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Healthcare Reform Bill

What you NEED to know!

Legislative Watch—

Ground-breaking health care reform legislation OK'd by Congress

In the late evening of March 25, Congress, by a vote of 220-207, passed H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act). The President's signature of the measure into law will complete a massive overhaul of the U.S. health care system that will affect nearly all taxpayers, many employers, and many elements of the health care industry.

Earlier in the afternoon of March 25, the Senate by a vote of 56-43 approved H.R. 4872. However, the bill had to be sent back to the House for another vote after Senate Parliamentarian Alan Frumin, ruled in favor of two Republican objections to minor sections of a Pell Grant provision in the student loan part of the bill that violated budget rules. The House has now approved the Senate passed-bill without change, thus clearing the bill for the President's signature.

The Reconciliation Act modifies legislation signed into law earlier this week that contains the bulk of the health reform law, H.R. 3590, the Patient Protection and Affordable Care Act (Health Care Act, P.L. 111-148). However, the Reconciliation Act also includes new provisions that weren't part of the earlier legislation, such as codification of economic substance, elimination of a tax credit for "black liquor" and expanded dependent coverage in employer health plans.

For a summary of the key provisions in the new health reform legislation, see the Featured Article below. For a Special Study on tax changes in the new health reform law relating to the universal health coverage mandate, also see the Featured Article below.

Featured Articles—

Congress passes ground-breaking health reform law

In the late evening of March 25, Congress passed H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act). Once the President signs it, a massive overhaul of the U.S. health care system affecting nearly all taxpayers, many employers, and many elements of the health care industry will be complete.

The Reconciliation Act modifies legislation signed into law earlier this week that contains the bulk of the health reform law, H.R. 3590, the Patient Protection and Affordable Care Act (Health Care Act, P.L. 111-148). However, the Reconciliation Act also includes new provisions that weren't part of the earlier legislation, such as codification of economic substance, elimination of a tax credit for "black liquor" and expanded dependent coverage in employer health plans.

This article carries a summary of the key provisions in the new health reform legislation, along with Code Sections and amending Act Sections. Note some changes may be affected by more than one Health Care Act Section, or by both the Health Care Act and the Reconciliation Act. For a Special Study on tax changes relating to the new law's universal health coverage mandate, see the next article below.

Tax Changes Relating to Universal Health Coverage Mandate

<u>Penalty for remaining uninsured</u>. For tax years beginning after Dec. 31, 2013, non-exempt U.S. citizens and legal residents will have to maintain minimum essential coverage or pay a penalty.

Those failing to maintain minimum essential coverage in 2016 will be subject to a penalty equal to the greater of: (1) 2.5% of household income over the threshold amount of income required for income tax return filing, or (2) $695 per uninsured adult in the household. The fee for an uninsured individual under age 18 will be one-half of the fee for an adult. The total household penalty won't exceed 300% of the per adult penalty ($2,085), nor exceed the national average annual premium for the "bronze level" health plan offered through the Insurance Exchange that year for the household size.

The per adult annual penalty will be phased in as follows: $95 for 2014; $325 for 2015; and $695 in 2016. For years after 2016, the $695 amount will be indexed to CPI-U, rounded to the next lowest $50. The percentage of income will be phased in as follows: 1% for 2014; 2% in 2015; and 2.5% beginning after 2015. If a taxpayer files a joint return, the individual and spouse will be jointly liable for any penalty payment. The penalty, which will apply to any period the individual does not maintain minimum essential coverage (determined monthly) will be assessed through the Code.

Among those individuals who will be exempted from the penalty: 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; those who are exempted for religious reasons; and those residing outside of the U.S. (Code Sec. 5000A, as added by Health Care Act Sec. 1501, as amended by Health Care Act Sec. 10106, and as further amended by Reconciliation Act Sec. 1002)

Low-income tax credits for participating in health exchanges. For tax years ending after 2013, tax credits will be available for individuals and families with incomes up to 400% of the federal poverty level ($43,320 for an individual or $88,200 for a family of four) that are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage. These individuals and families will have to obtain health care coverage in newly established Insurance Exchanges in order to obtain credits. (New Code Sec. 36B, Health Care Act Sec. 1401, 1411 and 1412, as amended by Health Care Act Secs. 10104, 10105, and 1017, and as further amended by Heath Care Act Sec. 1001) A “cost-sharing subsidy” will be provided to low income individuals to help with health insurance costs. (Health Care Act Secs. 1402, 1411, and 1412, as amended by Health Care Act Sec. 10104, and further amended by Reconciliation Act Sec. 1001)

Employer responsibilities. For months beginning after Dec. 31, 2013, an “applicable large employer” (generally, one that employed an average of at least 50 full-time employees during the preceding calendar year) not offering coverage for all its full-time employees, offering minimum essential coverage that is unaffordable, or 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%, 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. The penalty for any month will 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.

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 will 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. (Code Sec. 4980H, as added by Health Care Act Sec. 1513, as amended by Health Care Act Sec. 10106, and as further amended by Reconciliation Act Sec. 1003)

“Free choice vouchers”. After Dec. 31, 2013, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage will have to provide qualified employees with a voucher whose value can be applied to purchase of a health plan through the Insurance

Exchange. Qualified employees are those employees:

- who do not participate in the employer's health plan;
- whose required contribution for employer sponsored minimum essential coverage (if they did participate in the plan) exceeds 8%, but does not exceed 9.5% of household income; and
- whose total household income does not exceed 400% of the poverty line for the family.

