

**PRESENT LAW AND BACKGROUND RELATING  
TO THE TAX-RELATED PROVISIONS  
IN THE AFFORDABLE CARE ACT**

Scheduled for a Public Hearing  
Before the  
SUBCOMMITTEE ON OVERSIGHT OF THE  
COMMITTEE ON WAYS AND MEANS  
on March 5, 2013

Prepared by the Staff  
of the  
JOINT COMMITTEE ON TAXATION



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## INTRODUCTION AND SUMMARY

The Subcommittee on Oversight of the Committee on Ways and Means has scheduled a public hearing on March 5, 2013, on the implementation of the tax and tax-related revenue provisions of the Patient Protection and Affordable Care Act (“PPACA”)<sup>1</sup> and the Health Care and Education Reconciliation Act of 2010 (“HCERA”).<sup>2</sup> These two Acts are collectively referred to as the Affordable Care Act (“ACA”).

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,<sup>3</sup> 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.

This document,<sup>4</sup> prepared by the staff of the Joint Committee on Taxation, provides a summary of health insurance changes made by the ACA and a description of the present-law rules with respect to the ACA revenue provisions<sup>5</sup> and includes a discussion of implementation<sup>6</sup>

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<sup>1</sup> Pub. L. No 111-148, enacted March 23, 2010.

<sup>2</sup> Pub. L. No. 111-152, enacted March 30, 2010

<sup>3</sup> All references to the Code and all section references in this document are to the Internal Revenue Code of 1986 unless otherwise specified.

<sup>4</sup> This document may be cited as follows: Joint Committee on Taxation, *Present Law and Background Relating to the Tax-Related Provisions in the Affordable Care Act* (JCS-6-12), March 4, 2013. This document can be found on our website at [www.jct.gov](http://www.jct.gov).

<sup>5</sup> A detailed description of these ACA revenue provisions may also be found in Joint Committee on Taxation, *General Explanation of Tax Legislation Enacted in the 111th Congress* (JCS-2-11), March 2011, pp. 252-384. Certain ACA revenue provisions that added or amended Code provisions (or other revenue laws) have been repealed, have been superseded, or have expired since the enactment of the ACA. Descriptions of these repealed,

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.

In the case of new Code provisions and the ACA revenue provisions creating new industry fees, this document describes the new provisions (reflecting post-enactment amendments, if any). In the case of pre-existing Code provisions amended by the ACA, this document 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.

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superseded, or expired provisions are not included in this document. The repealed provisions are section 9006 of PPACA (repealed by section 1858 of the Department of Defense and Full-year Appropriations Act of 2011, Pub. L. No. 112-10) which expanded the reporting of certain business payment, and section 10108 of HCERA (repealed by Section 3 of the Comprehensive 1099 Taxpayer protection and Repayment of Subsidy Overpayments Act of 2011, Pub. L. No. 112-9) which added a new Code section 139D providing for free-choice vouchers. Section 1410 of HCERA increased the corporate estimated tax payment otherwise due in July, August, or September, 2014 under section 202(b)(1) of the Corporate Estimated Tax Act of 2009. That increase in the corporate estimated tax for these quarters has been superseded by subsequent changes to section 202(b)(1) of the Corporate Estimated Tax Act of 2009. Section 48D (added by section 9023 of PPACA) provides an investment tax credit for qualifying therapeutic discovery projects that only applies to investments made in taxable years beginning in 2009 or 2010, and thus is an expired provision. Sections 23 and 137 that provide a tax credit for adoption expenses and an exclusion for employer paid adoption expenses were temporarily expanded by section 10909 of PPACA. The expansion does not apply to taxable years beginning after December 31, 2011.

<sup>6</sup> For more and other information related to the ACA, see the IRS's website at:<http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions?portlet=104>.

## I. ACA PROVISIONS IN EFFECT AS OF 2013

### A. Initial ACA Changes to Health Coverage

#### **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.<sup>7</sup>

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.<sup>8</sup> Compliance with these requirements is enforced through an excise tax.<sup>9</sup>

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.<sup>10</sup> 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 PPACA).<sup>11</sup> Most of the PHSA requirements added by the ACA apply also to health insurance

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<sup>7</sup> Sec. 5000(b)(1). By definition, a group health plan is a plan providing employment-related health benefits.

<sup>8</sup> These requirements for group health plans are contained in Chapter 100 of the Code, sections 9801 et seq. Certain group health plans (*e.g.*, governmental plans and plans covering fewer than two active employees) and certain types of coverage are exempt from these Code requirements.

<sup>9</sup> Sec. 4980D.

<sup>10</sup> Part 7 of Title I of ERISA, 29 U.S.C. 1181 et seq., and Title XXVII of the PHSA, 42 U.S.C. 300gg et seq. Similar requirements apply also under the Federal Employees Health Benefits Program.

<sup>11</sup> Secs. 1001-1004 of PPACA, as amended by section 10101 of PPACA and section 2301(b) of HCERA. In addition, as discussed in Part II.A, certain other new requirements apply as of plan years beginning on or after January 1, 2014.

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 PHS A and, subject to certain exceptions, apply under the Code and ERISA by cross-reference to the PHS A provisions.<sup>12</sup>

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);<sup>13</sup>
- No lifetime limits or annual limits on essential health benefits (except, for years before 2014, restricted annual limits are permitted);<sup>14</sup>
- Prohibition on discrimination under an insured group health plan in favor of highly compensated individuals;<sup>15</sup>
- 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 “SBC” and a uniform glossary);
- Required appeals process for benefit denials, including an internal appeal and external review;
- Prohibition on the rescission 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

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<sup>12</sup> Code sec. 9815 and ERISA sec. 715.

<sup>13</sup> Information about preventive services is available at <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html>.

<sup>14</sup> As of 2014, annual limits on essential health benefits are prohibited. As discussed in Part II.B.1, qualified health plans offered on an American Health Benefit Exchange must offer essential health benefits. Information about essential health benefits is available at <http://www.healthcare.gov/glossary/e/essential.html>.

<sup>15</sup> This ACA provision does not apply to self-insured health plans, which, under Code section 105(h), have been subject to nondiscrimination requirements since before ACA. These rules prohibit such a plan from discriminating (both as to eligibility for coverage and as to benefits provided under the plan) in favor of highly compensated individuals. Under IRS Notice 2011-1, 2011-2 I.R.B. 259, compliance with the ACA nondiscrimination prohibition for insured plans is not required until regulations or other guidance has been issued.

- 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.<sup>16</sup> 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.<sup>17</sup>

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<sup>16</sup> Sec. 1251 of PPACA, as amended by section 10103 of PPACA and section 2301(a) of HCERA.

<sup>17</sup> This guidance and additional information is available via the agency websites, such as <http://www.irs.gov/uac/Legal-Guidance-for-Group-Health-Plan-Requirements>, <http://cciio.cms.gov/programs/marketreforms/index.html>, and <http://www.dol.gov/ebsa/healthreform/>.



## **B. Tax Treatment of Medical Care Expenses for Individuals**

### **1. Tax treatment for health coverage for children under age 27<sup>18</sup>**

#### **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.<sup>19</sup> 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.<sup>20</sup> 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

#### **VEBAs and retiree medical accounts**

Employer-provided health coverage (and medical reimbursements) may also be provided through a voluntary employee beneficiary association ("VEBA").<sup>21</sup> 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.<sup>22</sup> Amounts in such accounts used to reimburse medical care expenses or purchase health insurance coverage for retirees are also excluded from gross income.<sup>23</sup>

#### **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.<sup>24</sup>

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<sup>18</sup> Section 1504 of HCERA amends sections 105, 162(l), 401(h) and 501(c)(9) of the Code.

<sup>19</sup> Sec. 106.

<sup>20</sup> Sec. 105(b).

<sup>21</sup> Sec. 501(c)(9).

<sup>22</sup> Sec. 401(h)

<sup>23</sup> Treas. Reg. 1.72-15(h).

<sup>24</sup> Sec. 162(l).

## **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.<sup>25</sup> 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.<sup>26</sup>

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, step children, 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).<sup>27</sup>

## **Implementation**

On April 22, 2010, IRS issued Notice 2010-38<sup>28</sup> 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.

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<sup>25</sup> Sec. 105(b). Dependent for this purpose is determined under section 152, without regard to section 152(b)(1), (b)(2), and (d)(1)(B).

<sup>26</sup> A child older than age 19 or 24 may also qualify as a dependent as a qualifying relative under section 152(d).

