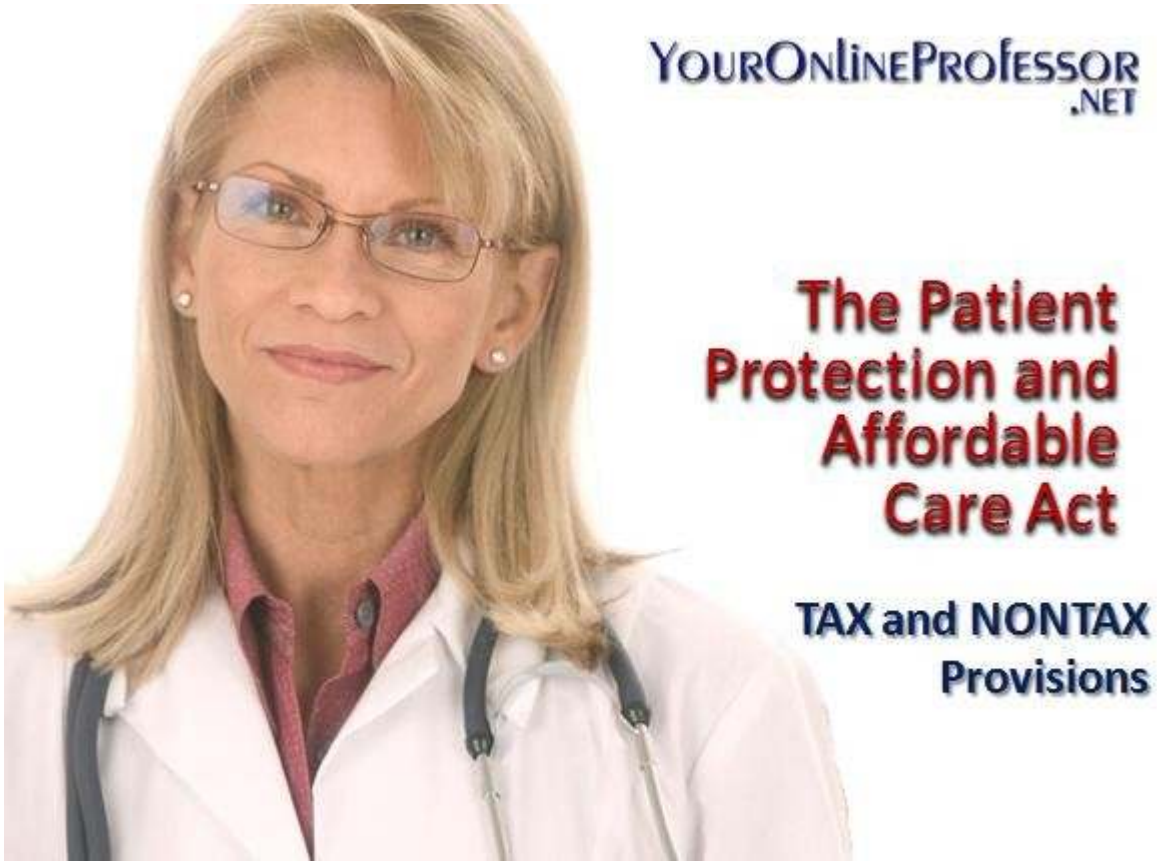
YourOnlineProfessor.net Presents...
A Course by Ted Perkins
JD, LLM, CPA



CPE CREDIT - 2.0 Hours
FIELD OF STUDY - Taxation - Interactive Self Study
PA / NJ CLE WEBCAST CREDIT - 2.0 Hours
PROGRAM LEVEL - Basic
PREREQUISITE - None
ADVANCE PREPARATION REQUIRED - None

YourOnlineProfessor.net
Keep Growing & Learning

PART I – Overview of Health Care Reform

I. Overview

A. Supreme Court Upholds the Constitutionality of the Health Care Law Reform

1. On June 28, 2012, the U. S. Supreme Court upheld the constitutionality of the 2010 health care reform legislation, including the "individual mandate" that requires individuals to pay a penalty if they fail to carry minimum essential health insurance (*National Federation of Independent Business, et al. v. Sebelius, SCt, 2012-2 USTC ¶50,423)*.

2. The Court, also held that the means used to require states to expand Medicaid eligibility was unconstitutional

3. By its decision, the Supreme Court removed the last major hurtle to the enactment and implementation of the Patient Protection and Affordable Care Act (the "PPACA") and the Health Care and Education Reconciliation Act (the "HCERA").

B. The Individual Mandate.

A major piece of the PPACA is the so-called "individual mandate". Under the individual mandate:

1. For tax years ending after Dec. 31, 2013, non-exempt U.S. citizens and legal residents will have to maintain minimum essential health insurance coverage or pay a penalty (the "shared responsibility payment").

2. "Minimum essential coverage" includes: (i) government sponsored programs (e.g., Medicare, Medicaid, Children's Health Insurance Program), (ii) eligible employer-sponsored plans, (iii) plans in the individual market, (iv) certain grandfathered group health plans, and (iv) other coverage as recognized by Health and Human Services (HHS) in coordination with IRS. See IRC Code Sec. 5000A.

C. Other PPACA Tax Provisions.

In addition to the individual mandate, PPACA also includes other far reaching provisions:

- For tax years beginning after Dec. 31, 2012, an additional 0.9% hospital insurance (HI) tax for high wage workers. (Code Sec. 1401(b)(2))

- For tax years beginning after Dec. 31, 2012, a 3.8% surtax on "net investment income" of higher-income taxpayers. (Code Sec. 911(a)(1))

- A so-called *"premium assistance credit"* as provided in Code Sec. 36B.

- For tax years beginning after Dec. 31, 2009, a small employer health insurance credit a provided under Code Sec. 45R.

- A rising of the qualification age for child as a dependent for employer-provided and other health coverage exclusions under Code Sec. 106 and Code Sec. 105(b) to 27.

- For tax years beginning after Dec. 31, 2013, a reimbursement (or direct payment) for the premiums for coverage under any "qualified health plan" through a health insurance

Exchange is a qualified benefit under a cafeteria plan if the employer is a qualified employer. (Code Sec. 125(f)(3)(B)).

- For months beginning after Dec. 31, 2013, a large employer that doesn't provide health care coverage for its full-time employees, offers minimum essential coverage that is unaffordable, or only offers minimum essential coverage o must pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee. (Code Sec. 4980H).

- For tax years beginning after Dec. 31, 2017, a 40% nondeductible excise tax will be levied on insurance companies and plan administrators for any health coverage plan to the extent that the annual premium exceeds $10,200 for single coverage and $27,500 for family coverage. An additional threshold amount of $1,650 for single coverage and $3,450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. (Code Sec. 4980I).

D. Non - Tax Provisions of the PPACA

The PPACA contains numerous non—tax provisions that will dramatically impact health care in the United States. Those provisions include the following:

1. The *PPACA* includes immediate changes to the way health insurance companies do business to protect consumers from discriminatory practices and provide Americans with better preventive coverage and the information they need to make informed decisions about their health insurance.

2. Uninsured Americans with a pre-existing condition will have access to an immediate insurance program to help them avoid medical bankruptcy and retirees will have greater certainty due to reinsurance provisions to help maintain coverage.

3. New health insurance Exchanges will make coverage affordable and accessible for individuals and small businesses.

4. Insurance companies will be barred from discriminating based on pre-existing conditions, health status, and gender.

5. A substantial investment in Community Health Centers will provide funding to expand access to health care in communities where it is needed most.

6. The *PPACA* expands eligibility for Medicaid to include all non-elderly Americans with income below 133 percent of the Federal Poverty Level (FPL), with substantial assistance to States for the cost of covering these individuals.

7. The *PPACA* maintains current funding levels for the Children's Health Insurance Program (CHIP) for an additional two years, through fiscal year 2015.

8. The *PPACA* promotes preventive health care and improves the public health to help Americans live healthy lives and help restrain the growth of health care costs over time.

9. The *PPACA* will eliminate co-pays and deductibles for recommended preventive care, including preventive care for women, provide individuals with the information they need to make healthy decisions, improve education on disease prevention and public health, and invest in a national prevention and public health strategy.

10. The *PPACA* will address shortages in primary care and other areas of practice by making necessary investments in our nation's health care workforce.

11. The *PPACA* will provide consumers with information about physician ownership of hospitals and medical equipment as well as nursing home ownership and other characteristics.

12. The *PPACA* will establish a regulatory pathway for FDA approval of biosimilar versions of previously licensed biological products.

13. The *PPACA* will also expand the scope of the existing 340B drug discount program, so that patients at children's hospitals, cancer hospitals, rural hospitals and in other underserved communities have access to medicines at lower cost.

14. The *PPACA* will make long-term supports and services more affordable for millions of Americans by providing a lifetime cash benefit that will help people with severe disabilities remain in their homes and communities. CLASS is a voluntary, self-funded, insurance program provided through the workplace.

II. Supreme Court Decision

A. Supreme Court Upholds Mandate.

1. In March of 2012, the Supreme Court heard three days of oral arguments n whether the Anti-Injunction Act applies, whether the individual mandate is a proper exercise of Congress' taxing power or its power under the Constitution's Commerce or Necessary and Proper Clauses; and whether the PPACA's expansion of Medicaid exceeds the government's spending authority.

3. The Court also heard arguments on the viability of the PPACA without the individual mandate.

4. On June 28, 2012, the Supreme Court by a 5-4 vote upheld the individual mandate on the ground that it reflects a constitutional exercise of Congress's taxing power.

5. In so holding, the majority determined that although not necessarily the most intuitive reading of the statute, the mandate could be interpreted as "*a tax hike on certain taxpayers who do not have health insurance.*"

6. Among the reasons advanced by the Court for its interpretation of the mandate as a tax were: (i) it is paid into the Treasury by taxpayers when they file their tax returns; (ii) it doesn't apply to individuals who don't pay federal income taxes because their household income doesn't

meet the filing threshold; and (iii) the amount of the payment, for those who owe it, is determined by factors such as taxable income, number of dependents, and filing status. (Code Sec. 5000A)

7. Although PPACA describes the payment as a penalty, not a tax, this label wasn't dispositive for purposes of the Court's constitutional analysis.

