Chapter 7: Healthcare Reform Act

Corrections were made to this workbook through January of 2013. No subsequent modifications were made.

Two major statutes ushered in healthcare reform: The Patient Protection and Affordable Care Act (referred to in this chapter as the PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA). The PPACA was enacted on March 23, 2010, and the HCERA was enacted shortly thereafter on March 30, 2010.

The scope of these two statutes is immense. Although it is not practical to address all the changes they introduce, this chapter addresses those changes that are most important to a tax preparer.

Many major changes are being phased in over a period of years. Major administrative changes and procedures must be developed by several government agencies that are affected by the new legislative requirements, such as the Social Security Administration, the Department of Health and Human Services (HHS), and the IRS. Beginning in 2014, the IRS will play a pivotal role in the administration and implementation of healthcare reform. Over the next several months, the IRS will undergo massive internal changes that are necessary for this undertaking.

Caution. As of July 2012, many major areas of anticipated tax changes are still without IRS guidance because the IRS continues to develop necessary procedures, forms, and administrative rules. Provisions in which further IRS guidance appears necessary or is anticipated are noted in gray text boxes throughout this chapter.

The PPACA and HCERA have been very controversial and have been the subject of a large number of legal challenges since they were signed into law. The states of Florida and Virginia joined a lengthy list of challengers to the legislation that eventually included universities, several state and federal legislators, private citizens, and others. A total of 26 states joined in the Florida lawsuit challenging the PPACA. Ultimately, as the legal and constitutional issues were developed in various federal district and appellate court rulings, the Supreme Court decided to hear a case involving these issues.

A long-awaited Supreme Court decision was announced on June 28, 2012. The Supreme Court's decision[1] included the following main points.

- The individual responsibility mandate, which requires individuals to obtain health coverage, was upheld.
- The employer responsibility mandate, which imposes cost-sharing, reporting, and other obligations on employers, was upheld.
- The PPACA and related HCERA amendments were upheld with the exception of the federal government's attempted expansion of Medicaid.

1. *National Federation of Independent Business, et al v. Sebelius, Secretary of Health and Human Services, et al.*, 567 U.S. ___(2012).

Medicaid is a joint federal and state program that provides health care to very low income and disabled persons. The federal government pays the states to assist in the provision of these health services. Seven Supreme Court justices agreed that the federal legislation unconstitutionally mandated that the states either broaden their Medicaid programs or lose existing funding. According to these justices, this was overreaching on the part of the federal government.

Despite the Supreme Court's ruling, substantial controversy continues to exist in connection with healthcare reform. As of late June 2012, 20 state legislatures had enacted laws related to further challenging or opting out of the PPACA provisions. Five states[2] passed restrictions on further compliance with the PPACA unless compliance is specifically approved by the state legislature. In addition, 16 states currently have statutory or state constitutional provisions that preclude the state government from enforcing any provision requiring state citizens to purchase insurance or requiring employers to make related payments in connection with insurance.[3]

Moreover, seven states[4] specifically enacted laws intended to create interstate health compacts, which seek to establish a group of states that will work together to establish healthcare laws and regulations on their own, apart from the PPACA. None of these compacts are yet functional and, because they would preempt federal PPACA law, Congress would need to approve these compacts. These continued state-level challenges to healthcare reform are particularly important given the substantial role that the states have in facilitating taxpayer access to coverage under the PPACA.

This chapter discusses the major aspects of healthcare reform that will gradually become effective over the next few years.

2013 CHANGES

In 2013, several key aspects of healthcare reform will be initiated. For example, a new 2.3% excise tax on the initial sale of medical devices by the manufacturer, producer, or importer becomes effective. Because devices generally purchased by the public at the retail level, such as eyeglasses, contact lenses, and hearing aids, are exempt from the tax, **individual taxpayers will not be affected.** The tax will affect hospitals and other organizations purchasing supplies and equipment subject to the tax.[5]

Certain health insurance companies will face limitations on the amount that can be deducted for executive compensation[6] starting in 2013. Public reporting of physician performance information will also begin in 2013[7] as a measure to provide additional information for consumers to use in making decisions about their health care.[8]

Effective for the 2013 tax year, there are also **tax** changes that will be important to tax return preparers. These include the following.

