income for the taxable year. Required contributions include salary reduction contributions under a cafeteria plan.

The proposed regulation provide three safe harbors that an employer can rely on to determine whether the coverage it offers its employees is affordable, i.e. the required contribution for self-only coverage that it offers to its employees exceeds this 9.5 percentage amount for any employee. If the required contribution for the coverage offered by the employer satisfies one of the safe harbors for all its full-time employees for a month, the employer is not subject to an assessable payment even if one of its employees receives a premium assistance credit or cost-sharing reduction. Under the first safe harbor, the annualized required contribution must not exceed 9.5 percent of the employee’s wages tips and other compensation from the employer as reported in Box 1 of the W-2. Under the second safe harbor, the 9.5 percent affordability test is applied to the employee’s hourly rate of pay for a month multiplied by 130. Finally if the employee’s required contribution is less than 9.5 percent of the Federal poverty level for a single individual, then the coverage is treated as affordable.

2. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE

Shared responsibility reporting requirements

For years beginning after December 31, 2013, the ACA adds a reporting requirement under which, each applicable large employer subject to the employer shared-responsibility requirement must report certain health insurance coverage information to both its full-time employees and to the IRS. In the case of coverage provided by a governmental unit, or any agency or instrumentality thereof, the reporting requirement applies to the person or employee appropriately designated for purposes of making the returns and statements required by the provision.
The information required to be reported includes: (1) the name, address and employer identification number of the employer; (2) a certification as to whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; (3) the number of full-time employees of the employer for each month during the calendar year; (4) the name, address and taxpayer identification number of each full-time employee employed by the employer during the calendar year and the number of months, if any, during which the employee (and any dependents) was covered under a plan sponsored by the employer during the calendar year; and (5) such other information as the Secretary may require.

Employers who offer the opportunity to enroll in minimum essential coverage must also report: (1) the length of any waiting period with respect to such coverage; (2) the months during the calendar year during which the coverage was available; (3) the monthly premium for the lowest cost option in each of the enrollment categories under the plan; (4) the employer’s share of the total allowed costs of benefits under the plan; and (5) such other information as the Secretary may require.

The employer is required to report to each full-time employee the above information required to be reported with respect to that employee, along with the name, address and contact information of the reporting employer, on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS.

An employer who fails to comply with these new reporting requirements is subject to the penalties for failure to file an information return and failure to furnish payee statements, respectively.

To the maximum extent feasible, the Secretary may provide that any information return or payee statement required to be provided may be provided as part of the form used to report the aggregate cost of employer-sponsored coverage of an employee (and related individuals) on Form W-2 or reports required by persons providing minimum essential coverage with respect to individuals covered. In the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include the information required with the information report required by a person providing minimum essential coverage.

The Secretary has the authority, in coordination with the Secretary of Labor, to review the accuracy of the information reported by the employer, including the employer’s share of the total allowed costs of benefits under the plan.

**Implementation**

In Notice 2012-33, issued April 26, 2012, the IRS and Treasury announced that they anticipate proposing regulations on the reporting requirement. The notice also requested comments on issues to address, including how to coordinate and minimize duplication between data employers must report under this requirement and the data they must report with respect to providing minimum essential coverage under an employer sponsored plan or other applicable reporting requirements.
3. OFFERING OF QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS

Effective for taxable years beginning after December 31, 2013, reimbursement (or direct payment) for the premiums for coverage under any qualified health plan offered through an Exchange is a qualified benefit under a cafeteria plan only if the employer is a qualified employer. Under section 1312(f)(2) of the Act, a qualified employer is generally a small employer that elects to make all its full-time employees eligible for one or more qualified plans offered in the small group market through an Exchange. Otherwise, reimbursement (or direct payment) for the premiums for coverage under any qualified health plan offered through an Exchange is not a qualified benefit under a cafeteria plan. Thus, an employer that is not a qualified employer cannot offer to reimburse an employee for the premium for a qualified health plan that the employee purchases through the individual market in an Exchange as a health insurance coverage option under its cafeteria plan.

Employer Shared Responsibility Provisions FAQs

Who Is Subject to the Employer Shared Responsibility Provisions

Q1. I understand that the employer shared responsibility provisions apply only to employers employing at least a certain number of employees? How does an employer know whether it employs enough employees to be subject to the provisions?