<sup>27</sup> Sec. 152(f)(1).

<sup>28</sup> 2010-1 C.B. 682.

## **2. Dollar limit on health flexible spending arrangements under cafeteria plans<sup>29</sup>**

### **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.<sup>30</sup>

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”).<sup>31</sup>

### **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.<sup>32</sup> 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”).<sup>33</sup> 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.<sup>34</sup> A health FSA

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<sup>29</sup> Section 9005 of the PPACA (as amended by 10902 of PPACA and 1403 of HCERA) adds section 125(i) of the Code.

<sup>30</sup> Sec. 106.

<sup>31</sup> Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

<sup>32</sup> Sec. 125 and Prop. Treas. Reg. sec. 1.125-5.

<sup>33</sup> Sec. 125(d)(2) and Prop. Treas. Reg. sec. 1.125-5(c).

<sup>34</sup> Notice 2005-42, 2005-1 C.B. 1204, and Prop. Treas. Reg. sec. 1.125-1(e).

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).<sup>35</sup>

### **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.<sup>36</sup> This amount is adjusted for increases in the 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<sup>37</sup> 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<sup>38</sup>**

### **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))

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<sup>35</sup> Prop. Treas. Reg. sec. 1-125-5(b).

<sup>36</sup> Sec. 125(i).

<sup>37</sup> 2012-1 C.B. 1046.

<sup>38</sup> Section 9022 of the ACA adds section 125(j) to the Code.

through a cafeteria plan.<sup>39</sup> 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.<sup>40</sup> 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<sup>41</sup> on business days during either of the two preceding years.<sup>42</sup> 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

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<sup>39</sup> A key employee generally is an employee who, at any time during the year is (1) a five-percent owner of the employer, or (2) a one-percent owner with compensation of more than \$150,000 (not indexed for inflation), or (3) an officer with compensation more than \$160,000 (for 2010). A special rule limits the number of officers treated as key employees. If the employer is a corporation, a five-percent owner is a person who owns more than five percent of the outstanding stock or stock possessing more than five percent of the total combined voting power of all stock. If the employer is not a corporation, a five-percent owner is a person who owns more than five percent of the capital or profits interest. A one-percent owner is determined by substituting one percent for five percent in the preceding definitions. For purposes of determining employee ownership in the employer, certain attribution rules apply.

<sup>40</sup> For cafeteria plan purposes, a “highly compensated individual” is (1) an officer, (2) a five-percent shareholder, (3) an individual who is highly compensated, or (4) the spouse or dependent of any of the preceding categories. A “highly compensated participant” is a participant who falls in any of those categories. “Highly compensated” is not defined for this purpose. Under section 105(h), a self-insured medical expense reimbursement plan must not discriminate in favor of a “highly compensated individual,” defined as (1) one of the five highest paid officers, (2) a 10-percent shareholder, or (3) an individual among the highest paid 25 percent of all employees. Under section 129 for a dependent care assistance program, eligibility for benefits, and the benefits and contributions provided, generally must not discriminate in favor of highly compensated employees within the meaning of section 414(q).

<sup>41</sup> The determination of whether an employer is an eligible small employer is determined by applying the controlled group rules of sections 52(a) and (b) under which all members of the controlled group are treated as a single employer. In addition, the definition of employee includes leased employees within the meaning of sections 414(n) and (o).

<sup>42</sup> If an employer was not in existence throughout the preceding year, the determination is based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year. If an employer was an eligible employer for any year and maintained a simple cafeteria plan for its employees for such year, then, for each subsequent year during which the employer continues, without interruption, to maintain the cafeteria plan, the employer is deemed to be an eligible small employer until the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

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<sup>43</sup>) 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 nonhighly 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 nonhighly compensated employees.<sup>44</sup> 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 employee 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).

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<sup>43</sup> A SIMPLE is permitted to exclude employees who (1) have not attained the age of 21 (or a younger age provided in the plan) before the close of a plan year, (2) have fewer than 1,000 hours of service for the preceding plan year, (3) have not completed one year of service with the employer as of any day during the plan year, (4) are covered under an agreement that the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or (5) are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States). An employer may have a shorter age and service requirement but only if such shorter service or younger age applies to all employees.

<sup>44</sup> A simple cafeteria plan is permitted to provide for the matching contributions in addition to the minimum required but only if matching contributions with respect to salary reduction contributions for any highly compensated employee or key employee are not made at a greater rate than the matching contributions for any nonhighly compensated employee. Nothing in this provision prohibits an employer from making contributions to provide qualified benefits under the plan in addition to the required contributions.

#### **4. Increase in tax on nonqualified distributions from health savings accounts and Archer MSAs<sup>45</sup>**

##### **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”).<sup>46</sup> 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.<sup>47</sup> 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.

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<sup>45</sup> Sec. 9004 amends section 220(f) and 223(f) of the Code.

<sup>46</sup> Sec. 223. Generally, a high deductible health plan for an HSA is a health plan that, for 2013, has an annual deductible that is at least \$1,250 for self-only coverage or \$2,500 for family coverage and that has an out-of-pocket expense limit that is no more than \$6,250 in the case of self-only coverage and \$12,500 in the case of family coverage. Out-of-pocket expenses include deductibles, co-payments, and other amounts (other than premiums) that the individual must pay for covered benefits under the plan. A plan does not fail to be a high deductible health plan by reason of failing to have a deductible for preventive care.

<sup>47</sup> Sec. 220.

## **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**

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<sup>48</sup>**

### **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”).<sup>49</sup>

### **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 definition of medical care<sup>50</sup>**

### **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.<sup>51</sup> Medical care does not include toiletries

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<sup>48</sup> Section 9013 of PPACA amends section 213(a).

<sup>49</sup> Sec. 213(a).



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).<sup>52</sup>

Under an HRA or Health FSA, amounts available for reimbursement for medical care must be used exclusively for that purpose.<sup>53</sup> 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.<sup>54</sup>

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.<sup>55</sup>

### **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.<sup>56</sup> The term prescribed drug means a drug or biological which requires a prescription of a physician for its use by an individual.<sup>57</sup> 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.<sup>58</sup>

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

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<sup>50</sup> Section 9003 of PPACA adds section 106(f), amends sections 220(d), and 223(d).

<sup>51</sup> Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.

<sup>52</sup> Treas. Reg. sec. 1.213-1(g)(2) provides that medicine and drugs do not these items and that amounts expended for these items are not amounts expended for medical care.

<sup>53</sup> Treas. Reg. sec. 1.105-2.

<sup>54</sup> Proposed Treas. Reg. sec. 1.125-6 and Rev. Rul. 2003-43 (2003-1CB 935), amplified, Notice 2006-6 (2006-31 IRB 107), Notice 2007-2 (2007-2 IRB 254); Rev. Proc. 98-25 (1998-1 CB 689).

<sup>55</sup> This is similar to the treatment of other individual tax-favored accounts, for example, whether an exception to the 10-percent early withdrawal tax applies to a distribution from an individual retirement arrangement.

<sup>56</sup> Sec. 213(b).

<sup>57</sup> Sec. 213(d)(3).

<sup>58</sup> Rev. Rul. 2003-58, 2003-1 CB 959.

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.<sup>59</sup>

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<sup>60</sup> and Notice 2011-5,<sup>61</sup> 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.

## **7. Exclusion of health benefits provided by Indian tribal governments<sup>62</sup>**

Present law generally provides that gross income includes all income from whatever source derived.<sup>63</sup> Exclusions from income are provided, however, for certain health care benefits.<sup>64</sup>

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<sup>59</sup> Rev. Rul. 2003-102, 2003-2 C.B. 559, now obsoleted by Rev. Rul. 2010-23, 2010-2 C.B.388.

<sup>60</sup> 2010-2 C.B. 756.

<sup>61</sup> 2011-1 C.B. 314.

<sup>62</sup> Section 9021 of PPACA adds new section 139D to the Code.

<sup>63</sup> Sec. 61.

<sup>64</sup> For example, employees generally are not taxed on (that is, may “exclude” from gross income) the value of employer-provided health coverage under an accident or health plan. Sec. 106. In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income. Sec. 105(b).

Outside the employment context, there is an IRS administrative rule called the general welfare doctrine that operates to exclude certain payments from gross income that are made from a governmental fund, for the promotion of general welfare, and which do not represent compensation for services. Prior to the enactment of section 139D of

## **Exclusion from income for specified Indian tribe health care benefits**

Under ACA, Indian tribe members<sup>65</sup> are not taxed on (that is, may “exclude” from gross income) the value of any qualified Indian health care benefit.<sup>66</sup> 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;<sup>67</sup> (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;<sup>68</sup> (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.