After 2014, the 8% and 9.5% will be indexed to the excess of premium growth for the preceding calendar year. The value of the voucher is equal to the dollar value of the employer contribution to the employer offered health plan and is not includable in income to the extent it is used for the purchase of health plan coverage. If the value of the voucher exceeds the premium of the health plan chosen by the employee, the employee is paid the excess value of the voucher. The excess amount received by the employee is includible in gross income. If an individual receives a voucher, he is disqualified from receiving any tax credit or cost sharing credit for the purchase of a plan in the Insurance Exchange. Similarly, if any employee receives a free choice voucher, the employer is not assessed a shared responsibility payment on behalf of that employee. (Code Sec. 139D, as added by Health Care Act Sec. 10108)

Tax credits for small employers offering health coverage. For tax years beginning after Dec. 31, 2009, an eligible small employer will be given a tax credit for nonelective contributions to purchase health insurance for its employees. An eligible small employer generally is an employer with no more than 25 full-time equivalent employees (FTEs) employed during the employer's tax year, and whose employees have annual full-time equivalent wages that average no more than $50,000. However, the full amount of the credit is 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. These wage limits will be indexed to the Consumer Price Index for Urban Consumers ("CPI-U") for years beginning in 2014.

For tax years beginning in 2010 through 2013, the credit will be 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. In 2014 and later, eligible small employers who purchase coverage through the Insurance Exchange will be eligible for a tax credit for two years of up to 50% of their contribution. (Code Sec. 45R, as added by Health Care Act Sec. 1421, as amended by Health Care Act Sec. 10105)

Dependent coverage in employer health plans. Effective on the enactment date of the Reconciliation Act, the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan is extended to any child of an employee who has not attained age 27 as of the end of the tax year. The Committee Report says this change is also intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child. Also, self-employed individuals may take a deduction for any child of the taxpayer who has not attained age 27 as of the end of the tax year. (Code Sec. 105, Code Sec. 162, Code Sec. 401, and Code Sec. 501, as amended by Reconciliation Act Sec. 1004(b))

Health-Related Revenue Raisers

Excise tax on high-cost employer-sponsored health coverage. 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.

The tax will 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). Stand-alone dental and vision plans will be disregarded in applying the tax. The dollar amount thresholds will 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.

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

The excise tax will be levied at the insurer level. Employers will be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax. (Code Sec. 4980I, as added by Health Care Act Sec. 9001, as amended by Health Care Act Sec. 10901, and as further amended by Reconciliation Act Sec. 1401)

Cost of employer sponsored health coverage included on Form W-2. For tax years beginning after Dec. 31, 2010, employers must disclose the value of the benefit provided by them for each employee's health insurance coverage on the employee's annual Form W-2. (Code Sec. 6051(a)(14), as amended by Health Care Act Sec. 9002)

Other new employer reporting responsibilities for health coverage. For calendar years beginning after 2013, insurers (including employers who self-insure) that provide minimum essential coverage to any individual during a calendar year must report the following to both the covered individual and to IRS: (1) name, address, and taxpayer identification number (TIN) of the primary insured, and name and TIN of each other individual obtaining coverage under the policy; (2) the dates during which the individual was covered under the policy during the calendar year; (3) whether the coverage is a qualified health plan offered through an exchange; (4) the amount of any premium tax credit or cost-sharing reduction received by the individual with respect to such coverage; and (5) such other information as IRS may require. To the extent coverage is through an employer-provided group health plan, the insurer is also required to report the name, address and employer identification number of the employer, the portion of the premium, if any, required to be paid by the employer, and any other

information IRS may require to administer the new tax credit for eligible small employers (see discussion above). (Code Sec. 6056, as added by, and Code Sec. 6724, as amended by, Health Care Act Sec. 1514)

Additional Hospital Insurance Tax (HI) for high wage workers. For tax years beginning after Dec. 31, 2012, the HI tax rate is increased by 0.9 percentage points on an individual taxpayer earning over $200,000 ($250,000 for married couples filing jointly); these figures are not indexed. (Code Sec. 1401 and Code Sec. 3101, as amended by Health Care Act Sec. 9015, as amended by Health Care Act Sec. 10906)

Surtax on unearned income. For remuneration received, and tax years beginning after, Dec. 31, 2012, a 3.8% surtax (called the Unearned Income Medicare Contribution) will apply to net investment income of higher income taxpayers. The surtax for individuals is 3.8% of the lesser of (1) net investment income or (2) the excess of modified adjusted gross income (AGI) over the threshold amount. The threshold amount is $250,000 for a joint return or surviving spouse, $125,000 for a married individual filing a separate return, and $200,000 in any other case. Modified AGI is AGI increased by the amount excluded from income as foreign earned income under Code Sec. 911(a)(1) (net of the deductions and exclusions disallowed with respect to the foreign earned income).

For an estate or trust, the surtax is 3.8% of the lesser of: (1) undistributed net investment income or (2) the excess of AGI (as defined in Code Sec. 67(e)) over the dollar amount at which the highest income tax bracket applicable to an estate or trust begins.