A1. To be subject to the Employer Shared Responsibility provisions, an employer must employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50 (for example, 40 full-time employees employed 30 or more hours per week on average plus 20 half-time employees employed 15 hours per week on average are equivalent to 50 full-time employees). Employers will determine each year, based on their current number of employees, whether they will be considered a large employer for the next year. For example, if an employer has at least 50 full-time employees, (including full-time equivalents) for 2013, it will be considered a large employer for 2014. Employers average their number of employees across the months in the year to see whether they meet the large employer threshold. The averaging can take account of fluctuations that many employers may experience in their work force across the year. For those employers that may be close to the 50 full-time employee (or equivalents) threshold and need to know what to do for 2014, special transition relief is available to help them count their employees in 2013.

Q2. If two or more companies have a common owner or are otherwise related, are they combined for purposes of determining whether they employ enough employees to be subject to the Employer Shared Responsibility provisions?

A2. Yes, consistent with longstanding standards that apply for other tax and employee benefit purposes, companies that have a common owner or are otherwise related generally are combined together for purposes of determining whether or not they employ at least 50 full-time employees (or an equivalent combination of full-time and part-time employees). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions, even those companies that individually do not employ enough employees to meet the threshold. (The rules for combining related employers do not apply for purposes of determining whether an employer owes an Employer Shared Responsibility payment or the amount of any payment). The proposed regulations provide information on the rules for determining whether companies are related and how they are applied for purposes of the Employer Shared Responsibility provisions.
Q3. Do the Employer Shared Responsibility provisions apply only to large employers that are for-profit businesses or to other large employers as well?
A3. All employers that employ at least 50 full-time employees or an equivalent combination of full-time and part-time employees are subject to the Employer Shared Responsibility provisions, including for-profit, non-profit and government entity employers.

Q4. Are companies with employees working outside the United States subject to the Employer Shared Responsibility provisions?
A4. For purposes of determining whether an employer meets the 50 full-time employee (or full-time employees and full-time employee equivalents) threshold, an employer generally will take into account only work performed in the United States. For example, if a foreign employer has a large workforce worldwide, but less than 50 full-time (or equivalent) employees in the United States, the foreign employer generally would not be subject to the Employer Shared Responsibility provisions.

Q5. Are companies that employ US citizens working abroad subject to the Employer Shared Responsibility provisions?
A5. A company that employs U.S. citizens working abroad generally would be subject to the Employer Shared Responsibility provisions only if the company had at least 50 full-time employees (or the equivalent combination of full-time and part-time employees), determined by taking into account only work performed in the United States. Accordingly, employees working only abroad, whether or not U.S. citizens, generally will not be taken into account for purposes of determining whether an employer meets the 50 full-time employee (or equivalents) threshold. Furthermore, for employees working abroad the time spent working for the employer outside of the U.S. would not be taken into account for purposes of determining whether the employer owes an Employer Shared Responsibility payment or the amount of any such payment.

Liability for the Employer Shared Responsibility Payment

Q6. Under what circumstances will an employer owe an Employer Shared Responsibility payment?
A6. In 2014, if an employer meets the 50 full-time employee threshold, the employer generally will be liable for an Employer Shared Responsibility payment only if:

(a) The employer does not offer health coverage or offers coverage to less than 95% of its full-time employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on an Exchange; OR

(b) The employer offers health coverage to at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on an Exchange, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee or did not provide minimum value.

After 2014, the rule in paragraph (a) applies to employers that do not offer health coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees.
Q7. How does an employer know whether the coverage it offers provides minimum value?
A7. A minimum value calculator will be made available by the IRS and the Department of Health and Human Services (HHS). The minimum value calculator will work in a similar fashion to the actuarial value calculator that HHS is making available. Employers can input certain information about the plan, such as deductibles and co-pays, into the calculator and get a determination as to whether the plan provides minimum value by covering at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan.

Q8. If an employer wants to be sure it is offering coverage to all of its full-time employees, how does it know which employees are full-time employees? Does the employer need to offer the coverage to all of its employees because it won’t know for certain whether an employee is a full-time employee for a given month until after the month is over and the work has been done?
A8. The proposed regulations provide a method to employers for determining in advance whether or not an employee is to be treated as a full-time employee, based on the hours of service credited to the employee during a previous period. Using this look-back method to measure hours of service, the employer will know the employee’s status as a full-time employee at the time the employer would offer coverage. The proposed regulations are consistent with IRS notices that have previously been issued and describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees, and teachers who have time off between school years.