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the Code, there was some uncertainty concerning the application of this doctrine to payments of health care benefits provided by Indian tribes to their members. The issue was whether the tribal governments could provide such benefits without considering the financial need of the members. After ACA, reliance on the general welfare doctrine is no longer necessary because section 139D of the Code specifically excludes qualified Indian health care benefits from income.

<sup>65</sup> To qualify for the exclusion, the recipient must be a member of an Indian tribe, the spouse of a member, or a dependent of a member of an Indian tribe. Employment by an Indian tribe alone does not qualify a recipient for the exclusion under Section 139D, but other provisions may exclude employer-provided health coverage. Internal Revenue Service, *Frequently Asked Questions (FAQs) about new Section 139D*, Q3, p. 1, [http://www.irs.gov/pub/irs-tege/139d\\_faqs\\_final\\_2\\_oc.pdf](http://www.irs.gov/pub/irs-tege/139d_faqs_final_2_oc.pdf).

<sup>66</sup> Sec. 139D (effective for benefits and coverage provided after March 23, 2010).

<sup>67</sup> The term “Indian tribe” means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined by, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et. seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Secs. 139D(c)(1), 45A(c)(6). The term “tribal organization” has the same meaning as such term in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(1)). Sec. 139D(c)(2).

<sup>68</sup> The terms “accident or health insurance” and “accident or health plan” have the same meaning as when used in section 105, which provides rules about the exclusion of certain amounts received under accident and health plans. Sec. 139D(c)(4). The term “medical care” is the same as the definition under section 213 which provides for a deduction for medical and dental expenses. Sec. 139D(c)(3). For purposes of the provision, dependents are determined under section 152, but without regard to subsections (b)(1), (b)(2), and (d)(1)(B). Sec. 139D(c)(5). Section 152(b)(1) generally provides that if an individual is a dependent of another taxpayer during a taxable year such individual is treated as having no dependents for such taxable year. Section 152(b)(2) provides that a married individual filing a joint return with his or her spouse is not treated as a dependent of a taxpayer. Section 152(d)(1)(B) provides that a “qualifying relative” (*i.e.*, a relative who qualifies as a dependent) does not include a person whose gross income for the calendar year in which the taxable year begins equals or exceeds the exempt amount (as defined under section 151).

## **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.”<sup>69</sup> 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.<sup>70</sup> 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.<sup>71</sup>

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<sup>69</sup> Internal Revenue Service, *Frequently Asked Questions (FAQs) about new Section 139D*, [http://www.irs.gov/pub/irs-tege/139d\\_faqs\\_final\\_2\\_oc.pdf](http://www.irs.gov/pub/irs-tege/139d_faqs_final_2_oc.pdf).

<sup>70</sup> Chief Couns. Adv. 201051021, December 23, 2010 (citing Rev. Proc. 2008-48, 2008-36 I.R.B. 586).

<sup>71</sup> Chief Couns. Adv. 201302021, December 5, 2010.

## **C. Provisions Affecting the Tax Treatment of Employers and Employer-Sponsored Health Plans**

### **1. Credit for small employer health insurance expenses<sup>72</sup>**

#### **In general**

The ACA provides a tax credit for an eligible small employer for nonelective contributions to purchase health insurance for its employees.<sup>73</sup> 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.<sup>74</sup> 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.<sup>75</sup> 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.<sup>76</sup>

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

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<sup>72</sup> Section 1421 of PPACA (as amended by section 10105 of PPACA) adds new section 45R to the Code.

<sup>73</sup> A nonelective contribution is an employer contribution other than an employer contribution pursuant to a salary reduction arrangement. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 is not a nonelective contribution for purposes of the credit.

<sup>74</sup> Wages for this purpose is defined as under the Federal Insurance Contributions Act (“FICA”), sections 3101-3128, without regard to the dollar limit on FICA wages under section 3121(a). The wage amounts relevant for purposes of the credit are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) for years beginning after 2013.

<sup>75</sup> Section 414(b), (c), (m) and (o).

<sup>76</sup> Sec. 414(n)(2).

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.<sup>77</sup>

### **Implementation**<sup>78</sup>

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).<sup>79</sup>

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;

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<sup>77</sup> For this purpose, “payroll taxes” means: (1) the amount of income tax required to be withheld from its employees’ wages; (2) the amount of hospital insurance tax required to be withheld from its employees’ wages; and (3) the amount of the hospital insurance tax imposed on the employer.

<sup>78</sup> The IRS has also posted information about the credit and undertaken outreach to employers potentially eligible for the credit. IRS implementation of the small employer health insurance credit is discussed in a report by the Treasury Inspector General for Tax Administration (“TIGTA”), Ref. No. 2011-40-103, Affordable Care Act: Efforts to Implement the Small Business Health Care Tax Credit Were Mostly Successful, but Some Improvements Are Needed (September 2011) and in TIGTA testimony on November 19, 2011, before the Subcommittee on Oversight of the House Committee on Ways and Means, available at <http://waysandmeans.house.gov/uploadedfiles/georgetestimonyos911.pdf>.

<sup>79</sup> 2010-1 C.B. 717 and 2010-2 C.B. 857. In addition, Rev. Rul. 2010-13, 2010-1 C.B. 691 (issued May 3, 2010) provides the average premiums for self-only and family coverage in the small group market in each State for 2010.

- 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)<sup>80</sup> 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;<sup>81</sup> and
- Calculation of the credit, including the phase-outs.

## **2. Inclusion of cost of employer-sponsored health coverage on W-2<sup>82</sup>**

### **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.

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<sup>80</sup> Pub. L. No. 106-244.

<sup>81</sup> Notice 2010-44 provides a safe harbor for 2010 for determining whether an employer makes a uniform nonelective contribution of at least 50 percent of the premium cost of the employees' health insurance.

<sup>82</sup> Section 9002 of the PPACA adds section 6051(a)(14) to the Code.



## **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<sup>83</sup> 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 COBRA continuation coverage,<sup>84</sup> 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.

### **Implementation**

Notice 2012-9<sup>85</sup> 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.

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<sup>83</sup> For this reporting requirement, the definition of employer-sponsored health coverage in section 4980I(d)(1) applies.

<sup>84</sup> Sec. 4980B(f)(4).

<sup>85</sup> 2012-1 C.B. 315. This notice restates and amends the guidance in Notice 2011-28, 2011-1 C.B. 656.

## D. Other Provisions Affecting the Tax Treatment of Individuals

### 1. Additional hospital insurance tax on high income taxpayers<sup>86</sup>

#### 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.<sup>87</sup> 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”).<sup>88</sup> 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.<sup>89</sup> 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.<sup>90</sup>

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<sup>86</sup> Section 9015 of PPACA (as amended by section 10906 of PPACA and section 1402(b) of HCERA) amends sections 1401(b)(2) and 3101(b)(2) and adds section 3102(f) to the Code.

<sup>87</sup> Secs. 3101-3128.

<sup>88</sup> Secs. 3201-3233. Combined employer and employee rates apply to the RRTA compensation of an employee representative, defined under section 3231(c) generally as an officer or official representative of a railway labor organization.

<sup>89</sup> Secs. 1401-1403.

<sup>90</sup> In computing self-employment income, taxpayers are permitted a deduction equal to the product of the taxpayer’s net earnings (determined without regard to this deduction) and one-half of the sum of the rates for OASDI (12.4 percent) and HI (2.9 percent), *i.e.*, 7.65 percent of net earnings. This deduction parallels FICA in that the FICA rates apply to an employee’s wages, which do not include FICA taxes paid by the employer, whereas the self-employed individual’s net earnings are economically equivalent to an employee’s wages plus the employer share of FICA taxes. In addition, under section 164(f), a self-employed individual may deduct for income tax

## **Additional 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 receives 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.<sup>91</sup> 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.<sup>92</sup>

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purposes one-half of his or SECA taxes. This deduction parallels FICA in that an employee does not include in income FICA taxes paid by the employer.

<sup>91</sup> The additional HI tax is not taken into account for purposes of the deduction applicable in computing self-employment income or the income tax deduction for SECA taxes.

<sup>92</sup> There is no similar provision to apply only a single threshold amount for an individual (or individual and spouse) with both RRTA compensation and self-employment income or both FICA wages and RRTA compensation.