B. The Majority Opinion

1. Writing for the majority, Chief Justice John Roberts said that the government's reading of the statute - that it imposes a tax on individuals without insurance - is a reasonable one. *"Under the mandate, if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS…"*

2. The Chief Justice continued, "our precedent demonstrates that Congress had the power to impose the exaction in Section 5000A under the taxing power, and that Section 5000A need not be read to do more than impose a tax. That is sufficient to sustain it." Chief Justice Roberts was joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan in upholding the law under Congress' power to tax.

3. The majority acknowledged that Congress did not label Code Sec. 5000A as a tax but held that labels do not control.

a. The majority used the following example: "Suppose Congress enacted a statute providing that every taxpayer who owns a house without energy efficient windows must pay $50 to the IRS.

b. The amount due is adjusted based on factors such as taxable income and joint filing status, and is paid along with the taxpayer's income tax return. Those whose income is below the filing threshold need not pay. The required payment is not called a 'tax,' a 'penalty,' or anything else.

c. No one would doubt that this law imposed a tax, and was within Congress's power to tax. That conclusion should not change simply because Congress used the word 'penalty' to describe the payment."

4. In addressing the unconstitutionality of denying Medicaid funding to states that refuse to implement PPACA's Medicaid expansion, the majority found: "*Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding."* Since an estimated 17 million currently uninsured individuals would benefit from the Medicaid expansion, the impact that this part of the Court's decision will have on PPACA's overall goals remains to be seen.

C. The Dissent

1. In their dissent, Justices Scalia, Kennedy, Thomas, and Alito said, *"We have never held that any exaction imposed for violation of the law is an exercise of Congress' taxing power—even when the statute calls it a tax, much less when (as here) the statute repeatedly calls it a penalty."*

2. The dissent noted that "eighteen times in Section 5000A itself and elsewhere throughout the Act, Congress called the exaction in Section 5000A(b) a 'penalty.'"

3. The dissent would have struck down the entire law.

D. Unsettled Issues

1. Although the individual mandate and its associated penalty have been upheld by the Supreme Court as a valid exercise of Congress's taxing power, there still remain several lingering uncertainties about the PPACA(the "Act") and its implementation. For example, IRS is largely responsible for enforcing the mandate via collection of the penalty, but its traditional collection powers have been curtailed.

2. Several PPACA cases remain outstanding and need to be resolved.

   a. A case pending in the Fifth Circuit Court of Appeals, *Physician Hospitals v. Sebelius*, challenges the constitutionality of PPACA Section 6001, which imposes restrictions on physician-owned hospitals.

   b. Another case, *Coons v. Geithner*, currently pending in the district court of Arizona, raises several other issues, including the constitutionality of the Independent Payment Advisory Board, which PPACA created to find savings in Medicare.

3. As a result of the Supreme Court's decision, the core of the PPACA remains intact, and other challenges to the law based on those same grounds will not continue. However, other issues are still playing out, and one of them may provide the vehicle for invalidating significant PPACA provisions that are not related to the individual mandate or the Medicaid expansion.

PART II – Non-Tax Changes Relating to Universal Health Coverage Mandate

I. Overview

A. Introduction.

1. The *Patient Protection and Affordable Care Act* will ensure that all Americans have access to quality, affordable health care and will create the transformation within the health care system necessary to contain costs.

2. The Congressional Budget Office (CBO) has determined that the *Patient Protection and Affordable Care Act* is fully paid for, ensures that more than 94 percent of Americans have health insurance, bends the health care cost curve, and reduces the deficit by $118 billion over the next ten years and even more in the following decade.

B. Quality, Affordable Health Care for All Americans

1. The *Patient Protection and Affordable Care Act* includes immediate changes to the way health insurance companies do business to protect consumers from discriminatory practices and provide Americans with better preventive coverage and the information they need to make informed decisions about their health insurance.

2. Uninsured Americans with a pre-existing condition will have access to an immediate insurance program to help them avoid medical bankruptcy and retirees will have greater certainty due to reinsurance provisions to help maintain coverage.

3. New health insurance Exchanges will make coverage affordable and accessible for individuals and small businesses.

4. Premium tax credits and cost-sharing assistance will help those who need assistance.

5. Insurance companies will be barred from discriminating based on pre-existing conditions, health status, and gender.

6. A substantial investment in Community Health Centers will provide funding to expand access to health care in communities where it is needed most.

C. The Role of Public Programs

1. The *Patient Protection and Affordable Care Act* expands eligibility for Medicaid to include all non-elderly Americans with income below 133 percent of the Federal Poverty Level (FPL), with substantial assistance to States for the cost of covering these individuals.

2. The *Patient Protection and Affordable Care Act* maintains current funding levels for the Children's Health Insurance Program (CHIP) for an additional two years, through fiscal year 2015.

D. Improving the Quality and Efficiency of Health Care

1. The *Patient Protection and Affordable Care Act* will make Medicare a stronger, more sustainable program.

2. Medicare currently reimburses health care providers on the basis of the volume of care they provide rather than the value of care.

3. For each test, scan or procedure conducted, Medicare provides a separate payment, rewarding those who do more, regardless of whether the test or treatment contributes to helping a patient recover.

4. The *Patient Protection and Affordable Care Act* includes a number of proposals to move away from the "a la carte" Medicare fee-for-service system toward paying for quality and value and reducing costs to America's seniors.

E. Preventing Chronic Disease and Improving Public Health

1. The *Patient Protection and Affordable Care Act* promotes preventive health care and improves the public health to help Americans live healthy lives and help restrain the growth of health care costs over time.

2. The *Patient Protection and Affordable Care Act* will eliminate co-pays and deductibles for recommended preventive care, including preventive care for women, provide individuals with the information they need to make healthy decisions, improve education on disease prevention and public health, and invest in a national prevention and public health strategy.

F. Health Care Workforce

1. Currently, 65 million Americans live in communities where they cannot easily access a primary care provider, and an additional 16,500 practitioners are required to meet their needs.

2. The *Patient Protection and Affordable Care Act* will address shortages in primary care and other areas of practice by making necessary investments in our nation's health care workforce.

3. Specifically, the *Patient Protection and Affordable Care Act* will invest in the National Health Service Corps, scholarship and loan repayment programs to expand the health care workforce.

4. The bill also includes incentives for primary care practitioners and for providers to serve underserved areas.

G. Transparency and Program Integrity

1. The *Patient Protection and Affordable Care Act* will provide consumers with information about physician ownership of hospitals and medical equipment as well as nursing home ownership and other characteristics.

2. The bill also includes provisions that will crack down on waste, fraud, and abuse in Medicare, Medicaid, CHIP and private insurance.

3. Finally, the *Patient Protection and Affordable Care Act* will establish a private, non-profit entity to identify priorities for and provide for the conduct of comparative outcomes research.

H. Improving Access to Innovative Medical Therapies

1. The *Patient Protection and Affordable Care Act* will establish a regulatory pathway for FDA approval of biosimilar versions of previously licensed biological products.

2. The Patient Protection and Affordable Care Act will also expand the scope of the existing 340B drug discount program, so that patients at children's hospitals, cancer hospitals, rural hospitals and in other underserved communities have access to medicines at lower cost.

I. Community Living Assistance Services and Supports (CLASS)

1. The *Patient Protection and Affordable Care Act* will make long-term supports and services more affordable for millions of Americans by providing lifetime cash benefit that will help people with severe disabilities remain in their homes and communities. CLASS is a voluntary, self-funded, insurance program provided through the workplace.

2. For those whose employers participate, affordable premiums will be paid through payroll deductions. Participation by workers is entirely voluntary.

3. The Congressional Budget Office confirms that the program, which has been revised from earlier versions, is actuarially sound.

II. Quality, Affordable Health Care for All Americans

A. Overview.

1. The *Patient Protection and Affordable Care Act* will attempt to accomplish a fundamental transformation of health insurance in the United States through shared responsibility.

2. Systemic insurance market reform is aimed at eliminating discriminatory practices by health insurers such as pre-existing condition exclusions.

3. The stated objective of the Act is to achieve reform without increasing health insurance premiums will mean that all Americans must have coverage.

4. Tax credits for individuals, families, and small businesses are enacted to reduce the cost of health insurance.

B. Immediate Improvements.

1. Implementing health insurance reform will take some time. However, many immediate reforms will take effect in 2010.

2. The *Patient Protection and Affordable Care Act* will:

a. Eliminate lifetime and unreasonable annual limits on benefits, with annual limits prohibited in 2014

b. Prohibit rescissions of health insurance policies

c. Provide assistance for those who are uninsured because of a pre-existing condition

d. Prohibit pre-existing condition exclusions for children

e. Require coverage of preventive services and immunizations

f. Extend dependent coverage up to age 26

g. Develop uniform coverage documents so consumers can make apples-to-apples comparisons when shopping for health insurance

h. Cap insurance company non-medical, administrative expenditures

i. Ensure consumers have access to an effective appeals process and provide consumer a place to turn for assistance navigating the appeals process and accessing their coverage

j. Create a temporary re-insurance program to support coverage for early retirees

k. Establish an internet portal to assist Americans in identifying coverage options

l. Facilitate administrative simplification to lower health system costs

C. Health Insurance Market Reform.

1. Beginning in 2014, more significant insurance reforms will be implemented.

2. Across individual and small group health insurance markets in all states, new rules will end medical underwriting and pre-existing condition exclusions.

3. Insurers will be prohibited from denying coverage or setting rates based on gender, health status, medical condition, claims experience, genetic information, evidence of domestic violence, or other health-related factors.

4. Premiums will vary only by family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age (by not more than three to one).

D. Available Coverage.

1. A qualified health plan, to be offered through the new American Health Benefit Exchange, must provide essential health benefits which include cost sharing limits.

2. No out-of-pocket requirements can exceed those in Health Savings Accounts, and deductibles in the small group market cannot exceed $2,000 for an individual and $4,000 for a family.

3. Coverage will be offered at four levels with actuarial values defining how much the insurer pays: Platinum – 90 percent; Gold – 80 percent; Silver – 70 percent; and Bronze – 60 percent.