Calculation of the Employer Shared Responsibility Payment

Q9. If an employer that does not offer coverage or offers coverage to less than 95% of its employees owes an Employer Shared Responsibility payment, how is the amount of the payment calculated?
A9. In 2014, if an employer employs enough employees to be subject to the Employer Shared Responsibility provisions and does not offer coverage during the calendar year to at least 95% of its full-time employees, it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the year (minus 30) multiplied by $2,000, as long as at least one full-time employee receives the premium tax credit. (Note that for purposes of this calculation, a full-time employee does not include a full-time equivalent). For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered. The amount of the payment for the month equals the number of full-time employees the employer employed for the month (minus up to 30) multiplied by 1/12 of $2,000. If the employer is related to other employers (see question 5 above), then the 30-employee exclusion is allocated among all the related employers. The payment for the calendar year is the sum of the monthly payments computed for each month for which coverage was not offered. After 2014, these rules apply to employers that do not offer coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees.
Making an Employer Shared Responsibility Payment

**Q10. How will an employer know that it owes an Employer Shared Responsibility payment?**  
**A10.** The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after employees’ individual tax returns are due for that year claiming premium tax credits and after the due date for employers that meet the 50 full-time employee (plus full-time equivalents) threshold to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).

**Q11. How will an employer make an Employer Shared Responsibility payment?**  
**A11.** If it is determined that an employer is liable for an Employer Shared Responsibility payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the Employer Shared Responsibility payment on any tax return that they file.

Transition Relief

**Q12. I understand that the Employer Shared Responsibility provisions do not go into effect until 2014. However, the health plan that I offer to my employees runs on a fiscal plan year that starts in 2013 and will run into 2014. Do I need to make sure my plan complies with these new requirements in 2013 when the next fiscal plan year starts?**  
**A12.** For an employer that as of December 27, 2012, already offers health coverage through a plan that operates on a fiscal year (a fiscal year plan), transition relief is available. First, for any employees who are eligible to participate in the plan under its terms as of December 27, 2012 (whether or not they take the coverage), the employer will not be subject to a potential payment until the first day of the fiscal plan year starting in 2014. Second, if (a) the fiscal year plan (including any other fiscal year plans that have the same plan year) was offered to at least one third of the employer’s employees (full-time and part-time) at the most recent open season or (b) the fiscal year plan covered at least one quarter of the employer’s employees, then the employer also will not be subject to the Employer Shared Responsibility payment with respect to any of its full-time employees until the first day of the fiscal plan year starting in 2014, provided that those full-time employees are offered affordable coverage that provides minimum value no later than that first day. So, for example, if during the most recent open season preceding December 27, 2012, an employer offered coverage under a fiscal year plan with a plan year starting on July 1, 2013 to at least one third of its employees (meeting the threshold for the additional relief), the employer could avoid liability for a payment if, by July 1, 2014, it expanded the plan to offer coverage satisfying the Employer Shared Responsibility provisions to the full-time employees who had not been offered coverage. For purposes of determining whether the plan covers at least one quarter of the employer’s employees, an employer may look at any day between October 31, 2012 and December 27, 2012.
**Q13.** Is transition relief available to help employers that are close to the 50 full-time employee threshold determine their options for 2014?

**A13.** Yes. Rather than being required to use the full twelve months of 2013 to measure whether it has 50 full-time employees (or an equivalent number of part-time and full-time employees), an employer may measure using any six-consecutive-month period in 2013. So, for example, an employer could use the period from January 1, 2013, through June 30, 2013, and then have six months to analyze the results, determine whether it needs to offer a plan, and, if so, choose and establish a plan.

**Additional Information**

**Q14.** When can an employee receive a premium tax credit?

**A14.** Premium tax credits generally are available to help pay for coverage for employees who

- are between 100% and 400% of the federal poverty level and enroll in coverage through an Affordable Insurance Exchange,
- are not eligible for coverage through a government-sponsored program like Medicaid or CHIP, and
- are not eligible for coverage offered by an employer or are eligible only for employer coverage that is unaffordable or that does not provide minimum value.