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

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

Net investment income for surtax purposes is interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Investment income is reduced by properly allocable deductions to such income to arrive at nest investment income. (Code Sec. 1411, as added by Reconciliation Act Sec. 1402)

New limit on health FSA contributions. For tax years beginning after Dec. 31, 2012, the amount of contributions to health flexible spending accounts (FSAs) will be limited to $2,500 per year. The dollar amount will be inflation indexed after 2013. (Code Sec. 125 , as amended by Health Care Act Sec. 9005, as amended by Health Care Act Sec. 10902, and as further amended by Reconciliation Act Sec. 1403)

Restricted definition of medical expenses for employer provided coverage. 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 is generally conformed to the definition for purposes of the itemized deduction for medical expenses. But this change does not apply to doctor prescribed over-the-counter medicine. Thus, the cost of over-the-counter medicine (other than insulin or doctor prescribed medicine) cannot be reimbursed through a health FSA or HRA. In addition, the cost of over-the-counter medicines (other than insulin or doctor prescribed medicine) cannot be reimbursed on a tax-free basis through an HSA or Archer MSA. These changes for HSAs and Archer MSAs apply for amounts paid with respect to tax years beginning after Dec. 31, 2010. The changes for health FSAs and HRAs apply for expenses incurred with respect to tax years beginning after Dec. 31, 2010. (Code Sec. 106(f), Code Sec. 220(d)(2), and Code Sec. 223(d)(3), as amended by Health Care Act Sec. 9003)

Increased tax on nonqualifying HSA or Archer MSA distributions. For distributions made after Dec. 31, 2010, the additional tax for HSA withdrawals before age 65 that are used for purposes other than qualified medical expenses is increased from 10% to 20%, and the additional tax for Archer MSA withdrawals that are used for purposes other than qualified medical expenses is increased from 15% to 20%. (Code Sec. 220(f)(4)(A) and Code Sec. 223(f)(4)(A), as amended by Health Care Act Sec. 9004)

Modified threshold for claiming medical expense deductions. For tax years beginning after Dec. 31, 2012, the adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses will be increased from 7.5% to 10%. However, the 7.5%-of-AGI threshold will continue to apply through 2016 to individuals age 65 and older (and their spouses). (Code Sec. 56(b)(1)(B), Code Sec. 213(a), and Code Sec. 213(f), as amended by Health Care Act Sec. 9004)

Deduction for employer Part D is eliminated. For tax years beginning after Dec. 31, 2012, the deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees will be eliminated. (Health Care Act Sec. 9012, as amended by Reconciliation Act 1407)

Industry-specific revenue raisers. The following revenue raising changes will be imposed on health related industries:

- A new deduction limit on executive compensation applies to insurance providers. 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 new health reform law ("covered health insurance provider"), an annual $500,000 per tax year compensation deduction limit will apply for all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider. The limit applies to tax years beginning after Dec. 1, 2009, with respect to services performed after that date. (Code Sec. 162(m)(6), as amended by Health Care Act Sec. 9014)
- Pharmaceutical manufacturers and importers will have to pay an annual flat fee beginning in 2011 allocated

across the industry according to market share. The schedule for the flat fee will be: 2011, $2.5 billion; 2012 to 2016, $3 billion; 2017, $4 billion; 2018, $4.1 billion; 2019 and later, $2.8 billion. The fee will not apply to companies with sales of branded pharmaceuticals of $5 million or less. (Health Care Act Sec. 9008, as amended by Reconciliation Act Sec. 1404)

- For sales after Dec. 31, 2012, manufacturers or importers of medical devices will 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 taxable medical device is any device, defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act, intended for humans. The excise tax will 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. (Code Sec. 4191, as added by Reconciliation Act Sec. 1405)
- Health insurance providers will face an annual flat fee on the health insurance sector effective for calendar years beginning after Dec. 31, 2013. The fee will be allocated based on market share of net premiums written for a U.S. health risk for calendar years beginning after Dec. 31, 2012. The aggregate annual flat fee for the industry will be: $8 billion for 2014; $11.3 billion for 2015 and 2016; $13.9 billion for 2017; and $14.3 billion for 2018. The fee will be indexed to the rate of premium growth for later years. The fee will not apply to companies whose net premiums written are $25 million or less. (Health Care Act Sec. 9010, as amended by Health Care Act Sec. 10905, as further amended by Reconciliation Act Sec. 1406)
- For services provided on or after July 1, 2010, the indoor tanning industry will be hit with a 10% excise tax on indoor tanning services. (Code Sec. 5000B , as added by Health Care Act Sec. 9017, as amended by Health Care Act Sec. 10907)
- For tax years beginning after Dec. 31, 2009, nonprofit Blue Cross Blue Shield organizations must 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. (Code Sec. 833(c)(5) , as amended by Health Care Act Sec. 9016)

Non-Health Related Revenue Raisers

Corporate information reporting. For payments made after Dec. 31, 201, businesses that pay any amount greater than $600 during the year to corporate providers of property and services will have to file an information report with each provider and with IRS. (Code Sec. 6041(h), as amended by Health Care Act Sec. 9006)

Codification of economic substance doctrine and imposition of penalties. The economic substance doctrine is a judicial doctrine that has been used by the courts to deny tax benefits when the transaction generating these tax benefits lacks economic substance. The courts have not applied the economic substance doctrine uniformly. For transactions entered into after the enactment date of the Reconciliation Act, and to underpayments, understatements, and refunds and credits attributable to transactions entered into after the enactment date of the Reconciliation Act, the manner in which the economic substance doctrine should be applied by the courts is clarified and a penalty is imposed on understatements attributable to a transaction lacking economic substance. (Code Sec. 6662, Code Sec. 6662A, Code Sec. 6664, Code Sec. 6676, and Code Sec. 7701, as

amended by Reconciliation Act Sec. 1409)