4. A less costly catastrophic-only plan will be offered to individuals under age 30 and to others who are exempt from the individual responsibility requirement.

E. American Health Benefit Exchanges.

1. By 2014, each state will establish an Exchange to help individuals and small employers obtain coverage.

2. Plans participating in the Exchanges will be accredited for quality, will present their benefit options in a standardized manner for easy comparison, and will use one, simple enrollment form. Individuals qualified to receive tax credits for Exchange coverage must be ineligible for affordable, employer-sponsored insurance any form of public insurance coverage.

3. Undocumented immigrants are ineligible for premium tax credits.

4. Federal support will be available for new non-profit, member run insurance cooperatives, and the Office of Personnel Management will supervise the offering by private insurers of multi-State plans, available nationwide.

5. States will have flexibility to establish basic health plans for non-Medicaid, lower-income individuals; states may also seek waivers to explore other reform options; and states may form compacts with other states to permit cross-state sale of health insurance.

6. No federal dollars may be used to pay for abortion services.

F. Making Coverage Affordable.

1. New, refundable tax credits will be available for Americans with incomes between 100 and 400 percent of the federal poverty line (FPL) (about $88,000 for a family of four).

2. The credit is calculated on a sliding scale beginning at two percent of income for those at 100 percent FPL and phasing out at 9.8 percent of income at 300-400 percent FPL.

3. If an employer offer of coverage exceeds 9.8 percent of a worker's family income, or the employer pays less than 60 percent of the premium, the worker may enroll in the Exchange and receive credits.

4. Out of pocket maximums ($5,950 for individuals and $11,900 for families) are reduced to one-third for those with income between 100-200 percent FPL, one-half for those with incomes between 200-300 percent FPL, and two-thirds for those with income between 300-400 percent FPL.

5. Credits are available for eligible citizens and legally-residing aliens.

6. A new credit will assist small businesses with fewer than 25 workers for up to 50 percent of the total premium cost.

G. Shared Responsibility.

1. Beginning in 2014, most individuals will be responsible for maintaining minimum essential coverage or paying a penalty of $95 in 2014, $495 in 2015 and $750 in 2016, or up to two percent of income by 2016, with a cap at the national average bronze plan premium.

2. Families will pay half the amount for children up to a cap of $2,250 for the entire family.

3. After 2016, dollar amounts will increase by the annual cost of living adjustment.

4. Exceptions to this requirement are made for religious objectors, those who cannot afford coverage, taxpayers with incomes less than 100 percent FPL, Indian tribe members, those who receive a hardship waiver, individuals not lawfully present, incarcerated individuals, and those not covered for less than three months.

5. Any individual or family who currently has coverage and would like to retain that coverage can do so under a "grandfather" provision.

6. This coverage is deemed to meet the individual responsibility to have health coverage.

7. Similarly, employers that currently offer coverage are permitted to continue offering such coverage under the „grandfather" policy.

8. Employers with more than 200 employees must automatically enroll new full-time employees in coverage.

9. Any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit will make a payment of $750 per full-time employee.

10. An employer with more than 50 employees that offers coverage that is deemed unaffordable or does not meet the standard for minimum essential coverage and but has at least one full-time employee receiving the premium assistance tax credit because the coverage is either unaffordable or does not cover 60 percent of total costs, will pay the lesser of $3,000 for each of those employees receiving a credit or $750 for each of their full-time employees total.

III. The Role of Public Programs

A. Overview.

1. The *Patient Protection and Affordable Care Act* expands eligibility for Medicaid to lower income persons and assumes federal responsibility for much of the cost of this expansion.

2. It provides enhanced federal support for the Children's Health Insurance Program, simplifies Medicaid and CHIP enrollment, improves Medicaid services, provides new options for long-term services and supports, improves coordination for dual-eligibles, and improves Medicaid quality for patients and providers.

B. Medicaid Expansion.

1. States may expand Medicaid eligibility as early as April 1, 2010.

2. Beginning on January 1, 2014, all children, parents and childless adults who are not entitled to Medicare and who have family incomes up to 133 percent FPL will become eligible for Medicaid. Between 2014 and 2016, the federal government will pay 100 percent of the cost of covering newly-eligible individuals. In 2017 and 2018, states that initially covered less of the newly-eligible population ("Other States") will receive more assistance than states that covered at least some non-elderly, non-pregnant adults ("Expansion States").

3. States will be required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement would be extended through September 30, 2019 for children currently in Medicaid.

C. Children's Health Insurance Program.

1. States will be required to maintain income eligibility levels for CHIP through September 30, 2019.

2. The current reauthorization period of CHIP is extended for two years, to September 30, 2015.

3. Between fiscal years 2016 and 2019, states would receive a 23 percentage point increase in the CHIP federal match rate, subject to a 100 percent cap.

D. Simplifying Enrollment.

1. Individuals will be able to apply for and enroll in Medicaid, CHIP and the Exchange through state-run websites.

2. Medicaid and CHIP programs and the Exchange will coordinate enrollment procedures to provide seamless enrollment for all programs.

3. Hospitals will be permitted to provide Medicaid services during a period of presumptive eligibility to members of all Medicaid eligibility categories.

E. Community First Choice Option.

A new optional Medicaid benefit is created through which states may offer community-based attendant services and supports to Medicaid beneficiaries with disabilities who would otherwise require care in a hospital, nursing facility, or intermediate care facility for the mentally retarded.

F. Disproportionate Share Hospital Allotments.

1. States disproportionate share hospital (DSH) allotments are reduced once a state's uninsured rate decreases by 45 percent.

2. The initial reduction for States that spent 99.90 percent of their allotments over the five-year period of 2004 through 2008 would be 50 percent, unless they are defined as low DSH states, in which case they would receive a 25 percent reduction.

3. The initial reduction for states that spent greater than 99.90 percent of their allotments would be 35 percent, or 17.5 percent for low DSH states in this category.

4. As the uninsured rate continues to decline, states" DSH allotments would be reduced by a corresponding amount.

5. At no time could a state's allotment be reduced by more than 50 percent compared to its FY2012 allotment.

G. Dual Eligible Coverage and Payment Coordination.

The Secretary of Health and Human Services (HHS) will establish a Federal Coordinated Health Care Office by March 1, 2010 to integrate care under Medicare and Medicaid, and improve coordination among the federal and state governments for individuals enrolled in both programs (dual eligibles).

IV. Improving the Quality and Efficiency of Health Care

A. Overview.

1. The *Patient Protection and Affordable Care Act* will improve the quality and efficiency of U.S. medical care services for everyone, and especially for those enrolled in Medicare and Medicaid. Payment for services will be linked to better quality outcomes, and the *Patient Protection and Affordable Care Act* will make substantial investments to improve the quality and delivery of care and support research to inform consumers about patient outcomes resulting from different approaches to treatment and care delivery.

2. New patient care models will be created and disseminated, rural patients and providers will see meaningful improvements, and payment accuracy will improve.

3. The Medicare Part D prescription drug benefit will be enhanced and the coverage gap, or donut hole, will be reduced.

4. An Independent Payment Advisory Board will develop recommendations to ensure long-term fiscal stability.

B. Linking Payment to Quality Outcomes in Medicare.

1. A value-based purchasing program for hospitals will launch in FY2013 to link Medicare payments to quality performance on common, high-cost conditions.

2. The Physician Quality Reporting Initiative (PQRI) is extended through 2014, with incentives for physicians to report Medicare quality data – physicians will receive feedback reports beginning in 2012.

3. Long-term care hospitals, inpatient rehabilitation facilities, certain cancer hospitals, and hospice providers will participate quality measure reporting starting in FY2014, with penalties for non-participating providers.

C. Strengthening the Quality Infrastructure.

The HHS Secretary will establish a national strategy to improve health care service delivery, patient outcomes, and population health. The President will convene an Interagency Working Group on Health Care Quality to collaborate on the development and dissemination of quality initiatives consistent with the national strategy.

D. Encouraging Development of New Patient Care Models.

1. A new Center for Medicare & Medicaid Innovation will research, develop, test, and expand innovative payment and delivery arrangements.

2. Accountable Care Organizations (ACOs) that take responsibility for cost and quality of care will receive a share of savings they achieve for Medicare.

3. The HHS Secretary will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute providers to improve patient care and achieve savings through bundled payments.

4. A new demonstration program for chronically ill Medicare beneficiaries will test payment incentives and service delivery using physician and nurse practitioner-directed home-based primary care teams. Beginning in 2012, hospital payments will be adjusted based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions.

E. Ensuring Beneficiary Access to Physician Care and Other Services.

1. The Act extends a floor on geographic adjustments to the Medicare fee schedule to increase provider fees in rural areas and gives immediate relief to areas affected by geographic adjustment for practice expenses.

2. The Act extends Medicare bonus payments for ground and air ambulance services in rural and other areas.

3. The Act creates a 12 month enrollment period for military retirees, spouses (and widows/widowers) and dependent children, who are eligible for TRICARE and entitled to Medicare Part A based on disability or ESRD, who have declined Part B.

F. Rural Protections.

1. The Act extends the outpatient hold harmless provision, allowing small rural hospitals and Sole Community Hospitals to receive this adjustment through FY2010 and reinstates cost reimbursement for lab services provided by small rural hospitals from July 1, 2010 to July 1, 2011.

2. The *Patient Protection and Affordable Care Act* extends the Rural Community Hospital Demonstration Program for five years and expands eligible sites to additional states and hospitals.

G. Improving Payment Accuracy.

1. The HHS Secretary will rebase home health payments starting in 2014 to better reflect the mix of services and intensity of care provided to patients.

2. The Secretary will update Medicare hospice claims forms and cost reports to improve payment accuracy and revise the underlying payment system to better reflect the cost of providing care to hospice patients.

3. The Secretary will revise Disproportionate Share Hospital (DSH) payments to better account for hospitals" costs of treating the uninsured and underinsured, including adjustments to DSH payments to reflect lower uncompensated care costs resulting from increases in the number of insured patients.