**Q15.** If an employer does not employ enough employees to be subject to the Employer Shared Responsibility provisions, does that affect the employer's employees' eligibility for a premium tax credit?

**A15.** No. The rules for how eligibility for employer-sponsored insurance affects eligibility for the premium tax credit are the same, regardless of whether the employer employs enough employees to be subject to the Employer Shared Responsibility provisions.
Chapter 14: Imposition of Annual Fee on Health Insurance Providers

An annual fee applies to any covered entity engaged in the business of providing health insurance with respect to United States health risks. The fee applies for calendar years beginning after 2013. The aggregate annual fee for all covered entities is the applicable amount. The applicable amount is $8 billion for calendar year 2014, $11.3 billion for calendar years 2015 and 2016, $13.9 billion for calendar year 2017, and $14.3 billion for calendar year 2018. For calendar years after 2018, the applicable amount is indexed to the rate of premium growth.

The annual payment date for a calendar year is determined by the Secretary of the Treasury, but in no event may be later than September 30 of that year.

Under the provision, the aggregate annual fee is apportioned among the providers based on a ratio designed to reflect relative market share of U.S. health insurance business. For each covered entity, the fee for a calendar year is an amount that bears the same ratio to the applicable amount as (1) the covered entity’s net premiums written during the preceding calendar year with respect to health insurance for any United States health risk, bears to (2) the aggregate net written premiums of all covered entities during such preceding calendar year with respect to such health insurance.

The provision requires the Secretary of the Treasury to calculate the amount of each covered entity’s fee for the calendar year, determining the covered entity’s net written premiums for the preceding calendar year with respect to health insurance for any United States health risk on the basis of reports submitted by the covered entity and through the use of any other source of information available to the Treasury Department. It is intended that the Treasury Department be able to rely on published aggregate annual statement data to the extent necessary, and may use annual statement data and filed annual statements that are publicly available to verify or supplement the reports submitted by covered entities.

Net written premiums is intended to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions. Net written premiums do not include amounts arising under arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance).

The amount of net premiums written that are taken into account for purposes of determining a covered entity’s market share is subject to dollar thresholds. A covered entity’s net premiums written during the calendar year that are not more $25 million are not taken into account for this purpose. With respect to a covered entity’s net premiums written during the calendar year that are more than $25 million but not more than $50 million, 50 percent are taken into account, and 100 percent of net premiums written in excess of $50 million are taken into account.

After application of the above dollar thresholds, a special rule provides an exclusion, for purposes of determining an otherwise covered entity’s market share, of 50 percent of net premiums written that are attributable to the exempt activities of a health insurance organization that is exempt from Federal income tax by reason of being described in
section 501(c)(3) (generally, a public charity), section 501(c)(4) (generally, a social welfare organization), section 501(c)(26) (generally, a high-risk health insurance pool), or section 501(c)(29) (a consumer operated and oriented plan ("CO-OP") health insurance issuer).

A covered entity generally is an entity that provides health insurance with respect to United States health risks during the calendar year in which the fee under this section is due. Thus for example, an insurance company subject to tax under part I or II of subchapter L, an organization exempt from tax under section 501(a), a foreign insurer that provides health insurance with respect to United States health risks, or an insurer that provides health insurance with respect to United States health risks under Medicare Advantage, Medicare Part D, or Medicaid, is a covered entity under the provision except as provided in specific exceptions.

Specific exceptions are provided to the definition of a covered entity. A covered entity does not include an employer to the extent that the employer self-insures the health risks of its employees. For example, a manufacturer that enters into a self-insurance arrangement with respect to the health risks of its employees is not treated as a covered entity. As a further example, an insurer that sells health insurance and that also enters into a self-insurance arrangement with respect to the health risks of its own employees is treated as a covered entity with respect to its health insurance business, but is not treated as a covered entity to the extent of the self-insurance of its own employees' health risks.

A covered entity does not include any governmental entity. For this purpose, it is intended that a governmental entity includes a county organized health system entity that is an independent public agency organized as a nonprofit under State law and that contracts with a State to administer State Medicaid benefits through local care providers or health maintenance organizations (HMOs).