Elimination of credit for "black liquor". A $1.01 per gallon tax credit applies for the production of biofuel from cellulosic feedstocks in order to encourage the development of new production capacity for biofuels that are not derived from food source materials. Congress is aware that some taxpayers are seeking to claim the cellulosic biofuel tax credit for unprocessed fuels, such as "black liquor." For fuel sold or used after Dec. 31, 2009, eligibility for the tax credit under the Reconciliation Act will be limited to processed fuels (i.e., fuels that could be used in a car engine or in a home heating application). (Code Sec. 40 , as amended by Reconciliation Act Sec. 1408)

Estimated taxes for large corporations. The required corporate estimated tax payments factor for corporations with assets of at least $1 billion will be increased by 15.75 percentage points for payments due in July, August, and September of 2014. (Code Sec. 6655, as amended by Reconciliation Act Sec. 1410)

Other Tax Changes

Simple cafeteria plans for small businesses. For tax years beginning after 2010, a new employee benefit cafeteria plan known as a Simple Cafeteria Plan will be available. This plan will be subject to eased participation restrictions so that small businesses could provide tax-free benefits to their employees; it will include self-employed individuals as qualified employees. (Code Sec. 125(j), as amended by Health Care Act Sec. 9022)

Liberalized adoption credit and adoption assistance rules. For tax years beginning after Dec. 31, 2009, the adoption tax credit will be increased by $1,000, and made refundable. The adoption assistance exclusion also will be increased by $1,000. Both credit and exclusion are extended through 2011. (Code Sec. 23 and Code Sec. 137, as amended by Health Care Act Sec. 10909)

New credit for new therapies. For expenses paid or incurred after Dec. 31, 2008, in tax years beginning after that date, a two-year temporary credit applies, subject to an overall cap of $1 billion, to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases. (Code Sec. 48D, as added by Health Care Act Sec. 9023)

New exclusion for certain health professionals. Payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas are excluded from gross income, effective for amounts received by an individual in tax years beginning after Dec. 31, 2008. (Code Sec. 108(f) , as amended by Health Care Act Sec. 10908) (A separate provision excludes from gross income the value of specified Indian tribal health benefits, effective for benefits and coverage provided after Mar. 23, 2010 (the enactment date of the Health Care Act.) (Code Sec. 139D, as added by Health Care Act Sec. 9021)

Source: Federal Tax Updates on Checkpoint Newsstand tab 3/26/2010

Special Study: Tax Changes in New Health Reform Law Relating to Universal Health Coverage Mandate

The centerpiece in the health reform law that Congress has passed—consisting of H.R. 3590, the Patient Protection and Affordable Care Act (Health Care Act, P.L. 111-148), and H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act)—is the mandate for most residents of the United States to obtain health insurance. This mandate carries with it a host of new tax rules, such as new penalties for individuals who choose to remain uninsured, tax credits and other sweeteners for participating in new insurance coverages, new penalties for larger employers that don't provide insurance (or provide coverage deemed inadequate or unaffordable), plus a voucher system for certain lower income employees who choose not to be covered by the company health plan. Additionally, the definition of who is a dependent for employer health plan (and other purposes) has been expanded.

This Special Study features highlights of the tax changes in the new health reform law that relate to the universal health coverage mandate. It includes citations to the Health Care Act and Reconciliation Act, and the applicable Code Sections they amend. Note that some changes may be affected by more than one Health Care Act Section, or by both the Health Care Act and the Reconciliation Act. For an overall summary of key provisions in the new health reform legislation, see the article above.

Individuals Who Have No Health Insurance After 2013 Face Tax Penalty

Under pre-Act law, Federal law does not require individuals to carry health insurance. Only Massachusetts, through its statewide program, requires individuals to have health insurance.

New law. For tax years beginning after Dec. 31, 2013, non-exempt U.S. citizens and legal residents must maintain minimum essential coverage, which includes government sponsored programs (e.g., Medicare, Medicaid, Children's Health Insurance Program), eligible employer-sponsored plans, plans in the individual market, certain grandfathered group health plans and other coverage as recognized by Health and Human Services (HHS) in coordination with IRS. (Code Sec. 5000A, as added by Health Care Act Sec. 1501, as amended by Health Care Act Sec. 10106, and as further amended by Reconciliation Act Sec. 1002)
The coverage requirement does not apply to:

- 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 for the year. After 2014, the 8% exemption is increased by the amount by which premium growth exceeds income growth. If self-only coverage is affordable to an employee, but family coverage is unaffordable, the employee is subject to the mandate penalty if he does not maintain minimum essential coverage. However, any individual eligible for employer coverage due to a relationship with an employee (e.g. spouse or child

of employee) is exempt from the penalty if that individual does not maintain minimum essential coverage because family coverage is not affordable (i.e., exceeds 8% of household income).
- Taxpayers with income below the income tax filing threshold (which for 2010 generally is $9,350 for a single person or a married person filing separately and is $18,700 for married filing jointly).
- Those exempted for religious reasons (who must be members of a recognized religious sect exempting them from self-employment taxes).
- Individuals residing outside of the U.S. (who are deemed to maintain minimum essential coverage).
- Individuals who are incarcerated or are not legally present in the U.S.
- All members of Indian tribes. (Code Sec. 5000A(d), Code Sec. 5000A(e), Code Sec. 5000A(f))

Individuals may also apply to HHS for a hardship exemption due to hardship in obtaining coverage.