4. The bill also makes changes to improve payment accuracy for imaging services and power-driven wheelchairs.

5. The Secretary will study and report to Congress on reforming the Medicare hospital wage index system and will establish a demonstration program to allow hospice eligible patients to receive all other Medicare covered services during the same period.

H. Medicare Advantage (Part C).

1. Medicare Advantage (MA) payments will be based on the average of the bids submitted by insurance plans in each market.

2. Bonus payments will be available to improve the quality of care and will be based on an insurer's level of care coordination and care management, as well as achievement on quality rankings.

3. New payments will be implemented over a four-year transition period.

4. MA plans will be prohibited from charging beneficiaries cost sharing for covered services greater than what is charged under fee-for-service.

5. Plans providing extra benefits must give priority to cost sharing reductions, wellness and preventive care prior to covering benefits not currently covered by Medicare.

I. Medicare Prescription Drug Plan Improvements (Part D).

1. In order to have their drugs covered under the Medicare Part D program, drug manufacturers will provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010.

2. The initial coverage limit in the standard Part D benefit will be expanded by $500 for 2010.

J. Ensuring Medicare Sustainability.

1. A productivity adjustment will be added to the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities.

2. The Act creates a 15-member Independent Payment Advisory Board to present Congress with proposals to reduce costs and improve quality for beneficiaries.

3. When Medicare costs are projected to exceed certain targets, the Board's proposals will take effect unless Congress passes an alternative measure to achieve the same level of savings.

4. The Board will not make proposals that ration care, raise taxes or beneficiary premiums, or change Medicare benefit, eligibility, or cost-sharing standards.

K. Health Care Quality Improvements.

1. The *Patient Protection and Affordable Care Act* will create a new program to develop community health teams supporting medical homes to increase access to community-based, coordinated care.

2. It supports a health delivery system research center to conduct research on health delivery system improvement and best practices that improve the quality, safety, and efficiency of health care delivery.

3. And, it support medication management services by local health providers to help patients better manage chronic disease.

V. Prevention of Chronic Disease and Improving Public Health

A. Overview.

1. To better orient the nation's health care system toward health promotion and disease prevention, a set of initiatives will provide the impetus and the infrastructure.

2. A new interagency prevention council will be supported by a new Prevention and Public Health Investment Fund. Barriers to accessing clinical preventive services will be removed.

3. Developing healthy communities will be a priority, and a 21st century public health infrastructure will support this goal.

B. Modernizing Disease Prevention and Public Health Systems.

1. A new interagency council is created to promote healthy policies and to establish a national prevention and health promotion strategy.

2. A Prevention and Public Health Investment Fund is established to provide an expanded and sustained national investment in prevention and public health.

3. The HHS Secretary will convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign to raise awareness of activities to promote health and prevent disease across the lifespan.

C. Increasing Access to Clinical Preventive Services.

The Act authorizes important new programs and benefits related to preventive care and services:

1. For the operation and development of School-Based Health Clinics.

2. For an oral healthcare prevention education campaign.

3. To provide Medicare coverage – with no co-payments or deductibles – for an annual wellness visit and development of a personalized prevention plan.

4. To waive coinsurance requirements and deductibles for most preventive services, so that Medicare will cover 100 percent of the costs.

5. To provide States with an enhanced match if the State Medicaid program covers: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force and (2) adult immunizations recommended by the Advisory Committee on Immunization Practices without cost sharing.

6. To require Medicaid coverage for counseling and pharmacotherapy to pregnant women for cessation of tobacco use.

7. To award grants to states to provide incentives for Medicaid beneficiaries to participate in programs providing incentives for healthy lifestyles.

D. Creating Healthier Communities.

1. The Secretary will award grants to eligible entities to promote individual and community health and to prevent chronic disease.

2. The CDC will provide grants to states and large local health departments to conduct pilot programs in the 55-to-64 year old population to evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment to reduce risk.

3. The Act authorizes all states to purchase adult vaccines under CDC contracts.

4. Restaurants which are part of a chain with 20 or more locations doing business under the same name must disclose calories on the menu board and in written form.

E. Support for Prevention and Public Health Innovation.

1. The HHS Secretary will provide funding for research in public health services and systems to examine best prevention practices.

2. Federal health programs will collect and report data by race, ethnicity, primary language and any other indicator of disparity.

3. The CDC will evaluate best employer wellness practices and provide an educational campaign and technical assistance to promote the benefits of worksite health promotion.

4. A new CDC program will help state, local, and tribal public health agencies to improve surveillance for and responses to infectious diseases and other important conditions.

5. An Institute of Medicine Conference on Pain Care will evaluate the adequacy of pain assessment, treatment, and management; identify and address barriers to appropriate pain care; increase awareness; and report to Congress on findings and recommendations.

VI. Health Care Workforce

A. Overview.

1. To ensure a vibrant, diverse and competent workforce, the *Patient Protection and Affordable Care Act* will encourage innovations in health care workforce training, recruitment, and retention, and will establish a new workforce commission. Provisions will help to increase the supply of health care workers.

2. These workers will be supported by a new workforce training and education infrastructure.

B. Innovations in the Health Care Workforce.

1. The *Patient Protection and Affordable Care Act* establishes a National Health Workforce commission to review current and projected workforce needs and to provide comprehensive information to Congress and the Administration to align federal policies with national needs.

2. It will also establish competitive grants to enable state partnerships to complete comprehensive workforce planning and to create health care workforce development strategies.

C. Increasing the Supply of Health Care Workers.

1. The federal student loan program will be modified to ease criteria for schools and students, shorten payback periods, and to make the primary care student loan program more attractive.

2. The Nursing Student Loan Program will be expanded and updated.

3. A loan repayment program is established for pediatric subspecialists and providers of mental and behavioral health services to children and adolescents who work in a Health Professional Shortage Area, a Medically Underserved Area, or with a Medically Underserved Population.

4. Loan repayment will be offered to public health students and workers in exchange for working at least three years at a federal, state, local, or tribal public health agency.

5. Loan repayment will be offered to allied health professionals employed at public health agencies or in health care settings located in Health Professional Shortage Areas, Medically Underserved Areas, or with Medically Underserved Populations.

6. A mandatory fund for the National Health Service Corps scholarship and loan repayment program is created. A $50 million grant program will support nurse-managed health clinics.

7. A Ready Reserve Corps within the Commissioned Corps is established for service in times of national emergency.

8. Ready Reserve Corps members may be called to active duty to respond to national emergencies and public health crises and to fill critical public health positions left vacant by members of the Regular Corps who have been called to duty elsewhere.

D. Enhancing Health Care Workforce Education and Training.

New support for workforce training programs is established in these areas:

1. Family medicine, general internal medicine, general pediatrics, and physician assistantship.

2. Rural physicians.

3. Direct care workers providing long-term care services and supports.

4. General, pediatric, and public health dentistry.

5. Alternative dental health care provider.

6. Geriatric education and training for faculty in health professions schools and family caregivers.

7. Mental and behavioral health education and training grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and pre-service or in-service training to paraprofessionals in child and adolescent mental health.

8. Cultural competency, prevention and public health and individuals with disabilities training.

9. Advanced nursing education grants for accredited Nurse Midwifery programs.

10. Nurse education, practice, and retention grants to nursing schools to strengthen nurse education and training programs and to improve nurse retention.

11. Nurse practitioner training program in community health centers and nurse-managed health centers.

12. Nurse faculty loan program for nurses who pursue careers in nurse education.

13. Grants to promote the community health workforce to promote positive health behaviors and outcomes in medically underserved areas through use of community health workers.

14. Fellowship training in public health to address workforce shortages in state and local health departments in applied public health epidemiology and public health laboratory science and informatics.

15. A U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavior health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response in affiliated institutions.

E. Supporting the Existing Health Care Workforce.

1. The *Patient Protection and Affordable Care Act* reauthorizes the Centers of Excellence program for minority applicants for health professions, expands scholarships for disadvantaged students who commit to work in medically underserved areas, and authorizes funding for Area Health Education Centers (AHECs) and Programs.

2. A Primary Care Extension Program is established to educate and provide technical assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

F. Strengthening Primary Care and Other Workforce Improvements.

1. Beginning in 2011, the HHS Secretary may redistribute unfilled residency positions, redirecting those slots for training of primary care physicians.

2. A demonstration grant program is established to serve low-income persons including recipients of assistance under Temporary Assistance for Needy Families (TANF) programs to develop core training competencies and certification programs for personal and home care aides.

3. Also, a grant program is established to provide grant funding and payments to teaching health centers that are focused on training primary care providers in the community. Medicare is also directed to test new models for improving the training of advance practice nurses.

G. Improving Access to Health Care Services.

1. The *Patient Protection and Affordable Care Act* authorizes new and expanded funding for federally qualified health centers and reauthorizes a program to award grants to states and medical schools to support the improvement and expansion of emergency medical services for children needing trauma or critical care treatment.

2. Also supported are grants for coordinated and integrated services through the co-location of primary and specialty care in community-based mental and behavioral health settings.

3. A Commission on Key National Indicators is established.

VII. Transparency and Program Integrity

A. Overview.

To ensure the integrity of federally financed and sponsored health programs, the Act creates new requirements to provide information to the public on the health system and promotes a new set of requirements to combat fraud and abuse in public and private programs.

B. Physician Ownership and Other Transparency.

1. Physician-owned hospitals that do not have a provider agreement prior to August 2010 will not be able to participate in Medicare.

2. Drug, device, biological and medical supply manufacturers must report gifts and other transfers of value made to a physician, physician medical practice, a physician group practice, and/or a teaching hospital.

3. Referring physicians for imaging services must inform patients in writing that the individual may obtain such service from a person other than the referring physician, a physician who is a member of the same group practice, or an individual who is supervised by the physician or by another physician in the group.

4. Prescription drug makers and distributors must report to the HHS Secretary information pertaining to drug samples currently being collected internally.

5. Pharmacy benefit managers (PBM) or health benefits plans that provide pharmacy benefit management services that contract with health plans under Medicare or the Exchange must report information regarding the generic dispensing rate; rebates, discounts, or price concessions negotiated by the PBM.