A covered entity does not include an entity that (1) qualifies as nonprofit under applicable State law, (2) meets the private inurement and limitation on lobbying provisions described in section 501(c)(3), and (3) receives more than 80 percent of its gross revenue from government programs that target low-income, elderly, or disabled populations (including Medicare, Medicaid, the State Children’s Health Insurance Plan ("SCHIP"), and dual-eligible plans).

A covered entity does not include an organization that qualifies as a VEBA under section 501(c)(9) that is established by an entity other than the employer (i.e., a union) for the purpose of providing health care benefits. This exclusion does not apply to multiple-employer welfare arrangements ("MEWAs").

For purposes of the provision, all persons treated as a single employer under section 52(a) or (b) or section 414(m) or (o) are treated as a single covered entity (or as a single employer, for purposes of the rule relating to employers that self-insure the health risks of employees), and otherwise applicable exclusion of foreign corporations under those rules is disregarded. However, the exceptions to the definition of a covered entity are applied on a separate entity basis, not taking into account this rule. If more than one person is liable for payment of the fee by reason of being treated as a single covered entity, all such persons are jointly and severally liable for payment of the fee.
A United States health risk means the health risk of an individual who is a U.S. citizen, is a U.S. resident within the meaning of section 7701(b)(1)(A) (whether or not located in the United States), or is located in the United States, with respect to the period that the individual is located there. In general, it is intended that risks in the following lines of business reported on the annual statement as prescribed by the National Association of Insurance Commissioners and as filed with the insurance commissioners of the States in which insurers are licensed to do business constitute health risks for this purpose: comprehensive (hospital and medical), vision, dental, Federal Employees Health Benefit plan, title XVIII Medicare, title XIX Medicaid, and other health.

For purposes of the provision, health insurance does not include coverage only for accident, or disability income insurance, or a combination thereof. Health insurance does not include coverage only for a specified disease or illness, nor does health insurance include hospital indemnity or other fixed indemnity insurance. Health insurance does not include any insurance for long-term care or any Medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

For purposes of procedure and administration under the rules of Subtitle F of the Code, the fee under this provision is treated as an excise tax with respect to which only civil actions for refund under Subtitle F apply. The Secretary of the Treasury may redetermine the amount of a covered entity’s fee under the provision for any calendar year for which the statute of limitations remains open.

For purposes of section 275, relating to the nondeductibility of specified taxes, the fee is considered to be a nondeductible tax described in section 275(a)(6).

A reporting rule applies under the provision. A covered entity is required to report to the Secretary of the Treasury the amount of its net premiums written during any calendar year with respect to health insurance for any United States health risk.

A penalty applies for failure to report, unless it is shown that the failure is due to reasonable cause. The amount of the penalty is $10,000 plus the lesser of (1) $1,000 per day while the failure continues, or (2) the amount of the fee imposed for which the report was required. The penalty is treated as a penalty for purposes of subtitle F of the Code, must be paid on notice and demand by the Treasury Department and in the same manner as tax, and with respect to which only civil actions for refund under procedures of subtitle F apply. The reported information is not treated as taxpayer information under section 6103.

An accuracy-related penalty applies in the case of any understatement of a covered entity’s net premiums written. For this purpose, an understatement is the difference between the amount of net premiums written as reported on the return filed by the covered entity and the amount of net premiums written that should have been reported on the return. The penalty is equal to the amount of the fee that should have been paid in the absence of an understatement over the amount of the fee determined based on the understatement. The accuracy-related penalty is subject to the provisions of subtitle F of the Code that apply to assessable penalties imposed under Chapter 68.
The provision provides authority for the Secretary of the Treasury to publish guidance necessary to carry out the purposes of the provision and to prescribe regulations necessary or appropriate to prevent avoidance of the purposes of the provision, including inappropriate actions taken to qualify as an exempt entity under the provision.

**Implementation**

On March 1, 2013, the IRS issued proposed regulations with respect to the fee on health insurance providers. The proposed regulations provide (1) an explanation of terms; (2) reporting requirements and associated penalties; (3) details of the fee calculation; (4) procedures for notice of preliminary fee calculation; (5) an error correction process; (6) procedures for notification of final fee calculation and payment; (7) tax treatment of the fee; and (8) procedures for refund claims.
Assignment 3 – Review Questions

The following questions are designed to ensure that you have a complete understanding of the information presented in the assignment. They do not need to be submitted in order to receive CPE credit. They are included as an additional tool to enhance your learning experience.