- Medicare tax changes (including a new Medicare tax on passive and portfolio income)
- Changes to itemization of qualified medical expenses
- New requirements and limits for health flexible spending account (FSA) arrangements

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2. Missouri, Montana, New Hampshire, Utah, and Wyoming.
3. *State Legislation and Actions Challenging Certain Health Reforms, 2011–2012*. Jul. 10, 2012. National Conference of State Legislatures. [www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-aca.aspx] Accessed on Jul. 27, 2012.
4. Georgia, Indiana, Missouri, Oklahoma, South Carolina, Utah, and Texas.
5. See HCERA §1405.
6. IRC §162(m)(6).
7. PPACA §10331.
8. Information on hospitals, physicians, and other healthcare providers will be available at www.healthcare.gov. Some basic information is already available on this website.

MEDICARE TAX CHANGES

Through 2012, the Medicare tax remains at 2.9% of wages, with half (or 1.45%) of the amount paid by the employee and the other half paid by the employer. Self-employed persons pay the full 2.9% on net earnings from self employment and deduct half of the total tax paid. Although social security tax is paid on wages up to the 2012 limit of $110,100, Medicare tax is paid on all wages without an upper limit.

Effective in 2013, the following Medicare tax changes will occur.

- A 3.8% Medicare tax on **net investment income** if modified adjusted gross income (MAGI) exceeds $200,000 (or $250,000 for joint filers)
- A 0.9% increase to the current 1.45% (2.35% total) in Medicare taxes on earned income (including net self-employment income) in excess of $200,000 (or $250,000 for joint filers)

> **Note.** In this section, the 0.9% increase noted above is referred to as the "**Medicare earned income increase" (MEII)** and the new 3.8% Medicare tax on net investment income is referred to as the "**Medicare tax on unearned income" (MTUI).**

For taxpayers with MAGI amounts high enough to trigger the 3.8% MTUI, the new Medicare tax applies to the **lesser of:**

- The amount of net investment income, **or**
- The amount of MAGI in excess of the $200,000 threshold (or $250,000 for joint filers).

"Net investment income" is composed of the following amounts, less any otherwise deductible expenses properly attributable to these items.

- Gross income from interest, dividends, annuities, royalties, and rents unless such income is received in the ordinary course of a trade or business
- Other gross income from any passive trade or business

> **Observation.** In determining whether the trade or business activity is passive, it is generally necessary to look at the taxpayer's role in the activity, not the nature of the activity itself. The rules on passive activities and active participation may be found in Chapter 6, Rental Activities, in the 2011 *University of Illinois Federal Tax Fundamentals* workbook.

- Net realized gain arising from the disposition of property other than property held in a trade or business (For purposes of determining net investment income, a trade or business **does not** include a taxpayer's **passive activity** under IRC §469 or **trading in financial instruments and commodities** as defined in IRC §475(e)(2). Accordingly, income from these activities is considered investment income.)

Net investment income does **not** include the following items that are otherwise excluded from income.

- Income from IRAs, pensions, §401(k) plans, and other qualified plans
- Interest on tax-exempt bonds
- Veteran's benefits
- Gain from the sale of a principal residence **up to the $250,000/$500,000 §121 limits**[9]

[9] Joint Committee on Taxation report JCX-18-10, March 30, 2010, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010" as Amended, in Combination with the "Patient Protection and Affordable Care Act."*

For purposes of the MTUI, MAGI is calculated by increasing AGI by any amount that was deducted under the foreign earned income or housing exclusion provided by IRC §911.[10]

Note. The term "net investment income" for purposes of MTUI is not the same as that applicable to Form 4952, *Investment Interest Expense Deduction,* under IRC §163(d)(4)(B) with respect to trade or business income.

Example 1. Larry and Marc are equal shareholders in an S corporation. Marc materially participates in the day-to-day business activity of the S corporation and receives a reasonable wage. Larry initially contributed capital and is an investor. For 2013, the net ordinary income of the S corporation is $100,000. Both Marc and Larry are above the required income threshold. Marc is not subject to the 3.8% MTUI or the 0.9% MEII because he is a material participant in a trade or business. Larry, however, is subject to the 3.8% MTUI because he is a passive investor in a trade or business.