C. Nursing Home Transparency and Improvement.

1. The Act requires that skilled nursing facilities (SNFs) under Medicare and nursing facilities (NFs) under Medicaid make available information on ownership. SNFs and NFs will be required to implement a compliance and ethics program.

2. The Secretary of HHS will publish new information on the Nursing Home Compare Medicare website such as standardized staffing data, links to state internet websites regarding state survey and certification programs, a model standardized complaint form, a summary of complaints, and the number of instances of criminal violations by a facility or its employee.

3. The Secretary also will develop a standardized complaint form for use by residents in filing complaints with a state survey and certification agency or a state long-term care ombudsman.

D. Targeting Enforcement.

1. The Secretary may reduce civil monetary penalties for facilities that self-report and correct deficiencies.

2. The Secretary will establish a demonstration project to test and implement a national independent monitoring program to oversee interstate and large intrastate chains.

3. The administrator of a facility preparing to close must provide written notice to residents, legal representatives of residents, the state, the Secretary and the long-term care ombudsman program in advance of the closure.

E. Improving Staff Training.

Facilities must include dementia management and abuse prevention training as part of pre-employment training for staff.

F. Nationwide Program for Background Checks on Direct Patient Access Employees of Long Term Care Facilities and Providers.

The Secretary will establish a nationwide program for national and state background checks of direct patient access employees of certain long-term supports and services facilities or providers.

G. Patient-Centered Outcomes Research.

1. The *Patient Protection and Affordable Care Act* establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private board appointed by the Comptroller General to provide for the conduct of comparative clinical outcomes research.

2. No findings may be construed as mandates on practice guidelines or coverage decisions and important patient safeguards will protect against discriminatory coverage decisions by HHS based on age, disability, terminal illness, or an individual's quality of life preference.

H. Medicare, Medicaid, and CHIP Program Integrity Provisions.

1. The Secretary will establish procedures to screen providers and suppliers participating in Medicare, Medicaid, and CHIP. Providers and suppliers enrolling or re-enrolling will

be subject to new requirements including a fee, disclosure of current or previous affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a Federal health care program, or has had their billing privileges revoked.

2. The Secretary is authorized to deny enrollment in these programs if these affiliations pose an undue risk.

I. Enhanced Medicare and Medicaid Program Integrity Provisions.

1. CMS will include in the integrated data repository (IDR) claims and payment data from Medicare (Parts A, B, C, and D), Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).

2. New penalties will exclude individuals who order or prescribe an item or service, make false statements on applications or contracts to participate in a Federal health care program, or who know of an overpayment and do not return the overpayment.

3. Each violation would be subject to a fine of up to $50,000. The Secretary may suspend payments to a provider or supplier pending a fraud investigation.

4. Health Care Fraud and Abuse Control (HCFAC) funding will be increased by $10 million each year for fiscal years 2011 through 2020.

5. The Secretary will establish a national health care fraud and abuse data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank (NPDB).

6. The Secretary will have the authority to disenroll a Medicare enrolled physician or supplier who fails to maintain and provide access to written orders or requests for payment for durable medical equipment (DME), certification for home health services, or referrals for other items and services.

7. The HHS Secretary will expand the number of areas to be included in round two of the DME competitive bidding program from 79 of the largest metropolitan statistical areas (MSAs) to 100 of the largest MSAs, and to use competitively bid prices in all areas by 2016.

J. Additional Medicaid Program Integrity Provisions.

1. States must terminate individuals or entities from their Medicaid programs if the individuals or entities were terminated from Medicare or another state's Medicaid program.

2. Medicaid agencies must exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity that: (1) has failed to repay overpayments; (2) is suspended, excluded, or terminated from

participation in any Medicaid program; or (3) is affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.

3. Agents, clearinghouses, or other payees that submit claims on behalf of health care providers must register with the state and the Secretary. States and Medicaid managed care entities must submit data elements for program integrity, oversight, and administration.

4. States must not make any payments for items or services to any financial institution or entity located outside of the United States.

K. Additional Program Integrity Provisions.

1. Employees and agents of multiple employer welfare arrangements (MEWAs) will be subject to criminal penalties if they provide false statements in marketing materials regarding a plan's financial solvency, benefits, or regulatory status.

2. A model uniform reporting form will be developed by the National Association of Insurance Commissioners, under the direction of the HHS Secretary.

3. The Department of Labor will adopt regulatory standards and/or issue orders to prevent fraudulent MEWAs from escaping liability for their actions under state law by claiming that state law enforcement is preempted by federal law.

4. The Department of Labor is authorized to issue "cease and desist" orders to temporarily shut down operations of plans conducting fraudulent activities or posing a serious threat to the public, until hearings can be completed.

5. MEWAs will be required to file their federal registration forms, and thereby be subject to government verification of their legitimacy, before enrolling anyone.

L. Elder Justice Act.

1. The Elder Justice Act will help prevent and eliminate elder abuse, neglect, and exploitation.

2. The HHS Secretary will award grants and carry out activities to protect individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities.

3. Owners, operators, and employees would be required to report suspected crimes committed at a facility.

4. Owners or operators of such facilities would be required to submit to the Secretary and to the state written notification of an impending closure of a facility within 60 days prior to the closure.

M. Sense of the Senate Regarding Medical Malpractice.

The Act expresses the sense of the Senate that health reform presents an opportunity to address issues related to medical malpractice and medical liability insurance, states should be encouraged to develop and test alternative models to the existing civil litigation system, and Congress should consider state demonstration projects to evaluate such alternatives.

VIII. Improving Access to Innovative Medical Therapies

A. Biologics Price Competition and Innovation.

1. The *Patient Protection and Affordable Care Act* establishes a process under which FDA will license a biological product that is shown to be biosimilar or interchangeable with a licensed biological product, commonly referred to as a reference product.

2. No approval of an application as either biosimilar or interchangeable is allowed until 12 years from the date on which the reference product is first approved.

3. If FDA approves a biological product on the grounds that it is interchangeable to a reference product, HHS cannot make a determination that a second or subsequent biological product is interchangeable to that same reference product until one year after the first commercial marketing of the first interchangeable product.

B. More Affordable Medicines for Children and Underserved Communities:

Drug discounts through the 340B program are extended to inpatient drugs and also to certain children's hospitals, cancer hospitals, critical access and sole community hospitals, and rural referral centers.

IX. Community Living Assistance Services and Supports

A. Overview

1. The *Patient Protection and Affordable Care Act* establishes a new, voluntary, self-funded long-term care insurance program, the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations.

2. The HHS Secretary will develop an actuarially sound benefit plan that ensures solvency for 75 years; allows for a five-year vesting period for eligibility of benefits; creates benefit triggers that allow for the determination of functional limitation; and provides a cash benefit that is not less than an average of $50 per day.

3. No taxpayer funds will be used to pay benefits under this provision.

PART III – Tax and Revenue Raising Provisions

I. Individual Tax Changes

A. *The Individual Mandate – The Shared Responsibility Penalty*

1. Overview.

a. Effective for tax years beginning after Dec. 31, 2013, non-exempt U.S. citizens and legal residents would have to maintain *"minimum essential coverage",* or pay a share responsibility penalty for each month of non-compliance.

b. Chief Justice Roberts wrote.

"For individuals who are not exempt and do not receive health insurance through a third party, the means of satisfying the requirement is to purchase insurance from a private company."

2. The Definition of "Minimum Essential Coverage" - The term *"minimum essential coverage"* means any of the following:

a. Certain government sponsored programs – including -

(1) Medicare,

(2) Medicaid,

(3) The CHIP program, and

(4) Medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

b. Employer-sponsored plan - Coverage under an eligible employer-sponsored plan;

c. Plans in the individual market - Coverage under a health plan offered in the individual market within a State;

d. Grandfathered health plan - Coverage under a grandfathered health plan.

3. The Penalty – the Shared Responsibility Penalty - Those failing to maintain minimum essential coverage in 2014 would be subject to a penalty.

a. The penalty would apply to any period the individual does not maintain "minimum essential coverage" (determined monthly) would be assessed through the Code.

b. The taxpayer's penalty is equal to the greater of: (i) a flat dollar amount; or (ii) a percentage of the taxpayer's household income, and is imposed on a monthly basis (one-twelfth per month of this 'greater of ' amount).

c. The annual flat dollar amount is assessed per individual or dependent without coverage and is scheduled to be phased in over three years ($95 for 2014; $325 for 2015; and $695 in 2016 and subsequent years, indexed for inflation - *the $695 amount would be indexed to CPI-U, rounded to the next lowest $50*).

d. The calculation of the percentage is based on a percentage of amounts by which the taxpayer's household income exceeds the income tax filing threshold.

(1) The applicable percentage is 1 percent for 2014, 2 percent for 2015, and 2.5 percent for 2016 and subsequent years.

(2) The current filing thresholds are: (i) $9,500 for single individuals; (ii) $19,000 for Married couples, filing jointly, and (iii) $3,700 for Marrieds filing separate returns.

Example: *Bill is a single individual with household income of $17,000 in 2016. He is self employed as a carpenter, and maintains no health coverage. Assuming a filing threshold of $9,500 for Singles in 2016, Bill's Shared Responsibility Penalty is calculated as follows:*

Household Income	$17,000
Filing Threshold	- 9,500
Excess	$6,500
Applicable Percentage	.025
Percentage Amount	$1,625
Flat Amount	$695
Shared Responsibility Penalty	$1,625

e. The definition of *"household income" is* an amount equal to the sum of:

(1) The modified adjusted gross income ("MAGI") of the taxpayer, plus

(2) The aggregate MAGIs of all other individuals who:

(a) are taken into account in determining the taxpayer's family size (i.e., all individuals the taxpayer claims as dependents), and

(b) are required to file an income tax return for the tax year.

f. "Modified adjusted gross income" used in determining household income for purposes of the Code Sec. 36B PTC will mean adjusted gross income (AGI) (within the meaning of Code Sec. 62, 21 *increased by*:

(1) Any amount excluded from gross income under Code Sec. 911 23—i.e., the foreign earned income and foreign housing costs exclusions for U.S. citizens and residents living abroad

(2) Any amount of tax-exempt interest received or accrued by the taxpayer during the tax year, and

(3) An amount equal to the portion of the taxpayer's social security benefits (as defined in Code Sec. 86(d)) that's excluded from gross income under Code Sec. 86 for the tax year.

g. The total household penalty cannot exceed 300% of the per adult penalty ($2,085), nor exceed the national average annual premium for the "bronze level" health plan offered through a health exchange.

h. If a taxpayer files a joint return, the individual and spouse would be jointly liable for any penalty payment.

i. The penalty for an uninsured individual under age 18 would be one-half of the penalties for an adult.

j. No penalty will be imposed on individuals without coverage for fewer than 90 days (with only one period of 90 days allowed in a year).