We recommend that you answer each review question and then compare your response to the suggested solution before answering the final exam questions related to this assignment.

1. Which of the following is a change made to health coverage as required by the ACA for group health plans applicable as of 2014:
   a) coverage of all dependents under the age of 22
   b) consistent coverage for individuals participating in approved clinical trials
   c) no waiting periods of more than 30 days
   d) the changes are the same as ACA provisions that went into effect in 2013

2. Starting in 2014, individuals and families who go through an American Health Benefits Exchange for health coverage will be:
   a) eligible for the premium assistance credit
   b) eligible for universal federal health insurance coverage
   c) mandated to pay an additional tax
   d) exempt from the failure to maintain minimum essential coverage tax in the future if they ever fail to maintain coverage

3. Which of the following is true of the ACA requirement to maintain minimum essential coverage:
   a) those who fail to maintain coverage will generally be subject to a tax
   b) the requirement begins in January 2013
   c) minimum essential coverage does not include Medicare or Medicaid
   d) every U.S. citizen is required to maintain minimum essential coverage

4. Which of the following people would be considered a dependent of 57 year-old Mary:
   a) Jeff, her 59 year-old husband
   b) Karla, her 18 year-old niece who is living with her for the summer
   c) Rob, her 25 year-old son who is in graduate school
   d) Stephanie, her 28 year-old daughter who just got married

5. The federal health care reform imposes a new annual fee on health care providers. How much will this fee be in 2018:
   a) $7 billion
   b) $11.3 billion
   c) $13.9 billion
   d) $14.3 billion
Assignment 3 – Solutions and Suggested Responses

1. **A:** Incorrect. Coverage of all dependents under the age of 22 is not one of the requirements applicable as of 2014.

   **B:** Correct. Individuals participating in approved clinical trials will receive consistent coverage.

   **C:** Incorrect. The ACA actually changed the requirements to include no waiting period of more than 90 days, not 30 days.

   **D:** Incorrect. There are numerous additional changes to group health care that differ from the provisions that went into effect as of 2013.

   (See page 69 of the course material.)

2. **A:** Correct. Individuals and families who purchase health coverage through an American Health Benefits Exchange may be eligible for a refundable tax credit called the premium assistance credit.

   **B:** Incorrect. Those who purchase health insurance through an American Health Benefits Exchange will *not* be eligible for universal federal health insurance coverage.

   **C:** Incorrect. Purchasing health care coverage through an American Health Benefits Exchange does not mean that they will have to pay an additional tax, but rather they may be eligible for a premium assistance credit.

   **D:** Incorrect. Individuals and families who purchase health coverage through an American Health Benefits Exchange will not be exempt from the failure to maintain minimum essential coverage tax if they ever fail to maintain coverage in the future.

   (See page 70 of the course material.)

3. **A:** Correct. Individuals who are not covered by a health plan that provides minimum essential coverage will be subject to a tax unless the individual qualifies for an exemption. Taxpayers who do not maintain minimum essential coverage for their dependents will also be liable for any tax for failure to maintain the coverage.

   **B:** Incorrect. The new requirement goes into effect starting January 2014.

   **C:** Incorrect. Medicaid and Medicare are government sponsored programs that do provide minimum essential coverage.

   **D:** Incorrect. There are a few exemptions for the tax for failure to maintain minimum essential coverage. The exemptions are as follows: individuals who are incarcerated, who are not legally present in the United States, who qualify for religious exemptions, who have income below the income tax filing threshold, or who do not have access to affordable coverage.

   (See pages 78 to 80 of the course material.)
4. A: Incorrect. Dependents do not include an employee’s spouse, so Jeff would not be a dependent of Mary.

B: Incorrect. Dependents do not include related individuals even if they are claimed as a dependent on the employee’s federal income tax return for the year. Karla is not legally Mary’s child, and therefore is not a dependent of Mary.

C: Correct. A dependent is defined as an employee’s child who has not reached the age of 26, so Rob would be a dependent of Mary.

D: Incorrect. Stephanie is older than 26, and therefore she is no longer a dependent of Mary.