Amount of penalty. The monthly penalty amount for any taxpayer for any month during which any failure to maintain minimum essential coverage occurred will be an amount equal to 1/12 of the greater of a flat dollar amount or a percentage of income.

The flat dollar amount used in determining the monthly penalty amount will be an amount equal to the lesser of—

- the sum of the applicable dollar amounts (see below) for all individuals with respect to whom a failure to maintain minimum essential coverage occurred during the month, or
- 300% of the applicable dollar amount (determined without regard to the special rule for individuals under age 18, see below) for the calendar year with or within which the tax year ends.

The percentage of income used in determining the monthly penalty amount will be the following percentage of (i) the excess of the taxpayer's household income for the tax year over (ii) the amount of gross income specified in Code Sec. 6012(a) with respect to the taxpayer (i.e., the threshold amount of income required for income tax return filing for that taxpayer) for the tax year:

- 1.0% for tax years beginning in 2014.
- 2.0% for tax years beginning in 2015.
- 2.5% for tax years beginning after 2015. (Code Sec. 5000A(c)(2))

Except for individuals under age 18 (see below), the "applicable dollar amount" will be:

- $95 for 2014,
- $325 for 2015, and
- $695 for 2016 and later years (subject to an adjustment for inflation after 2016, see below). (Code Sec. 5000A(c)(3))

For calendar years after 2016, the "applicable dollar amount" will be $695, multiplied by a cost-of-living adjustment

If an applicable individual has not attained the age of 18 as of the beginning of a month, the "applicable dollar amount" for him or her for the month will be equal to one-half of the "applicable dollar amount" for the calendar year in which the month occurs.

Household income is the sum of the modified adjusted gross incomes (AGIs) of the taxpayer and all individuals accounted for in the family size required to file a tax return for that year. Modified AGI means AGI increased by all tax-exempt interest and foreign earned income.

If a taxpayer files a joint return, the individual and spouse are jointly liable for any penalty payment. The penalty applies to any period the individual does not maintain minimum essential coverage, is determined monthly, is assessed through the Code and is accounted for as an additional amount of Federal tax owed. However, the penalty is not subject to the enforcement provisions of subtitle F of the Code and the use of liens and seizures otherwise authorized for collection of taxes does not apply to the collection of this penalty. Noncompliance with the personal responsibility requirement to have health coverage is not subject to criminal or civil penalties under the Code and interest does not accrue for failure to pay such assessments in a timely manner.

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

Refundable Tax Credit Providing Premium Assistance for Coverage Under a Qualified Health Plan

There is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance.

New law. For tax years ending after Dec. 31, 2013, there will be a new refundable tax credit (the "premium assistance credit") to qualifying taxpayers who get health insurance coverage by enrolling in a qualified health plan (QHP) through an Exchange (see below). (Code Sec. 36B , as added by Health Care Act Secs. 1401, 1411, and 1412, as amended by Health Care Act Secs. 10104, 10105, 10107, as further amended by Reconciliation Act Sec. 1001).

RIA observation: The Health Care Act requires each state to establish an "American Health Benefit Exchange" ("Exchange") by Jan. 1, 2014, and requires insurers to provide QHPs to be sold on these Exchanges. Thus,

while the Exchanges will not be insurers themselves, they will provide access to insurers' QHPs in a comparable way. Individuals will be able to get affordable, quality health insurance by enrolling in a QHP through an Exchange. The new premium assistance credit applies to QHPs purchased on these Exchanges. This means that qualifying individuals will be able to use the credit to reduce their health insurance costs, if they get the coverage by enrolling in a QHP on an Exchange.

The basic rules for the premium assistance credit and cost-sharing reductions are outlined below.

Starting in 2014, "applicable taxpayers" (generally, individuals whose household income is at least 100% but not more than 400% of the federal poverty line and who don't receive health insurance under an employer plan) will be allowed a refundable tax credit for the premiums paid during the tax year for QHP insurance coverage purchased on an Exchange. (Code Sec. 36B(a), Code Sec. 36B(c)(1))

The mechanics of the credit will be as follows: An eligible individual will enroll in a plan offered through an Exchange and report his or her income to the Exchange. Based on the information provided to the Exchange, the individual will receive a premium assistance credit based on income. IRS will pay the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then will pay to the plan in which he or she is enrolled the dollar difference between the premium assistance credit amount and the total premium charged for the plan. Individuals who fail to pay all or part of the remaining premium amount will be given a mandatory three-month grace period before an involuntary termination of their participation in the plan. For employed individuals who purchase health insurance through a state Exchange, the premium payments will be made through payroll deductions. Initial eligibility for the premium assistance credit will be based on the individual's income for the tax year ending two years before the enrollment period. (Committee Report)

The amount allowed as a premium assistance credit for a tax year will be equal to a percentage (based on the taxpayer's household income level relative to the federal poverty line) of the amounts paid for QHP coverage of the taxpayer and qualifying family members (spouse and dependents) for the year. The calculation is computed on a sliding scale starting at 2.0% of income for taxpayers at or above 100% of the poverty line and phasing out to 9.5% of income for those at 400% of the poverty line. The reference premium will be the second lowest cost silver plan available in the individual market in the rating area in which the taxpayer resides. (Code Sec. 36B(b))