3. Individuals Who Are Exempt from the Penalty

a. The following individuals would be exempt from the penalty:

(1) Individuals who cannot afford coverage because their required contribution for employer sponsored coverage or the lowest cost "bronze plan" in the local Insurance Exchange exceeds 8% of household income;

(2) Those that are exempted for religious reasons;

(3) Those residing outside of the U.S.

(4) Individuals covered by Medicaid and Medicare,

(5) Incarcerated individuals,

(6) Individuals not lawfully present in the United States,

(7) Health care ministry members, and

(8) Members of an Indian tribe

b. Generally, individuals with employer-provided health insurance, if it satisfies minimum essential coverage and affordability requirements, are also exempt.

c. No penalty will be imposed on individuals who are unable to afford coverage (generally, an individual will be treated as unable to afford coverage if the required contribution for employer-sponsored coverage or a bronze-level plan on an Exchange exceeds eight percent of the individual's household income for the tax year).

d. Those applicable individuals whose household income is below their income thresholds for filing income tax returns are also exempt.

B. Low-Income Tax Credits for Participating in Health Exchanges

1. The Sec 36B Credit.

a. For tax years ending after 2013, fully refundable "premium assistance tax credits" under IRC Sec. 36B, will be available for individuals and families with low incomes.

b. *Who Qualifies?* - In order to qualify for the Credit:

(1) A taxpayer's household income for the tax year must be at least 100 percent but not more than 400 percent of the Federal Poverty Line for the taxpayer's family size[1].

(2) Taxpayers that are eligible for other minimum essential coverage, including *employer-sponsored coverage that is affordable* and *provides minimum value* do not qualify for the credit.

(3) A taxpayer's family includes the individuals for whom the taxpayer claims a personal exemption for the tax year.

(4) In order to qualify for the credit these individuals and families will have to obtain health care coverage in newly established Insurance Exchanges in order to obtain credits.

(5) The final regulations clarify that a family may include individuals who are subject to the penalty for failing to maintain minimum essential coverage.

c. *Employer-sponsored coverage* –

(1) The final regulations treat an employer-sponsored plan as affordable for an employee and related individuals if the portion of the annual premium the employee must pay for self-coverage does not exceed the required contribution percentage (9.5 percent for tax years beginning before January 1, 2015) of the taxpayer's household income.

(2) For months beginning after 2013, large employers will be required to make an "assessable payment" to IRS if any full-time employee is certified to the employer as having purchased health insurance through an Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee, if the employer either: (i) does not offer health care coverage for all its full-time employees; or (ii) offers minimum essential coverage that either: (a) is unaffordable; or (b) consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%. (Code Sec. 4980H(a)). *See Sec. II.B., below.*

d. *The Definition of Minimum Value*

(1) A plan fails to provide "minimum value" if the plan provides less than 60 percent coverage of the total allowed costs

(2) If employer-sponsored coverage fails to provide minimum value, an employee may be eligible for the credit.

[1] The Federal Poverty Line for 2012, ranges from $11,170, for a household of one, to $38,890 for a household of 8.

(3) In *Notice 2012-31* the IRS requested comments on how to determine if health coverage under an employer-sponsored plan provides minimum value.

e. *The Amount of the Credit*

(1) The term *"premium assistance credit amount"* means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(2) The Premium Assistance Amount.

The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer and which were enrolled in through an Exchange established by the State , or

(B) the excess (if any) of—

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

(3) The Applicable Percentage.

The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is-	The final premium percentage is-
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%.

2. *How it Works* - Here is how the Code Sec. 36B credit is designed to work:

a. The eligible individual purchases affordable coverage through "Affordable Insurance Exchanges," which are intended as competitive one-stop marketplaces that allow consumers (both individuals and small businesses) to choose a private health insurance plan that best suits their needs. (Reg. § 1.36B-1, Reg. § 1.36B-2)

b. The Exchange makes subsidy payments to the qualified health plan on behalf of the individual. The subsidy payments take the form of an advance credit payment ("monthly premium assistance amount") under Code Sec. 36B.

c. Using information available at the time of enrollment, the Exchange determines (a) whether the individual meets the income and other requirements for advance credit payments, and (b) the amount of the advance payments.

Note: The monthly premium assistance amount is the lesser of the premium for the qualified health plan in which a taxpayer or family member enrolls, or the excess of the premium for the benchmark plan (the second-lowest "silver plan") over a percentage of the taxpayer's household income. (Code Sec. 36B(b)(1)).

d. At tax return time, the eligible individual reconciles the actual credit for the tax year with the amount of advance payments paid on his behalf.

(1) If a taxpayer's credit amount exceeds the amount of advance payments paid on his behalf for the tax year, he may receive the excess as an income tax refund.

(2) If advance payments made on the taxpayer's behalf exceed his credit amount, he owes the excess as an additional income tax liability, subject to certain limitations.

Example : Kate is single and has annual household income of $33,510 in January, 2014, which is at least 100 percent but not more than 400 percent of the Federal Poverty Line her household size. She is an employee of ABC Co., which offers its employees a health insurance plan that requires her to contribute $3,450 for self-only coverage for 2014. This represents 10.3 percent of Kate's household income. Because Kate's required contribution for self-only coverage exceeds 9.5 percent of household income, ABC's plan is not affordable for Kate, and Kate is eligible to purchase affordable coverage through "Affordable Insurance Exchanges and claim the 36B Credit.

In order to determine Kate's 36B Credit assume the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer and which were enrolled in through an Exchange established by the State is $850.00,

Assume further, that the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer is $775.00

Household Income	$33,510
Applicable Percentage	.095
HHI x Appl Percentage	$3,149
1/12	$263
Adjusted Monthly Silver Prem	$775
Excess	$512
Enrolled Premium	$850
Sec. 36B Credit	$512

e. The Act provides that advance payments of the premium assistance tax credit may be made directly to the insurer.

(1) Advance payments are reconciled against the amount of the family's actual premium tax credit, as calculated on the family's federal income tax return.

(2) Any excess payment must be repaid as additional tax but is subject to a cap for taxpayers with household income under 400 percent of FPL.

3. PPACA Opponents Challenge

a. Following the Supreme Court's decision to largely uphold the PPACA critics of the law have turned their attention to final IRS regs implementing the post-2013 health insurance premium tax credit under Code Sec. 36B.

b. The point in contention is whether the subsidies will be available in federally-run exchanges, or limited to State-run exchanges.

(1) In describing the premium assistance amount, Code Sec. 36B(b)(2)(A) refers to *"the monthly premiums for...qualified health plans offered in the individual market...which were enrolled in through an Exchange established by the State"* (emphasis added) under §1311 of PPACA.

(2) However, the regs issued under Code Sec. 36B provide that the premium tax credit isn't just limited to state Exchanges, but also includes federally-facilitated Exchanges. (Reg. § 1.36B-1(k))

c. Opponents of PPACA, and of IRS's regs, argue that the limitation to state-based Exchanges was intended to encourage States to establish an Exchange.

d. Supporters of PPACA say that this interpretation, while at odds with the statutory language, comports with 45 CFR 155.20's definition provided by the Secretary of Health and Human Services in implementing PPACA. Under that section, an "Exchange" refers to State, regional, subsidiary, and federally-facilitated Exchanges Proponents, however, say that denying the credit would be inconsistent with Congress's goal of

ensuring availability of coverage, including to those who need premium assistance, via a "fallback" federal Exchange.

e. IRS acknowledged this tension in T.D. 9590, but defended its interpretation as being consistent with the legislative history, as well as with the "purpose and structure" of Code Sec. 36B and PPACA as a whole. The Administration also supports this reading. Some proponents of PPACA dismiss the discrepancy as a mere drafting error.

f. This conflict also raises questions regarding the applicability of the assessable payment, as it is predicated on the allowance of a credit or cost-sharing reduction to an employee.

(1) Since an employee's receipt of the subsidy triggers a penalty on large employers, commentators have speculated that any judicial challenge to the law will likely come from employers.

(2) IRS's regs also face legislative challenge. Reps. Scott DesJarlais and Phil Roe (both R-TN) introduced H.J.Res.112, a joint resolution "disapproving the rule submitted by the Internal Revenue Service relating to the health insurance premium tax credit." H.J.Res.112 would provide that the credit "shall have no force or effect."

g. Despite the Supreme Court's decision, PPACA remains controversial and prone to attack.

(1) The House has scheduled a vote to repeal PPACA in its entirety, and the Code Sec. 36B regs may well face a court challenge in the near future.

(2) The November elections may provide some closure, but the political tension surrounding PPACA seems unlikely to resolve itself anytime soon.

C. Surtax on Unearned Income.

1 For tax years beginning after Dec. 31, 2012, a 3.8% surtax called the Unearned Income Medicare Contribution, would be placed on net investment income of a taxpayer earning over $200,000 ($250,000 for a joint return).

2. The tax is imposed on the lesser of an individual's net investment income for the tax year or modified adjusted gross income in excess of $200,000 ($250,000 for married couples filing a joint return and $125,000 for married couples filing a separate return).

3. Net investment income is the excess of the sum of the following items less any otherwise allowable deductions properly allocable to such income or gain:

a. Gross income from interest, dividends, annuities, royalties and rents unless such income is derived in the ordinary course of any trade or business (excluding a passive activity or financial instruments/commodities trading);

b. Other gross income from any passive trade or business; and

c. Net gain included in computing taxable income that is attributable to the disposition of property other than property held in any trade or business that is not a passive trade or business.

d. Net investment income includes the amount of capital gain on a home sale that exceeds the amount that can be excluded from taxation.