Example 2. Betty and Greg are married and file a joint tax return. In 2013, Betty earned $120,000 and Greg earned $180,000. They also had other items of income as illustrated below.

	MAGI	Investment Income Portion
Wages	$300,000	$ 0
Interest	10,000	10,000
Taxable annuity distributions		
Source: direct taxpayer investment[a]	20,000	20,000
Source: §403(b) annuity	30,000	0
Net gain on stock sale	40,000	40,000
Net gain from sale of principal residence	800,000	800,000
IRC §121 exclusion	(500,000)	(500,000)
Total	$700,000	$370,000

[a] A direct taxpayer investment generally refers to purchased commercial annuity contracts. An example is a fixed or variable annuity contract sold to individual investors.

Betty and Greg are subject to the Medicare tax increases on both their earned income and investment income because their combined earned income and MAGI for 2013 are above the threshold.

For purposes of MTUI, Betty and Greg will have a 2013 additional tax liability of $14,060 ($370,000 × 3.8%). The amount of tax is based on the lesser of their MAGI in excess of the threshold or investment income.

For purposes of MEII, Betty and Greg will have an additional 2013 tax liability of $450 ($300,000 total wages – $250,000 threshold × 0.9%). Their employers were not required to withhold the additional Medicare tax because each individual's wage was less than the $200,000 threshold. Consequently, Betty and Greg must include this tax on their 2013 return.

10. IRC §1411(d)(1).

The following table provides a summary of the changes in Medicare tax scheduled for 2012 to 2013.

	2012 Rate	2013 Rate
Medicare tax changes on wages		
Employee's Medicare tax rate on wages up to $200,000 ($250,000 for MFJ) threshold	1.45%	1.45%
Employee's Medicare tax rate on wages over $200,000 ($250,000 for MFJ) threshold	1.45%	2.35%[a]
Employer's Medicare tax rate	1.45%	1.45%[b]
Self-Employment Medicare rates		
Rate on net self-employment income up to $200,000 ($250,000 for MFJ) threshold	2.90%	2.90%
Rate on net self-employment income over $200,000 ($250,000 for MFJ) threshold	2.90%	3.80%[c]
Medicare tax on unearned income (MTUI)		
Tax rate if MAGI is below $200,000 ($250,000 for MFJ) threshold	0.00%	0.00%
Tax rate if MAGI is above $200,000 ($250,000 for MFJ) threshold	0.00%	3.80%

[a] The rate of 2.35% is composed of the "standard" Medicare tax rate of 1.45% plus the MEII of 0.9%.

[b] There is no change to the employer's Medicare tax rate of 1.45%.

[c] While current law allows a deduction of one-half of self-employment tax, there is presently no provision to deduct one-half of the 0.9% MEII increase for self-employed persons.

Note. The IRS is developing additional guidance on the application of these new rates.

Example 3. Franco and Francesca are married and file jointly in 2013. Their income information is as follows.

Combined employment wages	$240,000
Capital gain on sale of GM stock	40,000
MAGI	$280,000

As a result of the sale of their GM stock, Franco and Francesca have net investment income of $40,000 for the 2013 tax year. Franco and Francesca will pay additional Medicare tax in 2013.

The MEII affects Franco and Francesca as follows:

	Combined Wages under $250,000 Threshold (Subject to 1.45% Rate)	Combined Wages over $250,000 Threshold (Subject to 2.35% Rate)	Total
Combined wages	$240,000	$0	$240,000
Applicable Medicare tax rate	× 1.45%		
Total Medicare tax paid for 2013	$ 3,480	0	3,480

The MTUI affects Franco and Francesca as follows:

	Amount Subject to MTUI
A. Net investment income	$40,000
B. Excess MAGI over $250,000 threshold	30,000
Lesser of A or B	$30,000
Applicable MTUI rate	× 3.8%
MTUI payable for 2013	$ 1,140

Because Franco and Francesca have combined wages under the $250,000 threshold for joint filers, they are not affected by the MEII. However, they are affected by the MTUI and will pay an additional $1,140 in Medicare tax.