## **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.<sup>93</sup> 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, including liability for the additional HI tax;
- 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.

## **2. Tax on net investment income for high-income taxpayers<sup>94</sup>**

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.

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<sup>93</sup> REG-130074-11, 77 Fed. Reg. 72268 (December 5, 2012) and [www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax](http://www.irs.gov/Businesses/Small-Businesses-&Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax).

<sup>94</sup> Section 1402 of HCERA adds new section 1411 to the Code.

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.<sup>95</sup>

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.<sup>96</sup>

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<sup>95</sup> Gross income does not include items, such as interest on tax-exempt bonds, veterans' benefits, and excluded gain from the sale of a principal residence, which are excluded from gross income under the income tax.

<sup>96</sup> For this purpose, a business of trading financial instruments or commodities is not treated as an active trade or business.

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”).<sup>97</sup> 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.<sup>98</sup>

### **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).

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<sup>97</sup> 77 Fed. Reg. 72612, December 5, 2012.

<sup>98</sup> The full text of the Proposed Regulations can be found at <http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29238.pdf>.

### 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.

### **3. Exclusion for assistance provided to participants in state student loan repayment programs for certain health professionals<sup>99</sup>**

#### **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.

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<sup>99</sup> Section 10908 of PPACA adds new section 108(f)(4) to the Code.

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.

## **E. Other Changes in Business Deduction and Credits**

### **1. Limitation on deduction for remuneration paid by health insurance providers<sup>100</sup>**

#### **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<sup>101</sup> of a publicly held corporation<sup>102</sup> to no more than \$1 million per year for each executive.<sup>103</sup> 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.<sup>104</sup>

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<sup>105</sup>). 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

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<sup>100</sup> Sec. 9014 of PPACA adds section 162(m)(6) to the Code.

<sup>101</sup> See section 162(m)(3) and Notice 2007-49, 2007-1 C.B. 1429 for the group of executives covered.

<sup>102</sup> A corporation is treated as publicly held if it has a class of common equity securities that is required to be registered under section 12 of the Securities Exchange Act of 1934.

<sup>103</sup> Sec. 162(m). This deduction limitation applies for purposes of the regular income tax and the alternative minimum tax.

<sup>104</sup> The \$1 million cap is reduced by excess parachute payments (as defined in sec. 280G, discussed below) that are not deductible by the corporation.

<sup>105</sup> Sec. 132.

taxable year to remuneration not in excess of \$500,000.<sup>106</sup> 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<sup>107</sup> 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.<sup>108</sup>

### 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.

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<sup>106</sup> All members of any controlled group of corporations (within the meaning of section 414(b)), other businesses under common control (within the meaning of section 414(c)), or affiliated service group (within the meaning of sections 414(m) and (o)) are generally treated as a single employer for purposes of the deduction limitation.

<sup>107</sup> For years before 2013, Health insurance coverage within the meaning of section 9832(b)(1) replaces minimum essential coverage for purposes of determining whether an insurance provider is a covered health insurance provider.

<sup>108</sup> Employers with self-insured plans are excluded from the definition of covered health insurance provider.

## **Implementation**

On December 22, 2010, the IRS released Notice 2011-02<sup>109</sup> 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<sup>110</sup>**

### **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").<sup>111</sup> 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.<sup>112</sup> 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.

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<sup>109</sup> 2011-1 C.B. 260.

<sup>110</sup> Section 9012 of PPACA (as amended by section 1407 of HCERA) amends section 139A of the Code.

<sup>111</sup> Sec. 1860D-22 of the Social Security Act (SSA), 42 U.S.C. sec. 1395w-132.

<sup>112</sup> Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

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.<sup>113</sup>

### **3. Modification of section 833 treatment of certain health organizations<sup>114</sup>**

#### **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,<sup>115</sup> 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

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<sup>113</sup> [www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy](http://www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy).

<sup>114</sup> Section 9016 of PPACA amends section 833 of the Code.

<sup>115</sup> See H. Rep. No. 99-426, Tax Reform Act of 1985, December 7, 1985, p. 664. The Committee stated, “[T]he availability of tax-exempt status under [then-]present law has allowed some large insurance entities to compete directly with commercial insurance companies. For example, the Blue Cross/Blue Shield organizations historically have been treated as tax-exempt organizations described in sections 501(c)(3) or (4). This group of organizations is now among the largest health care insurers in the United States.” See also Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986* (JCS-10-87), May 4, 1987, pp. 583-592.

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.<sup>116</sup>

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<sup>116</sup> See Wednesday, March 24, 2010, Senate Floor statement of Senator Baucus relating to this provision, 156 Cong. Rec. S1989, stating in part, "First, it was our intention that, in calculating the medical loss ratios, these entities could include both the cost of reimbursement for clinical services provided to the individuals they insure and the cost of activities that improve health care quality. Determining the medical loss ratio under this provision using those two types of costs is consistent with the calculation of medical loss ratios elsewhere in the legislation. This determination would be made on an annual basis and would only affect the application of the special deductions for that year. Second, it was our intention that the only consequence for not meeting the medical loss ratio threshold would be that the 25 percent deduction for claims and expenses and the exception from the 20 percent reduction in the deduction for unearned premium reserves would not be allowed. The entity would still be treated as a stock property and casualty insurance company." A technical correction may be necessary so that the statute reflects this intent.

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.<sup>117</sup>

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<sup>117</sup> Notice 2010-79, 2010-49 I.R.B. 809, December 6, 2010; Notice 2011-04, 2011-2 I.R.B. 282, January 10, 2011; Notice 2011-51, 2011-27 I.R.B. 36, July 5, 2011; and Notice 2012-37, 2012-24 I.R.B. 1014, June 11, 2012.



## F. Industry, Product or Service Fees or Excise Taxes

### 1. Annual fee on branded prescription pharmaceutical manufacturers and importers<sup>118</sup>

#### 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

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<sup>118</sup> Section 9008 of PPACA, as amended by section 1404 of HCERA.

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 30<sup>th</sup> 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,<sup>119</sup> 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,<sup>120</sup> released on January 14, 2011. On April 29, 2011, the IRS released Rev. Proc. 2011-24,<sup>121</sup> 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,<sup>122</sup> 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 30<sup>th</sup> due date of each year’s fee.<sup>123</sup> The temporary

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<sup>119</sup> 2010-50 I.R.B. 822.

<sup>120</sup> 2011-6 I.R.B. 459.

<sup>121</sup> 2011-20 I.R.B. 787.

<sup>122</sup> 2011-25 I.R.B. 887.

<sup>123</sup> T.D. 9544, 76 Fed. Reg. 160, August 18, 2011.

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. This information is used by the IRS 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<sup>124</sup> 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.

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<sup>124</sup> I.R.B. 2012-51, December 15, 2012.

## **2. Excise tax on certain medical devices<sup>125</sup>**

### **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”).<sup>126</sup> 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<sup>127</sup> 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 CFR 807, pursuant to FDA requirements.

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<sup>125</sup> Section 1405 of HCERA adds section 4191 to the Code.

<sup>126</sup> 21 U.S.C. sec. 321.

<sup>127</sup> T.D. 9604, 77 Fed. Reg. 236, December 7, 2012.

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.

### **3. Study and report of effect on veterans health care<sup>128</sup>**

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<sup>129</sup>**

#### **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.<sup>130</sup> 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

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<sup>128</sup> Section 9011 of PPACA.

<sup>129</sup> Section 10907 of PPACA adds section 5000B to the Code.

<sup>130</sup> T.D. 9486, 75 Fed. Reg. 114, June 15, 2010.

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 tax is reported by the provider 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<sup>131</sup>**

### **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.<sup>132</sup> 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.<sup>133</sup>

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<sup>131</sup> Section 6301(e) PPACA adds sections 4375-4377 and 9511 to the Code.

<sup>132</sup> A specified policy does not include insurance if substantially all of the coverage provided under such policy consists of excepted benefits described in section 9832(c). Examples of excepted benefits described in section 9832(c) are coverage for only accident, or disability insurance, or any combination thereof; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; limited scope dental or vision benefits; benefits for long term care, nursing home care, community based care, or any combination thereof; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; and Medicare supplemental coverage.