4. This 3.8 percent tax would be on top of any increase in the dividends/capital gains/ordinary income rates that some lawmakers are currently considering upon expiration of the Bush-era tax cuts at the end of 2012.

D. Modified Threshold for Claiming Medical Expense Deductions.

1. For tax years beginning after Dec. 31, 2012, the adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses would be increased from 7.5% to 10%.

2. However, the 7.5%-of-AGI threshold would continue to apply through 2016 to individuals age 65 and older (and their spouses).

E. Additional Medicare Tax

1. For tax years beginning after December 31, 2012, an additional 0.9 percent Medicare tax is imposed on wages and self-employment income of higher-income individuals.

2. The additional Medicare tax applies to individuals with remuneration in excess of $200,000; married couples filing a joint return with incomes in excess of $250,000; and married couples filing separate returns with incomes in excess of $125,000.

F. Adoption Credit

1. The Act made the adoption credit refundable for 2010 and 2011.

2. The PPACA also increased the amount of the credit to $13,360 for 2011.

3. The IRS issued guidance on the temporary enhancements to the adoption credit in Notice 2010-66.

4. The PPACA's enhancements to the adoption credit have expired. Pending legislation would permanently extend the enhancements.

G. Dependent Coverage Until Age 26

1. The PPACA also requires group health plans and health insurance issuers providing dependent coverage for children to continue to make the coverage available for an adult child until turning age 26.

2. The coverage requirement is effective for the first plan year beginning on or after September 23, 2010.

3. For plan years beginning before January 1, 2014, grandfathered group plans do not have to offer dependent coverage as amended by the PPACA if a young adult is eligible for group coverage outside his or her parent's plan.

4. The IRS issued temporary regulations in TD 9482 (5/10/10).

a. The IRS explained that, with respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage for children other than in terms of a relationship between a child and the participant.

b. A plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors.

5. Example - *A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18. The IRS explained that the group health plan violates the regulations because the plan varies the terms for dependent coverage of children based on age.*

H. Medical Benefits For Children Under 27

1. The PPACA amended to extend the exclusion from gross income for medical care reimbursements under an employer-provided accident or health plan to any employee's child who has not attained age 27 as of the end of the tax year.

2. The amendment was effective March 30, 2010.

3. The IRS issued guidance in Notice 2010-38, which explains that the exclusion applies for reimbursements for health care of individuals who are not age 27 or older at any time during the tax year.

a. The tax year is the employee's tax year (generally a calendar year).

b. The IRS also explained that a child for purposes of the extended exclusion is an individual who is the son, daughter, stepson, or stepdaughter of the employee.

c. A child includes an adopted individual and an eligible foster child.

4. The exclusion applies only for reimbursements for medical care of individuals who are not age 27 or older at any time during the tax year.

a. The IRS explained in Notice 2010-38 that employers may assume that an employee's tax year is the calendar year: a child attains age 27 on the 27th anniversary of the date the child was born.

b. For example, an individual born on May 1, 1986 attains age 27 on May 1, 2013, and is therefore covered under this provision through 2012. Employers may rely on the employee's representation as to the child's date of birth.

5. There is no requirement that a child generally qualify as a dependent for tax purposes. There is also no requirement that an employer provide this coverage (as opposed to dependent coverage under age 26, described above).

I. Student Loan Repayment Programs

1. The PPACA provides for exclusion of assistance provided to participants in state student loan repayment programs for health professionals.

2. The assistance is intended to increase the availability of health care in areas traditionally underserved by health professionals.

3. As of the date of this Briefing, the IRS has not issued official guidance on the exclusion.

J. Indian Tribes

1. The PPACA excludes from gross income qualified health care benefits provided to the member of an Indian tribe, the member's spouse or the member's dependents.

2. The exclusion applies to benefits and coverage provided after March 23, 2010.

II. Business Tax Changes.

A. Overview

1. The PPACA also contains a number of tax provisions which effect businesses and business owners (the “employer mandate”).

2. Some of these provisions have general applicability and others are industry specific; among these are the following:

a. Penalty for not offering adequate coverage;

b. Tax credits for Small Employers offering health coverage;

c. Excise Tax on high- cost employer-sponsored health coverage;

d. Additional Hospital Insurance Tax (HI) for high wage workers;

e. New Limit on Health FSA Contributions;

f. Restricted definition of “medical expenses” for employer provided coverage;

g. Increased Tax on Nonqualifying HSA or Archer MSA distributions;

h Deduction for employer Part D is eliminated; and

i. Industry-specific revenue raisers.

B. Penalty for Not Offering Adequate Coverage

1. Effective for months beginning after Dec. 31, 2013:

a. An "applicable large employer" which is (i) not offering coverage for all its full-time employees, (ii) offering minimum essential coverage that is unaffordable; or (iii) is only offering minimum essential coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%.

b. Will have to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee.

2. The definition of an "applicable large employer is generally, one that employed an average of at least 50 full-time employees during the preceding calendar year.

a. Most small businesses are exempted from penalties for not offering coverage to their employees.

b. Employers with fewer than fifty employees aren't subject to the penalty provisions.

3. The penalty for any month would be an excise tax 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 tax credit or cost-sharing reduction) multiplied by one-twelfth of $2,000.

4. Also, 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 would be subject to a penalty if any full-time employee is certified to the employer as having enrolled in health insurance coverage purchased through a State exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees.

C. Tax Credits for Small Employers Offering Health Coverage.

1. Effective for tax years beginning after 2009, a "qualified small employer" is allowed a tax credit for nonelective contributions to purchase health insurance for its employees.

2. A "qualified small business employer" for this purpose generally would be :

a. An employer with no more than 25 full-time equivalent employees (FTEs) employed during the employer's tax year, and

b. Whose employees have annual full-time equivalent wages that average no more than $50,000.

3. However, the full amount of the credit would be available only to an employer with 10 or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than $25,000.

4. These wage limits would be indexed to the Consumer Price Index for Urban Consumers ("CPI-U") for years beginning in 2014.

5. For tax years beginning in 2010 through 2013, the credit is equal to 35% of the lesser of:

a. The total amount of nonelective contributions the employer makes on behalf of the employees during the year under a contribution arrangement for the payment of premiums for qualified health insurance coverage, or

b. The total amount of nonelective contributions the employer would have made during the year of each employee had enrolled in a qualified health plan that had a premium equal to the amount that the Secretary of Health and Human Services determines is the average premium for a small group market in the state in which the employer is offering health insurance.

6. The credit phases out gradually (but not below zero) for ESEs if the number of FTE employees exceeds 10 or if the average annual wages exceed $25,000.

a. If the number of FTE employees exceeds ten, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the number of FTE employees in excess of ten and the denominator of which is 15.

b. If average annual wages exceed $25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed $25,000 and the denominator of which is $25,000.

c, In both cases, the result of the calculation is subtracted from the otherwise applicable credit to determine the credit to which the employer is entitled.

d. For an employer with both more than ten FTE employees and average annual wages exceeding $25,000, the total reduction is the sum of the two reductions.

e. The phaseout can reduce the credit to zero for some employers with fewer than 25 FTE employees and average annual wages of less than $50,000. [30]

f. *Example: For the 2010 tax year, a taxable ESE has 12 FTE employees and average annual wages of $30,000. The employer pays $96,000 in health insurance premiums for its employees (which does not exceed the average premium for the small group market in the employer's state, and otherwise meets the requirements for the credit.*

The credit is calculated as follows:

>*Initial amount of credit determined before any reduction: (35% × $96,000) = $33,600.*

>Credit reduction for FTE employees in excess of ten: ($33,600 × 2/15) = $4,480.

>Credit reduction for average annual wages in excess of $25,000: ($33,600 × $5,000/$25,000) = $6,720.

>Total credit reduction: ($4,480 + $6,720) = $11,200.

>Total 2010 tax credit equals $22,400 ($33,600 − $11,200).

7. In 2014 and later, eligible small employers who purchase coverage through the Insurance Exchange would be eligible for a tax credit for two years of up to 50% of their contribution.

8. The Full Time Employees are determined by dividing the total hours of service (up to 2,080 hours of service determined by an employee's actual hours of service, a days-worked equivalency method, or a weeks-worked equivalency method) by 2,080. Code Sec.45R(d).

9. Average annual wages are determined by dividing (a) total wages (as defined for FICA purposes, without regard to the wage base limitation) paid to employees during the ESE's tax year by (b) the number of the FTEs for the year. The result is rounded down to the nearest $1,000 (if not otherwise a multiple of $1,000). (Code Sec. 45R(d)(3)(A),

10. Self-employed individuals, including partners and sole proprietors, 2% S corporation shareholders, and 5% owners of the employer (within the meaning of Code Sec. 416(i)(1)(B)(i)): (a) aren't treated as employees; (b) their wages or hours are not counted in determining either the number of FTEs or the amount of average annual wages; and (3) premiums paid on their behalf are not counted in determining the credit. (Code Sec. 45R(e)).

11. An employee-spouse of any of the following isn't taken into account: (1) a more-than-2% S shareholder; (2) a more-than-5% owner of a business; (3) a partner owning more than a 5% interest in a partnership; and (4) a sole proprietor.

12. In tax years beginning after 2013, an ESE has to offer insurance through an exchange and an ESE can only claim the credit for two consecutive tax years.

13. Small Business Employers will be allowed to take an ordinary and necessary business expense deduction equal to the amount of the employer contribution less the dollar amount of any credits that they are afforded, e.g. if the employer spends $100 dollars and receives a $50 credit, their deduction will be $50.

D. Excise Tax on High- Cost Employer-sponsored Health Coverage.

1. For tax years beginning after Dec. 31, 2017, the bill would place a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan to the extent that the annual premium exceeds $10,200 for single coverage and $27,500 for family coverage.

2. An additional threshold amount of $1,650 for single coverage and $3,450 for family coverage would apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

3. The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals).

4. Stand-alone dental and vision plans would be disregarded in applying the tax.

5. The dollar amount thresholds would be automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office (CBO) estimates in 2010.

6. Employers with age and gender demographics that result in higher premiums could value the coverage provided to employees using the rates that would apply using a national risk pool.