The cost-sharing (e.g., deductibles, co-payments) that may otherwise be required under a QHP will be reduced for individuals at or below 400% of the poverty line. The standard out-of-pocket maximum limits will be reduced by two-thirds for individuals with household income of more than 100% but not more than 200% of the poverty line, by one-half for individuals between 201% and 300% of the poverty line, and by one-third for individuals between 301% and 400% of the poverty line. The cost-sharing subsidy is available only for those months in which an individual receives a credit under Code Sec. 36B . (Health Care Act Sec. 1402)

Advance determinations and payments of premium assistance credits and cost-sharing reductions (sometimes referred to as "cost-sharing subsidies") are allowed. Advance payments of the credit will be made directly to the individual's insurance plan. (Health Care Act Sec. 1412)

The amount claimed as a premium assistance credit for a tax year must be adjusted to reflect premium assistance received through advance payments of the credit and any adjustments to the amount allowable as a credit. (Code Sec. 36B(f))

The Secretary of Health and Human Services (HHS Secretary) must establish procedures for determining whether an individual who is applying for coverage in the individual market by a QHP offered through an Exchange, or who is claiming a premium assistance credit or reduced cost-sharing, meets the necessary eligibility requirements. (Health Care Act Sec. 1411)

Large Employers Subject to Health Coverage Excise Tax After 2013

Under pre-Act law, there is no Federal requirement that employers offer health insurance coverage to employees or their families.

New law. For months beginning after Dec. 31, 2013, the Act provides that under the "shared responsibility for employers regarding health coverage" excise taxes, a large employer (generally, an employer with at least 50 full-time employees) that doesn't offer health care coverage for all its full-time employees, offers minimum essential coverage that is unaffordable, or offers 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%, 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 , as added by Health Care Act Sec. 1513, as amended by Health Care Act Act Sec. 10106 and Health Care Act Sec. 10108, and as further amended by Reconciliation Act Sec. 1003, Committee Report)

RIA observation: Generally, if an employee is offered affordable minimum essential coverage under an employer-sponsored plan, then he is ineligible for a premium tax credit and cost sharing reductions for health insurance purchased through a state exchange. But, if he is offered minimum essential coverage that is either "unaffordable" (coverage with a premium required to be paid by the employee that is more than 9.5% of the employee's household income, as defined for the premium tax credits) or that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%, then he is eligible, but only if he declines to enroll in the coverage, and purchases coverage through the exchange instead.

These excise taxes are payable on notice and demand by IRS. The payment of any assessable payment of these excise taxes on an annual, monthly, or other periodic basis, as IRS may prescribe. (Code Sec. 4980H(d))

These excise taxes are nondeductible under Code Sec. 275(a)(6) (which prohibits certain taxes from being deductible). (Code Sec. 4980H(c)(7)) Details on these two excise taxes follow:

Excise tax on employers not offering a health care plan. For months beginning after Dec. 31, 2013, if an "applicable large employer" (see below):

(1) fails to offer to its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan" for that month; and
(2) at least one full-time employee has been certified to the employer as having enrolled for that month in a qualified health plan for which an "applicable premium tax credit or cost-sharing reduction"—collectively referred to as "health coverage assistance," i.e., any Code Sec. 36B premium tax credit, cost-sharing reduction, and advance payment of the premium tax credit or cost-sharing reduction—is allowed or paid with respect to the employee;

then the employer must pay an assessable payment equal to: the "applicable payment amount" (see below) × the number of the employer's "full-time employees" (see below) during any month (reduced by 30 employees under the Code Sec. 4980H(c)(2) reduction rule). (Code Sec. 4980H(a)) The "applicable payment amount" is $166.67 for any month (that is, 1/12 of $2,000, which is adjusted for inflation after 2014). (Code Sec. 4980H(c)(1))

Illustration: In 2014, Employer fails to offer minimum essential coverage and has 100 full-time employees, ten of whom receive a tax credit for the year for enrolling in a state exchange-offered plan. For each employee over the 30-employee threshold, the employer owes $2,000, for a total penalty of $140,000 ($2,000 × 70 (that is, 100 − 30)). This penalty is assessed on a monthly basis. (Committee Report)

Excise tax on employers with employees qualifying for premium tax credits or cost-sharing assistance. For months beginning after Dec. 31, 2013, if an applicable large employer:

(1) offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan for that month; and
(2) at least one full-time employee of the employer has been certified to the employer as having enrolled for that month in a qualified health plan for which an applicable premium tax credit, or cost-sharing reduction, is allowed or paid with respect to the employee;

then, subject to an overall limit, the employer must pay an assessable payment equal to: the number of the employer's full-time employees for any month who receive premium tax credits or cost-sharing assistance × 1/12 of $3,000 (adjusted for inflation after 2014). (Code Sec. 4980H(b)(1)) But, the assessable payment won't be imposed for any month for any employee for whom the employer provides a free choice voucher for that month. (Code Sec. 4980H(b)(3)) An overall limit applies under which the aggregate amount of tax for

all employees of an applicable large employer for any month cannot exceed: the applicable payment amount × the number of the employer's full-time employees during that month (reduced by 30 employees under the Code Sec. 4980H(c)(2) reduction rule). (Code Sec. 4980H(b)(2))