Example 4. Use the same facts as **Example 3,** except Franco and Francesca have combined wage income of $280,000. Their income tax information and Medicare tax calculations for 2013 are as follows.

Combined wages	$280,000
Capital gain on sale of GM stock	40,000
MAGI	$320,000

The MEII affects Franco and Francesca as follows:

	Combined Wages under $250,000 Threshold (Subject to 1.45% Rate)	Combined Wages over $250,000 Threshold (Subject to 2.35% Rate)	Total
Combined wages	$250,000	$30,000	$280,000
Applicable Medicare tax rate	× 1.45%	× 2.35%	
Total Medicare tax paid for 2013	$ 3,625	$ 705	4,330

Franco and Francesca have combined wages in excess of the $250,000 joint-filer threshold and will pay the MEII on this amount. The increased rate on the amount of wages above the $250,000 threshold is 2.35% (which is the standard 1.45% rate plus the MEII of 0.9%).

The MTUI affects Franco and Francesca as follows:

	Amount Subject to MTUI
A. Net investment income	$40,000
B. Excess MAGI over $250,000 threshold	70,000
Lesser of A or B	$40,000
Applicable MTUI rate	× 3.8%
MTUI payable for 2013	$ 1,520

Medicare Tax Changes and Tax Return Issues

Beginning in 2013, employers will be required to withhold additional Medicare taxes for the MEII. If an employee's wages exceed $200,000, the additional increase of 0.9% must be withheld. This amount is reported, in addition to all other Medicare tax withheld for the year, in box 6 of Form W-2, *Wage and Tax Statement*. However, higher-income married couples may find that the additional tax withholding is not enough to fully cover the additional MEII tax liability. In addition, there are some situations that will result in an overpayment of Medicare on a married couple's tax return.

Example 5. Vincent is employed by State University as a faculty member in the department of chemistry. His wife, Victoria, is vice president of marketing at MegaWorldwide Enterprises, Inc. For 2013, the following amounts are reported on their respective Forms W-2.

	Vincent's Form W-2	Victoria's Form W-2	Total
Wages, tips and other compensation (box 1)	$200,000	$100,000	$300,000
Medicare wages and tips (box 5)	200,000	100,000	300,000
Medicare tax withheld	2,900	1,450	4,350

Each spouse's employer regards the employee as having income at or below the $200,000 individual threshold for MEII purposes and, therefore, neither employer withholds the additional 0.9%. However, when Vincent and Victoria file jointly, their return reflects the following.

Combined income on MFJ return	$300,000
Less: MFJ threshold of $250,000 for MEII purposes	(250,000)
Income subject to the additional 0.9% MEII	$ 50,000
	× 0.9%
Additional Medicare tax liability	$ 450

This additional Medicare tax liability is reported on Vincent and Victoria's 2013 joint tax return.

There is no provision for tax withholding on the new MTUI that applies to net investment income. These amounts are reported as additional tax liability on the tax return.

Note. Starting in 2013, taxpayers with substantial anticipated MEII underpayments and/or significant MTUI taxes payable may find it prudent to increase withholding amounts through an employer and/or make estimated tax payments to avoid underpayment penalties.

Example 6. Hadrian and Heather are married and file jointly in 2013. While Hadrian remains home to raise their two children, Heather works full time as marketing manager for a major pharmaceutical company. In 2013, Hadrian has no income, and Heather's wages are $240,000, which is subject to Medicare tax. Heather's employer withholds the following Medicare tax amounts in connection with Heather's income for the year as required and reflects these amounts on her 2013 Form W-2.

	Wages Subject to 1.45% Medicare Rate	Wages Subject to 2.35% Medicare Rate	Total
Wages received in 2013	$200,000	$40,000	$240,000
Applicable Medicare withholding for Heather	× 1.45%	× 2.35%	
Medicare taxes withheld	$ 2,900	$ 940	$ 3,840

However, when Hadrian and Heather file their joint 2013 return, all of Heather's $240,000 wages are under the MFJ threshold of $250,000 for MEII purposes. Their return reflects the following.