7. The excise tax would be levied at the insurer level. Employers would be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

E. New Limit on Health FSA Contributions.

The amount of contributions to health flexible spending accounts (FSAs) would be limited to $2,500 per year, effective for tax years beginning after Dec. 31, 2012. The dollar amount would be inflation indexed after 2013.

F. Restricted Definition of Medical Expenses for Employer Provided Coverage.

1. For purposes of employer provided health coverage (including health reimbursement accounts (HRAs) and health flexible savings accounts (FSAs), health savings accounts (HSAs), and Archer medical savings accounts (MSAs)), the definition of medicine expenses deductible as a medical expense would generally be conformed to the definition for purposes of the itemized deduction for medical expenses.

2. But this change would not apply to doctor prescribed over-the-counter medicine.

3. Thus, the cost of over-the-counter medicine (other than insulin or doctor prescribed medicine) could not be reimbursed through a health FSA or HRA.

4. In addition, the cost of over-the-counter medicines (other than insulin or doctor prescribed medicine) could not be reimbursed on a tax-free basis through an HSA or Archer MSA.

5. These changes would be effective for tax years beginning after Dec. 31, 2010.

G. Increased Tax on Non-qualifying HSA or Archer MSA distributions.

The additional tax for HSA withdrawals before age 65 that are used for purposes other than qualified medical expenses would be increased from 10% to 20%, and the additional tax for Archer MSA withdrawals that are used for purposes other than qualified medical expenses would be increased from 15% to 20%, both effective for distributions made after Dec. 31, 2010.

H. Deduction for Employer Part D would be Eliminated.

The deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees would be eliminated, for tax years beginning after Dec. 31, 2012.

I. Industry-specific Revenue Raisers.

The following revenue raising changes would be imposed on health related industries:

1. *Insurance Providers* - A new deduction limit on executive compensation would apply to insurance providers.

a. If at least 25% of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"), an annual $500,000 per tax year compensation deduction limit would apply for all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider.

b. The limit would apply for remuneration paid in tax years beginning after 2012, with respect to services performed after 2009.

2. *Pharmaceutical Manufacturers and Importers* - Pharmaceutical manufacturers and importers would have to pay an annual flat fee beginning in 2011 allocated across the industry according to market share.

a. The schedule for the flat fee would be: 2011, $2.5 billion; 2012 to 2016, $3 billion; 2017, $4 billion; 2018, $4.1 billion; 2019 and later, $2.8 billion.

b. The fee would not apply to companies with sales of branded pharmaceuticals of $5 million or less.

3 *Manufacturers or Importers of Medical Devices* - Manufacturers or importers of medical devices would have to pay a 2.3% of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of the device.

a. A taxable medical device would be any device, defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act, intended for humans.

b. The excise tax would not apply to eyeglasses, contact lenses, hearing aids, and any other medical device determined by IRS to be of a type that is generally purchased by the general public at retail for individual use.

4. *Health Insurance Providers* - Health insurance providers would face an annual flat fee on the health insurance sector effective for calendar years beginning after Dec. 31, 2013.

a. The fee would be allocated based on market share of net premiums written for a U.S. health risk for calendar years beginning after Dec. 31, 2012.

b. The schedule for the flat fee would be: 2014, $8 billion; 2015 and 2016, $11.5 billion; 2017, $13.5 billion; 2018, $14.3 billion and indexed to medical inflation for later years. The fee would not apply to companies whose net premiums written are $25 million or less.

5. Indoor Tanning Services - Amounts paid for indoor tanning services performed after June 30, 2010, are subject to a 10 percent excise tax.

a. Tanning salons are responsible for collecting the excise tax and paying over the tax on a quarterly basis. Tanning salons that fail to collect the tax from patrons are liable for the excise tax.

b. The excise tax does not apply to phototherapy performed by a licensed medical professional.

c. The IRS quickly issued final regulations (TD 9486, 6/14/10) on the indoor tanning tax only weeks before its starting date.

(1) The final regulations explain that payment for indoor tanning services is treated as made, and liability for the tax is imposed, at the time it can be reasonably determined that payment is made specifically for indoor tanning services.

(2) The regulations also address "bundled services," where indoor tanning is bundled with other goods and services, membership fees to a qualified physical fitness facility, and payment by gift card for indoor tanning services.

d. In 2012, the IRS followed up on the final regulations with more guidance.

e. The IRS released final, temporary and proposed regulations adding the indoor tanning services excise tax to the list of excise taxes for which disregarded entities are treated as separate entities effective for taxes imposed on amounts paid on or after July 1, 2012 (TD 9596, NPRM REG-125570-10 06/25/12). The temporary regulations also treat a single-owner eligible entity that is disregarded as an entity separate from its owner for any purpose under Reg. §301.7701-2 as a corporation with respect to the indoor tanning services excise tax.

f. Tanning services providers report the tax on Form 720, Quarterly Federal Excise Tax Return, and pay the excise tax on a quarterly basis: April 30 to report tax collected in January, February and March; July 31 to report tax collected in April, May and June; October 31 to report tax collected in July, August and September; and January 31 to report tax collected in October, November and December.

g. As a result of the 2012 temporary regulations, Form 720, Quarterly Federal Excise Tax Return, reporting of indoor tanning services excise taxes imposed on amounts paid on or after July 1, 2012, must be filed under the name and employer identification number (EIN) of the entity rather than under the name and EIN of the disregarded entity's owner. This affects returns of this tax that are due on or after October 31, 2012.

6. *Non-profit Blue Cross Blue Shield organizations* - Non-profit Blue Cross Blue Shield organizations would have to maintain a medical loss ratio of 85% or higher in order to take advantage of the special tax benefits provided to them, including the deduction for 25% of claims and expenses and the 100% deduction for unearned premium reserves. The provision is effective in 2010.

J. Reporting Requirements

1. Forms W-2

a. The PPACA generally requires employers to disclose the aggregate cost of applicable employer-sponsored coverage on an employee's Form W-2 for tax years beginning on or after January 1, 2011. Reporting is for informational purposes only.

b. In Notice 2010-69, the IRS made reporting optional for all employers for 2011.

c. In Notice 2012-9, the IRS provided transition relief for small employers.

(1) For 2012 Forms W-2 (and W-2s issued in later years, unless and until further guidance is issued), an employer is not subject to reporting for any calendar year if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year, the IRS explained.

(2) Whether an employer is required to file fewer than 250 Forms W-2 for a calendar year is determined based on the Forms W-2 that it would be required to file if it filed Forms W-2 to report all wages paid by the employer and without regard to use of an agent under Code Sec. 3504

2. Health Care Coverage Reporting

a. The PPACA requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and other entity that provides minimum essential coverage to file an annual return reporting information for each individual for whom minimum essential coverage is provided (Code Sec. 6055 reporting).

b. Additionally, every applicable large employer (within the meaning of Code Sec. 4980H(c)(2)) that is required to meet the shared employer responsibility requirements of the PPACA during a calendar year must file a return with the IRS reporting the terms and conditions of the health care coverage provided to the employer's full-time employees for the year (Code Sec. 6056 reporting). The reporting requirements apply to calendar years beginning on or after January 1, 2014.

c. In Notice 2012-32, the IRS requested comments on how to implement reporting. The IRS asked for comments on how to determine when an individual's coverage begins and ends for purposes of reporting the dates of coverage; how to minimize duplicative reporting, and more.

IV. The Role of the IRS.

1. Although known as a health care law, PPACA carries many tax provisions, the implementation and enforcement of which will fall largely to IRS.

2. Under Code Sec. 5000A(g), the penalty for failing to carry health insurance “shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty” under Code Sec. 6671 through Code Sec. 6725.

a. The IRS will not be permitted to (i) file a notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty, or (ii) levy on any property of a taxpayer with respect to such a failure. (Code Sec. 5000A(g)(2)(B)).

b. However, the authority to offset refunds or credits is not so limited.

3. Thus, if a taxpayer on whom the penalty is imposed is owed a tax refund, IRS will be allowed to reduce the amount of the refund it pays to the taxpayer by the amount of the penalty. Since IRS will not be allowed to use certain collection methods that are otherwise authorized for the collection of taxes (i.e., the filing of notices of liens and levies) to collect the penalty, offsetting refunds and credits may be the only practical way for the IRS to collect the penalty.

4. These limitations raise concerns about whether the individual mandate will be truly enforceable. Much of the responsibility of enforcing it has been delegated to IRS, but with limited powers and scant guidance on how to do so.

5. The extent of this issue is not yet known. Some taxpayers will no doubt decide to obtain health insurance instead of paying the penalty. Others, perhaps as an unintended consequence of PPACA, will simply forego insurance and exercise the perfectly legal option of instead paying the shared responsibility payment—knowing that they can rely on PPACA's protections for those with pre-existing conditions should any unexpected illness, injury, or condition arise. Others will also likely forego insurance and refuse to pay the penalty, forcing IRS to attempt to collect.

6. The Congressional Budget Office (CBO) has estimated that approximately 21 million nonelderly residents will be uninsured in 2016, but most of them won't be subject to the penalty—such as unauthorized immigrants and taxpayers whose income falls below the filing thresholds. CBO projected, accounting for likely compliance rates as well as IRS's ability to administer and enforce the penalty, that approximately 4 million people will pay the penalty in 2016 on account of being uninsured.

7. In addition to IRS's limited enforcement powers, IRS faces logistical hurdles as well. IRS has already been struggling to keep up with a tax code that is rapidly amended and arguably subject to political whim, and PPACA reflects the largest set of tax law changes in over 20 years. The uncertainty of PPACA's fate—in the political area—has made, and likely continues to make, planning even more difficult.

8. Numerous reports by the Government Accountability Office and Treasury Inspector General of Tax Administration have indicated that IRS is making progress on implementing PPACA, but still has lots of work to do.

Program Complete

Congratulations – you have finished reviewing the Course Material for "Tax News Update - Obamacare Edition."

If you have any questions or comments regarding the Course, please feel free to use the site's contact form or send an email to us directly at:

yop@youronlineprofessor.net

YOURONLINEPROFESSOR.NET
Keep Growing & Learning