(See pages 85 to 86 of the course material.)

5. A: Incorrect. $7 billion will not be the fee for 2018.

B: Incorrect. The annual fee for calendar years 2015-2016 will be $11.3 billion.

C: Incorrect. In 2017, insurance providers will pay a total of $13.9 towards the annual fee.

D: Correct. The annual fee for insurance providers for 2018 will be $14.3 billion.

(See page 94 of the course material.)
Effective for taxable years beginning after December 31, 2017, the ACA imposes an excise tax on the provider of applicable employer-sponsored coverage if the aggregate cost of the coverage for an employee (including a former employee, surviving spouse, or any other primary insured individual) exceeds a threshold amount. The tax is 40 percent of the amount by which aggregate cost exceeds the threshold amount (the “excess benefit”). For 2018, the annual threshold amount is $10,200 for self-only coverage and $27,500 for other coverage (such as family coverage), multiplied by the health cost adjustment percentage (described below), and then increased by an age and gender adjusted excess premium amount (described below).

The health cost adjustment percentage increases the thresholds if actual growth in the cost of U.S. health care between 2010 (when the ACA was enacted) and 2018 exceeds the projected growth for that period, determined by reference to the per employee cost of coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (“standard FEHBP coverage”). Specifically, the health cost adjustment percentage is 100 percent plus the excess, if any, of (1) the percentage by which the cost of standard FEHBP coverage for 2018 (determined according to specified criteria) exceeds the cost of standard FEHBP coverage for 2010, over (2) 55 percent.

The age and gender adjusted excess premium amount is the excess, if any, of (1) the premium cost of standard FEHBP coverage for the type of coverage provided to an individual if priced for the age and gender characteristics of all employees of the employer, over (2) the premium cost of standard FEHBP coverage if priced for the age and gender characteristics of the national workforce. The age and gender adjustment is determined annually after the adjustments to the threshold amount applicable for the year.

The excise tax is determined on a monthly basis, by reference to the monthly aggregate cost of applicable employer-sponsored coverage for the month and 1/12 of the annual threshold amount. The excise tax is not deductible.

**Applicable employer-sponsored coverage and determination of cost**

Subject to certain exceptions, applicable employer-sponsored coverage is coverage under any group health plan offered to an employee by an employer that is excludible from the employee’s gross income or that would be excludible if it were employer-sponsored coverage. Thus, applicable employer-sponsored coverage includes coverage for which an employee pays on an after-tax basis. Applicable employer-sponsored coverage includes coverage under any group health plan established and maintained primarily for its civilian employees by the Federal government or any Federal agency or instrumentality, or the government of any State or political subdivision thereof or any agency or instrumentality of a State or political subdivision.
Applicable employer-sponsored coverage includes both insured and self-insured health coverage, including coverage in the form of reimbursements under a health flexible spending account (“health FSA”) or a health reimbursement arrangement and contributions to a health savings account (“HSA”) or Archer medical savings account (“Archer MSA”). In the case of a self-employed individual, coverage is treated as applicable employer-sponsored coverage if the self-employed individual is allowed a deduction for all or any portion of the cost of coverage.

Some types of coverage are not included in applicable employer-sponsored coverage, such as long-term care coverage, separate insurance coverage substantially all the benefits of which are for treatment of the mouth (including any organ or structure within the mouth) or of the eye, and certain excepted benefits. Applicable employer-sponsored coverage does not include coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance if the cost of the coverage is not excludible from an employee’s income or deductible by a self-employed individual.

For purposes of the excise tax, the cost of applicable employer-sponsored coverage is generally determined under rules similar to the rules for determining the applicable premium for purposes of COBRA continuation coverage, except that any portion of the cost of coverage attributable to the excise tax is not taken into account. Cost is determined separately for self-only coverage and other coverage. Special valuation rules apply to retiree coverage, certain health FSAs, and contributions to HSAs and Archer MSAs.

**Calculation of excess benefit and imposition of excise tax**

In determining the excess benefit with respect to an employee (i.e., the amount by which the cost of applicable employer-sponsored coverage for the employee exceeds the threshold amount), the aggregate cost of all applicable employer-sponsored coverage of the employee is taken into account. The threshold amount for self-only coverage generally applies to an employee. The threshold amount for other coverage applies to an employee only if the employee and at least one other beneficiary are enrolled in coverage other than self-only coverage under a group health plan that provides minimum essential coverage and under which the benefits provided do not vary based on whether the covered individual is the employee or other beneficiary. For purposes of the threshold amount, any coverage provided under a multiemployer plan is treated as coverage other than self-only coverage.