Wages under $250,000 MFJ threshhold	$240,000
	× 1.45%
Medicare tax liability for wages under $250,000 MFJ threshhold	$ 3,480
Less: amount of Medicare tax withheld by employer	(3,840)
Overpayment	($ 360)

MEDICAL EXPENSE DEDUCTION

Through 2012, medical expenses in excess of 7.5% of AGI may be deducted by a taxpayer who itemizes deductions. Beginning in 2013, the 7.5% threshold increases to 10%. However, taxpayers or their spouses who attain age 65 before the end of the tax year are provided with a temporary waiver from the increased 10% threshold.[11] These taxpayers may continue to itemize medical deductions using the 7.5% threshold through 2016. For 2017 and subsequent years, taxpayers age 65 and over will be subject to the same 10% AGI threshold as all other taxpayers.

The 10% waiver for taxpayers age 65 or older does not have a joint-filing requirement. Accordingly, it appears that the lower 7.5% threshold would apply to both qualifying spouses even if they file separately.

> **Note**. If either spouse attains age 65 before the end of the year, both spouses filing jointly may continue to benefit from the lower 7.5% AGI threshold.[12]

HEALTH FSA LIMITATIONS

The PPACA ushered in two major changes to health FSAs.

- A change in the definition of "qualified medical expenses" that prohibits nonprescription **over-the-counter** drugs from qualifying for FSA reimbursement (effective **2011)**
- A new $2,500 maximum annual salary reduction contribution (effective in 2013)

Changes with Over-the-Counter Medication

The IRS previously ruled[13] that amounts reimbursed by an employer's FSA arrangement for employee costs for nonprescription medication such as antacids, allergy medication, pain relievers, or cold medicine are excludable from income under IRC §105(b) even if these expenses are not deductible as a medical expense under IRC §213. However, effective January 1, 2011, qualified medical expenses for FSA reimbursement purposes include amounts the taxpayer paid for medication **only if such medication is prescribed or if it is insulin.**[14] Accordingly, over-the-counter medications purchased without a prescription no longer qualify for FSA reimbursement.

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11. IRC §213(f).
12. Joint Committee on Taxation report JCX-18-10, March 30, 2010, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010" as Amended, in Combination with the "Patient Protection and Affordable Care Act."*
13. Rev. Rul. 2003-102, 2003-38 IRB 559.
14. IRC §106(f).

Changes in Maximum Annual Amount

Beginning in 2013, a health FSA will not be a qualified benefit within a cafeteria plan unless the plan specifically prohibits salary reductions in excess of $2,500. A written plan amendment reflecting this new limit is necessary.[15] If the terms of the plan do not include such a prohibition, the FSA will not be a qualified arrangement and all participating employees will be taxed on their distributions. This would eliminate the tax advantages of the FSA arrangement, including the advantages for amounts spent that do not exceed $2,500. Prior to this $2,500 annual limitation, no limit was imposed other than that which may have been stated as part of the terms of the employer's plan.

The $2,500 limit applies to **plan years** that begin after December 31, 2012. The plan year is the period for which salary reduction elections are made under the terms of the particular plan.[16]

In addition, if the plan provides for a grace period:

- The grace period cannot be longer than two months and 15 days, and
- Unused salary reduction contributions to the FSA for the plan year that are carried forward into the grace period do not count against the $2,500 limit applicable for the subsequent plan year.[17]

If the plan complies with the new limitation but one or more employees mistakenly contribute too much, a procedure exists to timely correct the mistake without negating the tax benefits of the plan. The mistake is timely corrected if all the following conditions are satisfied.

- The terms of the plan apply uniformly to all participants.
- The mistake is a reasonable one made by the employer (or employer's agent) and is not due to willful neglect.
- The contributions in excess of $2,500 are paid to the employee and reported as wages for income tax withholding and employment tax purposes on Form W-2 for the year in which the correction is made.[18]

For tax years after 2013, the $2,500 limitation will be subject to annual inflation adjustments.

CREDIT FOR SMALL EMPLOYER HEALTH INSURANCE PREMIUMS

Eligible small employers can use IRS Form 8941, *Credit for Small Employer Health Insurance Premiums,* to calculate a tax credit for small employer health insurance premiums paid for tax years after 2009. This credit is 35% of the premiums paid by the employer each year from 2010 thru 2013. Beginning with 2014, this tax credit increases to 50% of the premiums paid. The credit is 25% for tax-exempt organizations, which increases to 35% beginning in 2014.