<sup>133</sup> For this purpose, a prepaid health coverage arrangement is an arrangement under which fixed payments or premiums are received as consideration for a person’s agreement to provide, or arrange for the provision of,

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,<sup>134</sup> 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

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accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

<sup>134</sup> For this purpose, accident and health coverage means coverage that, if provided by an insurance policy, would cause the policy to be a specified policy. Thus, it includes only coverage for individuals residing in the United States, and the types of coverage excepted from the definition of specified policy are also excepted from the definition of applicable self-insured plan.



methods for determining the average number of lives covered under a policy or plan and the treatment of certain types of employer-provided coverage.<sup>135</sup>

The IRS subsequently issued proposed regulations on the fees on April 17, 2012 and final regulations on December 6, 2012.<sup>136</sup> 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.

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<sup>135</sup> 2011-1 C.B. 879.

<sup>136</sup> REG-136008-11, 77 Fed. Reg. 22691, and T.D. 9602, 77 Fed. Reg. 72721.

## G. Tax-Exempt Organizations

### 1. Additional requirements for charitable hospitals<sup>137</sup>

#### 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,<sup>138</sup> have access to tax-exempt financing through State and local governments (described in more detail below),<sup>139</sup> 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.<sup>140</sup> 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.<sup>141</sup>

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).<sup>142</sup> The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.<sup>143</sup> 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.<sup>144</sup> According to Revenue Ruling 69-545, community benefit can include,

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<sup>137</sup> Section 9007 of PPACA amends sections 501(c) and 6033 of the Code and adds new section 4959 to the Code.

<sup>138</sup> Sec. 170.

<sup>139</sup> Sec. 145.

<sup>140</sup> Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

<sup>141</sup> Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

<sup>142</sup> Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being “charitable” organizations, some might qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

<sup>143</sup> Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

<sup>144</sup> Rev. Rul. 69-545, 1969-2 C.B. 117. From 1956 until 1969, the IRS applied a “financial ability” standard, requiring that a charitable hospital be “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.” Rev. Rul. 56-185, 1956-1 C.B. 202.

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.<sup>145</sup>

### **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

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<sup>145</sup> IRS Form 990, Schedule H.

disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.<sup>146</sup>

#### 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" includes 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.

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<sup>146</sup> Sec. 6652.

## 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).<sup>147</sup> 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,<sup>148</sup> soliciting comments on various aspects of the new requirements for charitable hospitals. On July 25, 2011, the IRS issued Notice 2011-52,<sup>149</sup> 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

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<sup>147</sup> For example, assume the date of enactment is April 1, 2010. A calendar year taxpayer would test whether it meets the community health needs assessment requirement in the taxable year ending December 31, 2013. To avoid the penalty, the taxpayer must have satisfied the community health needs assessment requirements in 2011, 2012, or 2013.

<sup>148</sup> Notice 2010-39, 2010 I.R.B. 24, June 14, 2010.

<sup>149</sup> Notice 2011-52, 2011 I.R.B. 30, July 25, 2011.

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,<sup>150</sup> 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<sup>151</sup>**

### **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

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<sup>150</sup> Announcement 2011-37, 2011 I.R.B. 27, July 5, 2011.

<sup>151</sup> Section 1322 of PPACA adds new section 501(c)(29) to the Code and amends section 6033 of the Code.

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:

1. The organization is organized as a nonprofit, member corporation under State law;
2. 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;
3. None of the organization, a related entity, or a predecessor of either was a health insurance issuer as of July 16, 2009;
4. The organization is not sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision;
5. Governance of the organization is subject to a majority vote of its members;
6. The organization's governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference;
7. 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;
8. 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;
9. 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

10. 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.<sup>152</sup> In December 2011, the Department issued final regulations establishing the CO-OP Program, effective February 13, 2012.<sup>153</sup> 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.<sup>154</sup>

#### Guidance regarding applications for tax-exempt status

In early 2011, the IRS issued Notice 2011-23,<sup>155</sup> describing the requirements for tax exemption under new section 501(c)(29) and stating that the IRS will not accept applications for

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<sup>152</sup> 76 Fed. Reg. 139, pp. 43237-43250, July 20, 2011.

<sup>153</sup> 76 Fed. Reg. 239, pp. 77392-77415, December 13, 2011.

<sup>154</sup> See <http://ccio.cms.gov/Archive/Grants/new-loan-program.html> (last accessed February 19, 2013).



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<sup>156</sup> 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,<sup>157</sup> reduced the total appropriation available for CO-OP loans by \$2.2 billion, to \$3.8 billion.

The American Taxpayer Relief Act of 2012<sup>158</sup> ("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<sup>159</sup>**

#### **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,

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<sup>155</sup> Notice 2011-23, 2011-13 I.R.B. 588, March 11, 2011.

<sup>156</sup> Rev. Proc. 2012-11, 2012-7 I.R.B. 368, February 7, 2012.

<sup>157</sup> Pub. L. No. 112-10, April 15, 2011, sec. 1857.

<sup>158</sup> Pub. L. No. 112-240, January 2, 2013, sec. 644.

<sup>159</sup> Section 1341 of PPACA.

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.<sup>160</sup>

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<sup>160</sup> See <http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs>.

## H. Other Revenue Provisions

### 1. Codification of economic substance doctrine and imposition of penalties<sup>161</sup>

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.<sup>162</sup> However, there had been a lack of uniformity regarding the proper application of the economic substance doctrine.<sup>163</sup> 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.<sup>164</sup> Other courts used a narrower approach to conclude that either a business purpose or economic substance is sufficient to respect the transaction.<sup>165</sup> A third approach had regarded

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<sup>161</sup> Section 1409 of HCERA adds new section 7701(o) to the Code and amends Code sections 6662, 6662A, 6664, and 6676. The provision applies to transactions entered into after March 30, 2010 (the date of enactment) and to underpayments, understatements, and refunds and credits attributable to such transactions. For a more complete description, see Joint Committee on Taxation, General Explanation of Tax Legislation Enacted in the 111<sup>th</sup> Congress (JCS-3-11), March 2011, pp. 369-382.

<sup>162</sup> See, *e.g.*, *ACM Partnership v. Commissioner*, 157 F.3d 231 (3d Cir. 1998), *aff’d* 73 T.C.M. (CCH) 2189 (1997), *cert. denied* 526 U.S. 1017 (1999); *Klamath Strategic Investment Fund, LLC v. United States*, 472 F. Supp. 2d 885 (E.D. Texas 2007), *aff’d* 568 F.3d 537 (5th Cir. 2009); *Coltec Industries, Inc. v. United States*, 454 F.3d 1340 (Fed. Cir. 2006), *vacating and remanding* 62 Fed. Cl. 716 (2004) (slip opinion pp. 123-124, 128); *cert. denied*, 127 S. Ct. 1261 (Mem.) (2007).

Closely related doctrines also applied by the courts (sometimes interchangeable with the economic substance doctrine) include the “sham transaction doctrine” and the “business purpose doctrine.” See, *e.g.*, *Knetsch v. United States*, 364 U.S. 361 (1960) (denying interest deductions on a “sham transaction” that lacked “commercial economic substance”). Certain “substance over form” cases involving tax-indifferent parties, in which courts have found that the substance of the transaction did not comport with the form asserted by the taxpayer, have also involved examination of whether the change in economic position that occurred, if any, was consistent with the form asserted, and whether the claimed business purpose supported the particular tax benefits that were claimed. See, *e.g.*, *TIFD III-E, Inc. v. United States*, 666 F.3d 836 (2012); *BB&T Corporation v. United States*, 2007-1 USTC ¶ 50,130 (M.D.N.C. 2007), *aff’d* 523 F.3d 461 (4th Cir. 2008).

<sup>163</sup> “The casebooks are glutted with [economic substance] tests. Many such tests proliferate because they give the comforting illusion of consistency and precision. They often obscure rather than clarify.” *Collins v. Commissioner*, 857 F.2d 1383, 1386 (9th Cir. 1988).

<sup>164</sup> See, *e.g.*, *Pasternak v. Commissioner*, 990 F.2d 893, 898 (6th Cir. 1993) (“The threshold question is whether the transaction has economic substance. If the answer is yes, the question becomes whether the taxpayer was motivated by profit to participate in the transaction.”). See also, *Klamath Strategic Investment Fund v. United States*, 568 F.3d 537 (5th Cir. 2009) (even if taxpayers may have had a profit motive, a transaction was disregarded where it did not in fact have any realistic possibility of profit and funding was never at risk).