Illustration: In 2014, Employer offers health coverage and has 100 full-time employees, 20 of whom receive a tax credit for the year for enrolling in a state exchange-offered plan. For each employee receiving a tax credit, the employer owes $3,000, for a total penalty of $60,000. The maximum penalty for this employer is capped under the overall limit at the amount of the penalty that it would have been assessed for a failure to provide coverage, or $140,000 ($2,000 × 70 (that is, 100 − 30). Since the calculated penalty of $60,000 is less than the maximum amount, Employer pays the $60,000 calculated penalty. This penalty is assessed on a monthly basis. (Committee Report)

Applicable large employer defined. For a calendar year, an "applicable large employer" is one that employed an average of at least 50 "full-time employees" on business days during the preceding calendar year (for an employer that wasn't in existence throughout the preceding calendar year, the determination is based on the average number of employees reasonably expected to be employed on business days in the current calendar year). But under an exemption, an employer will not be considered to employ more than 50 full-time employees if: (a) the employer's workforce exceeds 50 full-time employees for 120 days, or fewer, during the calendar year; and (b) the employees in excess of 50 employed during that 120-day (or fewer) period were seasonal workers (as defined in Code Sec. 4980H(c)(2)(B)(ii)), e.g., retail workers employed exclusively during the holiday season. (Code Sec. 4980H(c)(2))

Solely for purposes of determining whether an employer is an applicable large employer, in addition to including the number of full-time employees for any month otherwise determined, under a full-time equivalent rule for counting part-time workers, an employer will also have to include for that month the number of full-time employees determined by dividing (a) the aggregate number of hours of service of employees who are not full-time employees for the month, by (b) 120. (Code Sec. 4980H(c)(2)(E))

The aggregation rules under Code Sec. 414(b) (controlled group of corporations), Code Sec. 414(c) (partnerships, proprietorships, etc., under common control), Code Sec. 414(m) (affiliated service group), and Code Sec. 414(o) (employee leasing and other arrangements treated by IRS as a single employer) apply in determining applicable large employer status. (Code Sec. 4980H(c)(2)(C)(i)) For persons treated as one employer under the aggregation rules, only one 30-employer reduction applies, allocated among the persons ratably on the basis of the number of full-time employees each employed. (Code Sec. 4980H(c)(2)(D))

Full-time employee defined. For any month, a "full-time employee" is an employee who is employed on average at least 30 hours of service per week. IRS, in consultation with DOL, is to prescribe regs, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for employees who aren't compensated on an hourly basis. (Code Sec. 4980H(c)(4)(B))

Medicaid coverage. An employer is not required to pay a penalty for any employees enrolled in Medicaid. (Committee Report)

Employers Providing Health Plans Must Provide "Free Choice" Vouchers to Non-Participating Employees

Effective for periods after Dec. 31, 2013, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage must provide qualified employees with a "free choice" voucher whose value can be applied to purchase of a health plan through the Insurance Exchange. (Code Sec. 139D, as added by Health Care Act Sec. 10108) The employer treats the free choice voucher it pays as an amount for compensation for personal services actually rendered. (Code Sec. 162(a))

Qualified employees are those employees:

- who do not participate in the employer sponsored plan;
- whose required contribution for employer sponsored minimum essential coverage (if they did participate in the plan) exceeds 8%, but does not exceed 9.5% of household income; and
- whose total household income does not exceed 400% of the poverty line for the family.

After 2014, the 8% and 9.5% will be indexed to the excess of premium growth for the preceding calendar year.

The amount of the free choice voucher is equal to the monthly portion of the cost of the eligible employer sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. The amount will be equal to the amount the employer would pay for an employee with self-only coverage unless the employee elects family coverage (in which case such amount will be the amount the employer would pay for family coverage). (Health Care Act Sec. 1018(d))

If the value of the voucher exceeds the premium of the health plan chosen by the employee, the employee is paid the excess value of the voucher, and the excess amount received by the employee is includible in gross income (otherwise, the voucher doesn't result in income to the employee). (Code Sec. 139D)

If an individual receives a voucher, he is disqualified from receiving any tax credit or cost sharing credit for the purchase of a plan in the Insurance Exchange. Similarly, if any employee receives a free choice voucher, the employer is not assessed a shared responsibility payment on behalf of that employee. (Health Care Act Sec. 1018(h) and (i))

Small Employer Health Insurance Credit

There is no tax credit for employers that provide health coverage for their employees.

New law. For tax years beginning after Dec. 31, 2009, a tax credit is provided for an eligible small employer for nonelective contributions to purchase health insurance for its employees. (Code Sec. 45R , as added by Health Care Act Sec. 1421, as amended by Health Care Act Sec. 10105) An eligible small employer (ESE) for this purpose generally is an employer with no more than 25 full-time equivalent employees ("FTEs") employed during its tax year, and whose employees have annual full-time equivalent wages that average no more than $50,000. (Code Sec. 45R(d)) However, the full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than $25,000. (Code Sec. 45R(c))

The contributions must be provided under an arrangement that requires the eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in certain defined qualifying health insurance offered to employees by the employer equal to a uniform percentage (not less than 50%) of the premium cost of the qualifying health plan. (Code Sec. 45R(d)(4))

The credit is only available to offset actual tax liability and is claimed on the employer's tax return. The credit is not payable in advance to the taxpayer or refundable. Thus, the employer must pay the employees' premiums during the year and claim the credit at the end of the year on its income tax return. (Committee Report). The credit is a general business credit, and can be carried back for one year and carried forward for 20 years. (Code Sec. 38(b), Code Sec. 39(a)) The credit is available for tax liability under the alternative minimum tax. (Code Sec. 38(c)(4)(B)(vi))

Year the credit is available. The credit is initially available for any tax year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage within the meaning of Code Sec. 9832, which is generally health insurance coverage purchased from an insurance company licensed under State law.

