TedPerkinsTax News

SPECIAL SUPPLEMENT
THE TAX PROVISIONS OF THE PATIENT PROTECTION ACT

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. 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.

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).

II. INDIVIDUAL TAX PROVISIONS

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	$7,500
Applicable Percentage	.025
Percentage Amount	$1,875
Flat Amount	$695
Shared Responsibility Penalty	*$1,875*

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. ***The Premium Assistance Tax Credit - Sec. 36B***

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

(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.

(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.

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 is 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. 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.*

G. 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).

H. 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.

I. 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.

III. BUSINESS TAX PROVISIONS

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

a. 35% for small employers with fewer than 25 employees and average annual wages of less than $50,000 who offer health insurance coverage to their employees.

b. 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.

6. 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.

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

B. 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.

1. 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)).

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

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.