<sup>165</sup> See, *e.g.*, *Rice’s Toyota World v. Commissioner*, 752 F.2d 89, 91-92 (4th Cir. 1985) (“To treat a transaction as a sham, the court must find that the taxpayer was motivated by no business purposes other than obtaining tax benefits in entering the transaction, and, second, that the transaction has no economic substance

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.<sup>166</sup>

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.<sup>167</sup> The notice generally reiterates the statutory language and provides guidance regarding adequate disclosures

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because no reasonable possibility of a profit exists.”); *IES Industries v. United States*, 253 F.3d 350, 358 (8th Cir. 2001) (“In determining whether a transaction is a sham for tax purposes [under the Eighth Circuit test], a transaction will be characterized as a sham if it is not motivated by any economic purpose outside of tax considerations (the business purpose test), and if it is without economic substance because no real potential for profit exists (the economic substance test).”). As noted earlier, the economic substance doctrine and the sham transaction doctrine are similar and sometimes are applied interchangeably. For a more detailed discussion of the sham transaction doctrine, see, e.g., Joint Committee on Taxation, *Study of Present-Law Penalty and Interest Provisions as Required by Section 3801 of the Internal Revenue Service Restructuring and Reform Act of 1998 (including Provisions Relating to Corporate Tax Shelters)* (JCS-3-99), p. 182.

<sup>166</sup> See, e.g., *ACM Partnership v. Commissioner*, 157 F.3d at 247; *James v. Commissioner*, 899 F.2d 905, 908 (10th Cir. 1995); *Sacks v. Commissioner*, 69 F.3d 982, 985 (9th Cir. 1995) (“Instead, the consideration of business purpose and economic substance are simply more precise factors to consider . . . We have repeatedly and carefully noted that this formulation cannot be used as a ‘rigid two-step analysis.’”)

<sup>167</sup> Notice 2010-62, 2010-2 C.B. 411.

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.<sup>168</sup>

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.<sup>169</sup> 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.<sup>170</sup>

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.<sup>171</sup>

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<sup>168</sup> Large and Mid-Size Business Division Directive, LMSB-20-0910-024, September 14, 2010.

<sup>169</sup> Large Business & International Division Directive, LB&I-4-0711-015, July 15, 2011.

<sup>170</sup> Chief Counsel Notice CC-2012-008.

<sup>171</sup> See, *e.g.*, Office of Tax Policy and IRS 2012-2013 Priority Guidance Plan, updated as of December 31, 2012 (released February 5, 2013), Tax Administration item 34.

## **2. Elimination of unintended application of cellulosic biofuel producer credit<sup>172</sup>**

### **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.<sup>173</sup>

### **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.<sup>174</sup>

“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 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

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<sup>172</sup> Section 1408 of HCERA.

<sup>173</sup> Chief Counsel Advice 200941011, June 30, 2009.

<sup>174</sup> In the case of cellulosic biofuel that is alcohol, the \$1.01 credit amount is reduced by the credit amount of the alcohol mixture credit, and for ethanol, the credit amount for small ethanol producers, as in effect at the time the cellulosic biofuel fuel is produced.

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.<sup>175</sup>

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<sup>175</sup> Section 2121 of the Small Business Jobs Act of 2010 (Pub. L. No. 111-240), precluded crude tall oil from qualifying for the cellulosic producer credit for fuels sold or used on or after January 1, 2010. Crude tall oil is generated by reacting acid with black liquor soap. Crude tall oil is used in various applications, such as adhesives, resins and inks. It also can be burned and used as a fuel. Section 2121 excluded cellulosic biofuel with an acid number greater than 25. Crude tall oil generally has an acid number between 100 and 175.

Section 404 of the American Taxpayer Relief Act of 2012 (Pub. L. No. 112-240) made modifications to the cellulosic biofuel producer credit. It renamed the credit the Second Generation Biofuel Producer Credit, extended the termination date an additional year, through December 31, 2013, and the included fuel produced from algae for purposes of the credit.

## **I. Disclosures to Carry Out the Reduction of Medicare Part D Subsidies for High Income Beneficiaries<sup>176</sup>**

### **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.<sup>177</sup>

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.<sup>178</sup> 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.<sup>179</sup> An action for civil damages also may be brought for unauthorized disclosure or inspection.<sup>180</sup>

### **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:

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<sup>176</sup> Sec. 3308(b)(2) adds section 6103(l)(20) to the Code.

<sup>177</sup> Pursuant to section 1839(i) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (42 U.S.C. 1395r), The Social Security Administration is to determine whether a Medicare Part B enrollee would pay a larger percentage of the Part B premium than an individual with income below the applicable threshold. Section 6103(l)(20) of Code authorizes the IRS to disclose return information with respect to Modified Adjusted Gross Income (“MAGI”) to the Social Security Administration for the purpose of adjusting the usual Part B premium subsidy for Medicare beneficiaries with MAGI above the applicable threshold.

<sup>178</sup> Sec. 7213.

<sup>179</sup> Sec. 7213A.

<sup>180</sup> Sec. 7431.



- 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.

This return information may be used by officers, employees, and contractors of the Social Security Administration 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 redisclose 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 redisclosure 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 redisclose 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.<sup>181</sup>

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<sup>181</sup> Computer Matching Program (SSA/Department of the Treasury, Internal Revenue Service (IRS))—Match Number 1310, 78 FR 12127-03 (Feb. 21, 2013) (concerning Medicare Part B and D); 72 FR 6309-01 (Feb. 9, 2007) (concerning Medicare Part B), and 71 FR 48963-02 (Aug. 22, 2006) (concerning Medicare Part B).

## II. PROVISIONS BECOMING EFFECTIVE IN 2014

### A. ACA Changes to Health Coverage Effective 2014

#### Requirements<sup>182</sup>

As discussed in Part I.A, group health plans (i.e., plans providing employment-related health benefits) are subject to various requirements under the Code, ERISA and the PHSA.<sup>183</sup>

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;<sup>184</sup>
- 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;<sup>185</sup>
- 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 Part I.A, 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.<sup>186</sup>

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<sup>182</sup> Secs. 1201 and 1255 of PPACA, as amended by section 10103 of PPACA. The specifics of the new requirements are contained in the PHSA and apply under the Code by cross-reference in Code section 9815 and under ERISA by cross-reference in ERISA section 715.

<sup>183</sup> The Code requirements are enforced through an excise tax under section 4980D.

<sup>184</sup> Under section 1255(2) of PPACA, the prohibition on preexisting condition exclusions applies for children under age 19 for plan years beginning on or after September 23, 2010.

<sup>185</sup> These requirements apply to individual insurance and insurance offered in the small group market, which, under section 1304(a)(3) and (b)(2) of PPACA generally means insurance for a group health plan of an employer with an average of at least one but not more than 100 employees.

## **B. Premium Assistance Credit and Reduced Cost-Sharing for Individuals Enrolled in Qualified Health Plans**

### **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.<sup>187</sup> 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”).<sup>188</sup> 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”).<sup>189</sup>

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”).<sup>190</sup>

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).<sup>191</sup> 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

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<sup>186</sup> This guidance and additional information is available via the agency websites, such as <http://www.irs.gov/uac/Legal-Guidance-for-Group-Health-Plan-Requirements>, <http://cciio.cms.gov/programs/marketreforms/index.html>, and <http://www.dol.gov/ebsa/healthreform/>.

<sup>187</sup> Under section 1312(f)(3) of PPACA, an individual who is not a citizen or national of the United States or an alien lawfully present in the United States is not eligible to enroll in individual coverage through an American Health Benefit Exchange. Under 1312(a)(2) and (f)(2) of PPACA, small employers can offer health insurance coverage to their employees through an American Health Benefit Exchange, and, beginning 2017, States may allow coverage for employees of large employers to be offered.

<sup>188</sup> Secs. 1311(b) and 1321(b) of PPACA and 45 CFR §§ 155.100ff; sec. 1311(f)(1) and (2) of PPACA and 45 CFR sec. 155.140.

<sup>189</sup> Section 1321(c) of PPACA and 45 CFR § 155.105(f). HHS guidance also provides the option of a State Partnership Exchange, a variation of a Federally-facilitated Exchange under which a State would handle certain Exchange functions, such as reviewing and approving qualified health plans. See, for example, the CCIIO memo dated January 3, 2013, Subject: Guidance on the State Partnership Exchange, available at <http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf>.

<sup>190</sup> Sections 1301 and 1302 of PPACA.

<sup>191</sup> Sections 1411-1412 of PPACA. HHS regulations dealing with this process are at 45 CFR Part 155, available at <http://cciio.cms.gov/programs/exchanges/index.html>.