A qualified small business employer is a business with no more than 25 full-time equivalent (FTE) employees with an average annual wage of no more than $50,000.

> **Note.** See Chapter 8, Small Business Issues, in the 2011 *University of Illinois Federal Tax Workbook* and Chapter 12, New Legislation, in the 2010 *University of Illinois Federal Tax Workbook* for a discussion of the small business healthcare credit.

15. IRS Notice 2012-40, 2012-25 IRB 1.
16. Ibid.
17. Ibid.
18. Ibid.

Certain individuals are not covered in the FTE employee computations. These people include:

1. Any partner
2. Any self-employed person
3. Seasonal workers
4. A greater than 2% shareholder in an S corporation
5. A greater than 5% owner in a C corporation or a limited liability company
6. Any related party

Employers are required to reduce their health insurance tax deduction by the credit amount. The amount of the employer's premiums is taken into consideration when calculating the credit because it cannot exceed the state average for premiums as noted in Revenue Ruling 2010-13.

An employer's FTE employees are determined by dividing total hours for which wages are paid to employees (not more than 2,080 hours per employee) by 2,080 hours.

INDIVIDUAL RESPONSIBILITY MANDATE

The PPACA added a new section to the Code in connection with the requirement for individuals to obtain coverage. This new section, IRC §5000A, states that every **applicable individual** must obtain **minimum essential coverage** for themselves and their **dependents**[19] or pay a **tax penalty.** This requirement is often referred to as the "individual responsibility mandate" or the "individual mandate." It becomes effective January 1, 2014. Applicable penalties will be calculated as additional tax on the individual's Form 1040 starting with the 2014 tax year.

APPLICABLE INDIVIDUALS

Applicable individuals are subject to the requirement to obtain and maintain appropriate coverage. Coverage must be maintained for each month that the applicable individual is subject to the individual mandate. Dependents who are applicable individuals must also have appropriate coverage.[20] All persons are applicable individuals for each month unless one of the following **exemptions** applies.

- Healthcare sharing ministry exemption
- Religious exemption
- Exemption for illegal aliens
- Exemption for prisoners

> **Note**. The healthcare legislation does not specify if a "month" means a full month, more than half a month, or if the first day of the month must be included in any exemption period for an exemption to apply. Presumably, the IRS will provide further guidance on how to apply this monthly rule. Many PPACA provisions are implemented on a monthly basis, so IRS clarification is essential. Accordingly, most examples in this chapter involve only the use of whole months for illustrative purposes and because it is not yet clear how a partial month will be addressed in calculation rules.

19. IRC §5000A(a).
20. Ibid.

Healthcare Sharing Ministry Exemption

Members of a healthcare sharing ministry (HCSM) are not subject to the individual mandate[21] for the months of such membership. An HCSM is an organization whose members typically pay a predetermined monthly amount. Members' payments are used to form a pooled fund, which pays approved healthcare expenses of the paying members. An HCSM must meet the following tests in order for its members to be exempt from the individual responsibility mandate.[22]

- The HCSM must be a tax-exempt §501(c)(3) organization.
- The HCSM members share medical expenses in accordance with their common ethical or religious beliefs. The expenses are shared without regard to the state jurisdiction in which a member is employed.
- Members must retain membership even after they develop a medical condition.
- The HCSM (or its predecessor organization) must have been continuously in existence since December 31, 1999.
- The HCSM's members must have continuously shared medical expenses since December 31, 1999.
- The HCSM must be audited annually by an independent accounting firm. The audit must be made available for public inspection and completed according to generally accepted accounting principles (GAAP).

Religious Exemption

A religious exemption[23] applies for any month that an individual:

- Is a member of certain religious sects, and
- Adheres to the religion's established teachings or tenets, which causes opposition to accepting private or public insurance that pays death, disability, retirement, or old age benefits or that pays for health care.

In order for the exemption to apply, an American Health Benefit Exchange must certify that the individual meets the above criteria.