The excise tax is imposed on the provider of the applicable employer-sponsored coverage (“coverage provider”). In the case of insured coverage (i.e., coverage under a policy, certificate, or contract issued by an insurance company), the health insurance issuer is liable for the excise tax. In the case of self-insured coverage, the person that administers the plan benefits (“plan administrator”) is generally liable for the excise tax. However, in the case of employer contributions to an HSA or an Archer MSA, the employer is liable for the excise tax.

The excise tax is allocated pro rata among the coverage providers, with each responsible for the excise tax on an amount equal to the total excess benefit multiplied by a fraction, the numerator of which is the cost of the applicable employer-sponsored coverage of that coverage provider and the denominator of which is the aggregate cost of all applicable employer-sponsored coverage of the employee.
The employer is generally responsible for calculating the amount of excess benefit allocable to each coverage provider and notifying each coverage provider (and the IRS) of the coverage provider’s allocable share. In the case of applicable employer-sponsored coverage under a multiemployer plan, the plan sponsor is responsible for the calculation and notification. Each coverage provider is then responsible for its share of the excise tax.

**Implementation**

The IRS has not issued guidance with respect to the excise tax on high cost employer-sponsored coverage.
Assignment 4 – Review Questions

The following questions are designed to ensure that you have a complete understanding of the information presented in the assignment. They do not need to be submitted in order to receive CPE credit. They are included as an additional tool to enhance your learning experience.

We recommend that you answer each review question and then compare your response to the suggested solution before answering the final exam questions related to this assignment.

1. For 2018, what is the annual threshold amount for the excise tax on high cost employer-sponsored health coverage for a family coverage plan:
   a) $10,200
   b) $15,750
   c) $20,150
   d) $27,500
Assignment 4 – Solutions and Suggested Responses

1. A: Incorrect. $10,200 is the threshold for self-only coverage, not a family coverage plan.
   
   B: Incorrect. The threshold for a family plan is higher than $15,750.
   
   C: Incorrect. $20,150 is not the threshold for a family coverage plan.
   
   D: Correct. The threshold for a family coverage plan is $27,500.

(See page 101 of the course material.)
Affordable coverage: coverage is considered affordable if the required contribution does not exceed eight percent of the household income for the year.

American Health Benefit Exchanges: state-based exchanges where individuals and groups can purchase insurance plans beginning in January, 2014.

Archer MSA: a tax-exempt trust or custodial account where employees of small employers and self-employed individuals with high deductible plans can make contributions.

Black liquor: the byproduct produced during the process of making paper.

Cafeteria plans: provide individuals an opportunity to receive certain benefits on a pretax basis; participants are permitted to choose among at least one taxable benefit and one qualified benefit.

Dependents: children of employee’s who have not attained age 26; spouses and other related individuals are not included.

Full-time employee: individuals employed on average for at least 30 hours of service per week during the measurement period.

Grandfathered Health Plan: a group or individual health insurance policy that was purchased on or before March 23, 2010.

Health flexible spending arrangement (FSA): an arrangement under which employees are allowed to reduce their current cash compensation and use the money to reimburse the employee for his or her medical expenses.

Health savings account (HSA): tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents.

Medical care: the amounts paid for diagnoses, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure of the body.

Multiemployer plan: a plan providing benefits under collective bargaining agreements to employees of two or more unrelated employers.

Net investment income tax: the 3.8 percent tax on unearned income on certain high-income individuals, estates, and trusts.

Premium assistance credit: a refundable tax credit provided for eligible individuals and families who purchase health insurance through an American Health Benefit Exchange.

Underwriting income: the premiums earned on insurance contracts during the year; the difference between premiums collected on insurance policies by the insurer, and expenses incurred and claims paid out.

Use or lose rule: the requirement that unused amounts remaining under a health FSA at the end of a plan year generally must be forfeited by the employee, but a 2½ month grace period immediately following the end of the plan year is currently permitted.
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