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).<sup>192</sup>

## **2. Premium assistance credit<sup>193</sup>**

### **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.<sup>194</sup>

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.<sup>195</sup> 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).<sup>196</sup> To be eligible for the premium assistance credit, taxpayers who are married (within the meaning of section

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<sup>192</sup> As discussed in Part II.D, if a full-time employee is approved for a premium assistance credit or reduced cost-sharing, the employer may be liable for an assessable payment under section 4980H. Under PPACA sections 1411(e)(4)(B)(ii) and (C) and (f)(2), an employer must be notified if one of its employees is determined to be eligible for a premium assistance credit or reduced cost-sharing and be provided with an appeals process.

<sup>193</sup> Section 1401 of PPACA (as amended by section 10105 of PPACA and sections 1001 and 1004 of HCERA) adds section 36B to the Code.

<sup>194</sup> Although the credit is generally payable in advance directly to the insurer, individuals may choose to pay the total health insurance premiums out-of-pocket and claim the credit at the end of the taxable year.

<sup>195</sup> Individuals who are lawfully present in the United States but are not eligible for Medicaid because of their immigration status are treated as having a household income equal to 100 percent of FPL (and thus eligible for the premium assistance credit) as long as their household income does not actually exceed 100 percent of FPL.

<sup>196</sup> Section 36B(d)(2)(B), as amended by section 401 of Pub. L. No. 112-56. The definition of modified adjusted gross income used in section 36B is incorporated by reference for purposes of determining eligibility to participate in certain other healthcare-related programs, such as reduced cost-sharing (discussed below), Medicaid for the nonelderly (section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) as modified by section 2002(a) of PPACA) and the Children’s Health Insurance Program (section 2102(b)(1)(B) of the Social Security Act (42 U.S.C. 1397bb(b)(1)(B)) as modified by section 2101(d) of PPACA).

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 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 1.—The Premium Assistance Credit Phase-Out**

<i>Household income (expressed as a percent of FPL)</i>	<i>Initial premium (percentage)</i>	<i>Final premium (percentage)</i>
100% up to 133%	2.0	2.0
133% up to 150%	3.0	4.0
150% up to 200%	4.0	6.3
200% up to 250%	6.3	8.05
250% up to 300%	8.05	9.5
300% up to 400%	9.5	9.5

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<sup>197</sup> 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<sup>198</sup> 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.<sup>199</sup> 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 2 below (one-half of the

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<sup>197</sup> Under section 1302(d) of PPACA, a qualified health plan is categorized by level (bronze, silver, gold or platinum), depending on its actuarial value, that is the percentage of the plan’s share of the total costs of benefits under the plan. A silver level plan must have an actuarial value of 70 percent.

<sup>198</sup> As defined in section 5000A(f).

<sup>199</sup> Sec. 36B(f)(3). Alternatively, another person carrying out responsibilities of an American Health Benefit Exchange under section 1131(f)(3) (or 1321(c) of PPACA) is required to report this information.

applicable dollar amount shown in Table 2 for unmarried individuals who are not surviving spouses or filing as heads of households).<sup>200</sup>

**Table 2.—Reconciliation**

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

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.<sup>201</sup> 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;

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<sup>200</sup> Section 36B(f)(2), as amended by section 208 of the Medicare and Medicaid Extenders Act of 2010, Pub. L. No. 111-309, and section 4 of the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, Pub. L. No. 112-9.

<sup>201</sup> REG-131491-10, 76 Fed.Reg. 50931; T.D. 9590, 77 Fed. Reg. 30377; and T.D. TD 9611, 77 Fed. Reg. 30377.



- 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;<sup>202</sup>
- 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

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<sup>202</sup> 45 CFR sec. 155.20.

an employee or family member who is eligible for the coverage may nonetheless be eligible for a premium assistance credit.<sup>203</sup> 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.<sup>204</sup> 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<sup>205</sup>**

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.<sup>206</sup> Individuals with household incomes between 100 and 400 percent 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.<sup>207</sup> 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.<sup>208</sup>

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<sup>203</sup> 2012-1 C.B. 906.

<sup>204</sup> 45 CFR sec. 156.145.

<sup>205</sup> Sections 1402 and 1411-1412 of PPACA, as amended by section 1001 of HCERA.

<sup>206</sup> Under section 1302(c)(1) of PPACA, an individual's or family's cost-sharing cannot be more than the limit on deductibles and out-of-pocket costs under a high deductible health plan as defined in Code section 223(c)(2)(A)(ii), currently \$6,250 for self-only coverage or \$12,500 for family coverage.

<sup>207</sup> Eligibility for reduced cost-sharing is determined using the information used to determine eligibility for an advance premium assistance credit.

<sup>208</sup> Under a silver plan, the plan's share of total costs is 70 percent, so this limit is already reached.

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.<sup>209</sup>

## **4. Disclosures to carry out eligibility requirements for certain programs<sup>210</sup>**

### **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.<sup>211</sup> 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.<sup>212</sup> An action for civil damages also may be brought for unauthorized disclosure or inspection.<sup>213</sup>

### **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”).<sup>214</sup>

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<sup>209</sup> Provisions relating to reduced cost-sharing are included in HHS regulations dealing with American Health Benefit Exchanges at 45 CFR Part 155.

<sup>210</sup> Section 1414 of PPACA (as amended by section 1004 of HCERA) adds section 6103(l)(21) to the Code.

<sup>211</sup> Sec. 7213.

<sup>212</sup> Sec. 7213A.

<sup>213</sup> Sec. 7431.

<sup>214</sup> For a more detailed explanation of the cost-sharing reduction and the premium tax credit, see II.B.1. and 2 of this pamphlet.

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 dependants 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.<sup>215</sup>

The Department of the Treasury published proposed regulations regarding this disclosure authority on April 30, 2012.<sup>216</sup> The proposed regulations note that in some situations, the IRS

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<sup>215</sup> 77 Fed. Reg. 18310, March 27, 2012.

<sup>216</sup> REG-119632-11, 77 Fed. Reg. 25378, April 30, 2012.

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.

## C. Requirement to Maintain Minimum Essential Coverage

### 1. Tax on individuals without minimum essential coverage<sup>217</sup>

#### 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<sup>218</sup> for failure to maintain the coverage. If an individual is a dependent<sup>219</sup> 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<sup>220</sup> and bona fide residents of possessions of the United States<sup>221</sup> 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,<sup>222</sup> veterans health care,<sup>223</sup> and health care for Peace Corps volunteers.<sup>224</sup> Eligible employer-sponsored plans include: governmental plans,<sup>225</sup> church plans,<sup>226</sup> grandfathered plans

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<sup>217</sup> Section 1501 of the PPACA, as amended by section 10106 of PPACA and 1002 of HCERA, added section 5000A to the Code.

<sup>218</sup> In *National Federation of Independent Business v. Sebelius*, 567 132 S. Ct. 2566, 2599 (2012), the Supreme Court upheld the constitutionality of section 5000A, which requires individuals to maintain minimum essential coverage or make a payment labeled as a penalty. The court concluded that the penalty may be reasonably characterized as a tax and that the Constitution permits such a tax.

<sup>219</sup> Sec. 152.

<sup>220</sup> This rule applies to any month that occurs during a period described in section 911(d)(1)(A) or (B) which is applicable to the individual.

<sup>221</sup> Bona fide residence in a possession is determined under section 937(a).

<sup>222</sup> 10 U.S.C. sec. 55 and 38 U.S.C. sec. 1781.

<sup>223</sup> Section 5000A is amended by Pub. L. No. 111-173 to clarify that minimum essential coverage includes any health care program under section 17 or 18 of Title 38 of the United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of HHS and the Secretary of Treasury.

<sup>224</sup> 22 U.S.C. sec. 2504(e).

<sup>225</sup> ERISA sec. 3(32).

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.<sup>227</sup> 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.<sup>228</sup>

### **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.<sup>229</sup> 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.<sup>230</sup>

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.<sup>231</sup>

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<sup>226</sup> ERISA sec. 3(33).

<sup>227</sup> 42 U.S.C. sec. 300gg-91(c)(1). Excepted benefits also include: (1) coverage only for accident, or disability income insurance; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers' compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

<sup>228</sup> 42 U.S.C. sec. 300gg-91(c)(2-4).