For tax years beginning in years after 2013, the credit is only available to an eligible small employer that purchases health insurance coverage for its employees through a State exchange and is only available for a maximum coverage period of two consecutive tax years beginning with the first year in which the employer or any predecessor first offers one or more qualified plans to its employees through an exchange.

Calculation of credit amount. The credit is equal to the lesser of the following two amounts multiplied by an applicable tax credit percentage: (1) the amount of contributions the ESE made on behalf of the employees during the tax year for the qualifying health coverage and (2) the amount of contributions that the employer would have made during the tax year if each employee had enrolled in coverage with a small business benchmark premium. (Code Sec. 45R(b)) To calculate the contributions under the second of these

two amounts, the benchmark premium is multiplied by the number of employees enrolled in coverage and then multiplied by the uniform percentage that applies for calculating the level of coverage selected by the employer. (Committee Report)

The applicable percentage is 35% for tax years beginning in after 2009 and before 2014. It is 50% for tax years beginning after 2013. (Code Sec. 45R(b))

The credit is reduced for employers with more than 10 FTEs but not more than 25 FTEs. It is also reduced for an employer for whom the average wages per employee is between $25,000 and $50,000. (Code Sec. 45R(c)) Tax-exempt 501(c) organizations are allowed the credit in a lesser amount against certain payroll taxes. (Code Sec. 45R(f))

Special rules. The credit reduces the employer's deduction under Code Sec. 162 for contributions. (Code Sec. 45R(e)(5))

Aggregation rules apply in determining the employer. (Code Sec. 45R(b))

Self-employed individuals, including partners and sole proprietors, 2% shareholders of an S Corporation, and 5% owners of the employer (within the meaning of Code Sec. 416(i)(1)(B)(i)) are not treated as employees for purposes of this credit. Any employee with respect to a self employed individual is not an employee of the employer for purposes of this credit if the employee is not performing services in the trade or business of the employer. Thus, the credit is not available for a domestic employee of a sole proprietor of a business. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. (Code Sec. 45R(e)(1); Committee Report)

Child Under Age 27 Qualifies as Dependent for Employer-Provided & Other Health Coverage Exclusions

Under Code Sec. 106, employees may exclude from gross income the value of employer-provided health coverage under an accident or health plan. The exclusion applies to coverage for personal injuries or sickness for employees (including retirees), their spouses and their dependents. In addition, under Code Sec. 105(b), any reimbursements under an accident or health plan for medical care expenses for employees (including retirees), their spouses, and their dependents (as defined in Code Sec. 152, i.e., a qualifying child or qualifying relative) generally are excluded from gross income. For this purpose, a "child" means an individual who is the taxpayer's son, daughter, stepson, stepdaughter or eligible foster child (i.e., an individual who is placed with the taxpayer by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction). Under pre-Act law, among the requirements for a child to be a qualifying child of a taxpayer under Code Sec. 152(c) was that the child had to be under age 19 (or under age 24 in the case of a full-time student). No age limit applies for individuals who are totally and permanently disabled at any time

during the calendar year.

Self-employed individuals can deduct the cost of health insurance for themselves and their spouses and dependents.

A voluntary employees' beneficiary association (VEBA) is a tax-exempt entity that is a part of a plan providing life, sick or accident benefits to its members or their dependents or designated beneficiaries if no part of the net earnings of the association inures (other than through the payment of life, sick, accident or other benefits) to the benefit of any private shareholder or individual.

A qualified pension or annuity plan can establish and maintain a separate account to provide for the payment of sickness, accident, hospitalization, and medical expenses for retired employees, their spouses and their dependents (i.e., a "401(h) account").

New law. Effective on the enactment date, the Act amends Code Sec. 105(b) to extend the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan to any child of an employee who hasn't attained age 27 as of the end of the tax year. (Code Sec. 105(b), as amended by Reconciliation Act Sec. 1004(d)) This change is also intended to apply to the exclusion for employer-proved coverage under an accident or health plan for injuries or sickness for such a child. (Committee Report)

A parallel change is made for VEBAs, (Code Sec. 501(c)(9)) and for Code Sec. 401(h) accounts. (Code Sec. 401(h)) The Reconciliation Act similarly amends Code Sec. 162(l) to allow self-employed individuals to take a deduction for any child of the taxpayer who has not attained age 27 as of the end of the tax year. (Code Sec. 162(l)(1)(D))

RIA observation: If an S corporation pays accident and health insurance premiums (under a plan "established" by the S corporation) on behalf of a more-than-2% shareholder who is also its employee and who must include the value of the premiums in his gross income, the shareholder is permitted to deduct the cost of the premiums paid on his behalf to the extent allowed under the Code Sec. 162(l) rules. Thus, the expanded definition of children for whom the self-employed deduction for health insurance premiums may be claimed also applies to more-than-2% S corporation shareholders entitled to claim the deduction.

Source: Federal Tax Updates on Checkpoint Newsstand tab 3/26/2010