Note. "American Health Benefit Exchange" refers to the health insurance coverage exchanges that states are required to establish under the PPACA. These exchanges are discussed later in this chapter.

Observation. The above criteria are the same ones used for the religious conscience exemption from self-employment taxes under IRC §1402(g)(1).

Illegal Alien Exemption

Applicable individuals for purposes of the individual mandate do not include individuals who are neither U.S. citizens nor aliens who are lawfully present in the United States.[24] A U.S. national is the equivalent of a U.S. citizen for purposes of this exemption.

Prisoners

Generally, an incarcerated individual is exempt for the months of incarceration. However, no exemption exists for an individual who is incarcerated pending the disposition of criminal charges.[25]

21. IRC §5000A(d)(2)(B).
22. Ibid.
23. IRC §5000A(d)(2)(A).
24. IRC §5000A(d)(3).
25. IRC §5000A(d)(4).

MINIMUM ESSENTIAL COVERAGE

Starting in 2014,[26] an applicable individual must have minimum essential coverage in order to meet the individual mandate.[27] The following forms of health insurance coverage satisfy the mandate.

- Medicare, Medicaid, and the Children's Health Insurance Program
- Health plans for active military personnel, veterans' medical programs, and civilian Department of Defense plan
- The Peace Corps health plan
- An eligible employer-sponsored plan
- A group health plan or health insurance coverage that the individual is already enrolled in (referred to as a "grandfathered plan")
- Coverage purchased in a state health benefits exchange
- Other plans that the Secretaries of the Treasury and HHS recognize

Non-Minimum Essential Coverage (Nonqualifying Coverage)

Several types of insurance coverage are not sufficient to meet the minimum essential coverage mandate. Some of the types of coverage that do not qualify are discussed below.

Medical Coverage Is Secondary or Incidental. Types of coverage that provide medical care as a secondary or **incidental benefit** to either the core coverage or other nonmedical purposes of the insurance are not sufficient to meet the coverage mandate. For example, the following types of coverage are referred to as "excepted benefits" that are not sufficient to meet the minimum essential coverage mandate.[28]

- Insurance only for accident or disability income
- General liability insurance, auto liability insurance, and coverage issued as a supplement to liability insurance
- Workers' compensation or similar insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Other similar types of coverage under which the medical care benefits are secondary or incidental to other insurance benefits (These other types of coverage are to be specified in regulations.)

Limited-Purpose Coverage. Policies or contracts covering the following **limited items** do not qualify as minimum essential coverage.[29]

- Limited benefits such as limited scope dental or vision benefits, long-term or nursing home care, home health care or community-based care, or any combination of these or other benefits to be specified by regulation
- Insurance that covers only a specified disease or illness
- Hospital indemnity or other fixed indemnity coverage
- Coverage supplemental to Medicare, to military medical and dental, or to a group health plan

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26. IRC §5000A(a).
27. IRC §§5000A(a) and (f).
28. IRC §5000A(f)(3)(A).
29. IRC §5000A(f)(3)(B).

TAX PENALTY

An applicable individual that fails to maintain coverage for some or all of the tax year is subject to a tax penalty.[30] This penalty is called a "shared-responsibility payment." The taxpayer's tax return will reflect the penalty for the tax year that coverage was not maintained for the appropriate period. MFJ taxpayers are jointly liable for any penalty.[31] **Taxpayers will first be subject to the penalty in 2014,** which is the first year of the penalty's **phase-in period.** Phase in continues in 2015 with higher rates. The penalty reaches its maximum level in 2016.

The penalty for a taxpayer who does not have minimum essential coverage is based on:

- The **flat dollar amount penalty,**
- The **percentage of income penalty,** and[32]
- The average national cost for "bronze-level" minimum essential coverage that is available to the taxpayer.

> **Note.** Bronze-level coverage is discussed later in this chapter. This is one level of coverage that will be available on state exchanges to applicable individuals.

The penalty is calculated as follows.

Step 1. Calculate the **flat dollar amount penalty.** For purposes of calculating the flat dollar amount, the $95 amount reflects the initial amount used when this aspect of the PPACA is phased in starting with the 2014 tax year. Increasing amounts apply for 2015 and 2016 calculations.