<sup>229</sup> Section 6012(a)(1). Generally, for 2013, the filing threshold is \$10,000 for a single individual under age 65 and is \$20,000 for married filing jointly (both spouses under age 65). See Rev. Proc. 2013-15, 2013-5 I.R.B. 444, January 11, 2013.

<sup>230</sup> See section 1302(d)(1)(A) for the definition of bronze level plan, as generally a plan designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

<sup>231</sup> Sec. 911.

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.<sup>232</sup> 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.<sup>233</sup> 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 a religious exemption. To qualify for a religious exemption, the individual must be a member of a recognized religious sect exempting them from self-employment taxes<sup>234</sup> 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<sup>235</sup> 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.<sup>236</sup>

#### 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

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<sup>232</sup> IRS authority to assess and collect taxes and to enforce the Code is generally provided in subtitle F, "Procedure and Administration" in the Code.

<sup>233</sup> The rules explaining when a statutory notice of deficiency is required, and assessment is thus restricted, are generally found in section 6213.

<sup>234</sup> Sec. 1402(g)(1).

<sup>235</sup> Tribal membership is defined in section 45A(c)(6).

<sup>236</sup> Sec. 1311(d)(4)(H) of PPACA.



income for the year.<sup>237</sup> 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.<sup>238</sup> 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<sup>239</sup> 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

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<sup>237</sup> In the case of an individual participating in a salary reduction arrangement, the taxpayer's household income is increased by any exclusion from gross income for any portion of the required contribution to the premium. The required contribution to the premium is the individual contribution to coverage through an employer or in the purchase of a bronze plan through the Exchange.

<sup>238</sup> REG-148500-12, 22 Fed. Reg. 7314.

<sup>239</sup> The proposed regulations label the tax under section 5000A for failure to maintain minimum essential coverage as a "shared responsibility payment."

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<sup>240</sup>**

### **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.

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<sup>240</sup> Section 1502 of the PPACA adds section 6055 to the Code.

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<sup>241</sup> 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.

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<sup>241</sup> 2012-1 C.B. 910.

## **D. Provisions Related to Employer Responsibility to Provide Health Coverage**

### **1. Shared responsibility for employers<sup>242</sup>**

#### **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<sup>243</sup> or a cost-sharing reduction<sup>244</sup> for health insurance.<sup>245</sup> 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.<sup>246</sup> 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.<sup>247</sup> In counting the number of employees for purposes of determining whether an employer is an applicable large employer, a full-time

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<sup>242</sup> Section 1513 of PPACA, as amended by 10106 of PPACA and section 1003 of HCERA, adds section 4980H to the Code.

<sup>243</sup> Sec. 36B.

<sup>244</sup> Sec. 1402 of the ACA.

<sup>245</sup> Liability is only based on one or more full-time employees receiving a premium assistance credit or cost-sharing reduction, not on individuals related to employees, such as an employee's spouse or children.

<sup>246</sup> For purposes of the provision, "employer" includes any predecessor employer. Further, the determination of whether an employer that was not in existence during the preceding calendar year is an applicable large employer is made based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year.

<sup>247</sup> A seasonal worker is a worker who performs labor or services on a seasonal basis (as defined by the Secretary of Labor), including retail workers employed exclusively during the holiday season and workers whose employment is, ordinarily, the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year 29 C.F.R. section 500.20(s)(1). Under section 5000.20(s)(1), a worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year.

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.<sup>248</sup> 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.

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<sup>248</sup> Sec. 1411(e)(4)(B)(ii) and (C) of PPACA.

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.<sup>249</sup> 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<sup>250</sup>

#### Hours of service

The proposed regulation 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

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<sup>249</sup> REG-138006-12, 78 Fed. Reg. 218, January 2, 2013.

<sup>250</sup> Section 4980H(d)(4)(B) directs the Secretary, in consultation with the Secretary of Labor, to issue, as necessary, rules, regulations and guidance to determine an employee's hours of service, including rules that apply to employees who are not compensated on an hourly basis.



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).<sup>251</sup> 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

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<sup>251</sup> Generally, under the proposed regulations, the measurement period and stability period selected by the applicable large employer member must be uniform for all employees. However, the applicable large employer member may apply different periods for the following categories of employees: (1) each group of collectively bargained employees covered by a separate collective bargaining agreement, (2) collectively bargained and noncollectively bargained employees, (3) salaried employees and hourly employees, and (4) employees whose primary places of employment are in different states.

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.<sup>252</sup> 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<sup>253</sup>**

### **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

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<sup>252</sup> Under § 36B(c)(2)(C)(ii), a plan fails to provide minimum value if the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

<sup>253</sup> Section 1514 of the PPACA adds section 6056 to the Code, and amends section 6724.

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<sup>254</sup> or reports required by persons providing minimum essential coverage with respect to individuals covered.<sup>255</sup> 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,<sup>256</sup> 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

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<sup>254</sup> See Part I.C.2. for additional information on this reporting requirement.

<sup>255</sup> See Part II.C.2. for additional information on this reporting requirement.

<sup>256</sup> 2012-1 C.B. 92.

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<sup>257</sup>**

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.<sup>258</sup> 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.

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<sup>257</sup> Section 1515 of the PPACA amends section 125(f) of the Code.

<sup>258</sup> Sec. 1312(f)(2) of PPACA. Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in a state to offer qualified plans in the large group market. In that event, a qualified employer includes an employer that elects to make all its full-time employees eligible for one or more qualified plans offered in the large group market through an American Health Benefit Exchange.

## E. Imposition of Annual Fee on Health Insurance Providers<sup>259</sup>

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).<sup>260</sup>

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 than \$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.

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<sup>259</sup> Section 9010 of PPACA, as amended by section 10905 of PPACA and section 1406 of HCERA.

<sup>260</sup> See *Helvering v. Le Gierse*, 312 U.S. 531 (1941).

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<sup>261</sup> of a health insurance organization that is exempt from Federal income tax<sup>262</sup> 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 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

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<sup>261</sup> The exempt activities for this purpose are activities other than activities of an unrelated trade or business defined in section 513.

<sup>262</sup> Section 501(m) of the Code provides that an organization described in section 501(c)(3) or (4) is exempt from Federal income tax only if no substantial part of its activities consists of providing commercial-type insurance. Thus, an organization otherwise described in section 501(c)(3) or (4) that is taxable (under the Federal income tax rules) by reason of section 501(m) is not eligible for the 50-percent exclusion under the insurance fee.

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.<sup>263</sup> 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.

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<sup>263</sup> REG-118315-12, Health Insurance Providers Fee, 78 Fed. Reg. 14034, March 4, 2013, available at <http://www.irs.gov/PUP/newsroom/REG-118315-12.pdf>.



### III. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE<sup>264</sup>

#### In general

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).<sup>265</sup>

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.<sup>266</sup>

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.<sup>267</sup>

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<sup>264</sup> Section 9001 of PPACA (as amended by section 10901 of PPACA and section 1401 of HCERA) adds section 4980I to the Code.

<sup>265</sup> Under section 4980I, the 2018 threshold amounts are increased by \$1,650 for self-only coverage or \$3,450 for other coverage in the case of certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines.

<sup>266</sup> For 2019, the 2018 threshold amounts (after application of the health cost adjustment percentage), and the increases for certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines, are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”), plus one percentage point, rounded to the nearest \$50. For 2020 and thereafter, the threshold amounts are indexed to CPI-U, rounded to the nearest \$50.

<sup>267</sup> Sec. 275(a)(6), referring to taxes imposed by chapter 43.

## **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.<sup>268</sup> 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.<sup>269</sup>

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.<sup>270</sup> 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,<sup>271</sup> 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.

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<sup>268</sup> Section 106 provides an exclusion for employer-provided coverage.

<sup>269</sup> Section 162(l) allows a deduction to a self-employed individual for the cost of health insurance.

<sup>270</sup> Excepted benefits for this purpose include (whether through insurance or otherwise) coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; and other similar insurance coverage (as specified in regulations), under which benefits for medical care are secondary or incidental to other insurance benefits.

<sup>271</sup> Sec. 4980B(f)(4).

## **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.<sup>272</sup>

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.<sup>273</sup>

## **Implementation**

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

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<sup>272</sup> As defined in section 414(f), a multiemployer plan is generally a plan to which more than one employer is required to contribute and that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

<sup>273</sup> The employer or multiemployer plan sponsor may be liable for a penalty if the total excise tax due exceeds the tax on the excess benefit calculated and allocated among coverage providers by the employer or plan sponsor.