The flat dollar amount is the **lesser of**:

- The applicable dollar amount of $95 per adult in the household ($48 for children under age 18) for applicable individuals who did not have coverage for the full 12-month period of the year, **or**
- Three times the applicable dollar amount of $95 (or $285).

The annual flat dollar amount for an individual attaining age 18 during the year is calculated by prorating the pre- and post-age-18 amounts. The $48 amount is used for the months during the year that the child was not 18 at the beginning of the month.[33] The table below indicates the appropriate amounts to use in the calculations for the 2014 to 2016 tax years.

Tax Year	Applicable Dollar Amount, Individual Age 18 or Older	Applicable Dollar Amount, Individual under Age 18
2014	$ 95	$ 48
2015	325	163
2016	695	348

For tax years after 2016, the $695 and $348 amounts are subject to adjustment for inflation.

> **Note.** There is a **flat dollar limit,** which is three times the applicable dollar amount for individuals age 18 and older.[34]

30. IRC §5000A(b)(1).
31. IRC §5000A(b)(3)(B).
32. IRC §5000A(c)(2).
33. IRC §5000A(c)(3)(C).
34. IRC §5000A(c)(2)(A).

Example 7. Fred and Sheila Morganstern file jointly for 2014 and have three children, Steven, Stephanie, and Francis. Francis was over age 18 for the entire tax year. Steven and Stephanie are under age 18. Fred and Sheila are applicable individuals who do not fall under any exception to the individual mandate's requirement to have minimum essential coverage. They did not have coverage for 11 months of 2014.

The following applicable dollar amounts apply to each member of the household.

Family Member	Applicable Dollar Amount
Fred	$ 95
Sheila	95
Steven	48
Stephanie	48
Francis	95
Total	$381

The total monthly flat dollar penalty for the Morganstern family is $31.75 ($381 ÷ 12). Because they did not have the required coverage for 11 months of the year, their flat dollar penalty amount is $349.25 ($31.75 × 11 months).

The maximum flat dollar penalty for the Morgansterns (flat dollar limit) is calculated using three times the applicable dollar amount for individuals age 18 and older. For 2014, the limit for the year is $285 (3 × $95). Because the Morgansterns did not have coverage for 11 months of the year, the maximum flat dollar penalty for 11 months is $261 ($^{11}/_{12}$ × $285). Therefore, the flat dollar penalty for the Morganstern family is $261.

Step 2. Calculate the **percentage of income penalty.** For tax years starting in 2014, this is 1.0% of the taxpayer's household income in excess of the filing threshold that applies to the taxpayer. The percentage of income penalty increases to 2% in 2015 and 2.5% in 2016.

To arrive at **household income** for the year, MAGI amounts for those individuals counted within the taxpayer's **family are added together.**[35]

For purposes of this rule, MAGI is calculated as follows.[36]

Adjusted gross income (AGI)
+ Any amount excluded from AGI as foreign earned income or foreign housing amount under IRC §911
+ Any tax-exempt interest received or accrued by the taxpayer for the year
MAGI

"Household income" is defined as the sum of MAGI of all family members who are applicable individuals for whom coverage should have been maintained for the year and who are required to file a tax return. This includes the taxpayer and the taxpayer's spouse if MFJ. In addition, the MAGI of each of the taxpayer's dependents is also included for those dependents whose taxable incomes exceed their applicable filing threshold for the tax year. This includes dependents subject to the "kiddie tax" with incomes not reported on a parent's return.

35. IRC §5000A(c)(4)(B).

36. IRC §5000A(c)(4)(C).

The filing thresholds consist of the standard deduction and applicable exemption amounts for the taxpayer's filing status.[37] For 2012, the filing thresholds are as follows.

Filing Status	2012 Filing Threshold Amount
MFJ	$19,500
MFJ (one spouse age 65+)	20,650
MFJ (both spouses age 65+)	21,800
Married filing separately	3,800
Single	9,750
Single (age 65+)	11,200
HoH	12,500
HoH (age 65+)	13,950
Qualifying Widow(er)	15,700
Qualifying Widow(er) (age 65+)	16,850

The following table shows the appropriate percentage of income penalty rate to be used.[38]

Tax Year	Percentage of Income Rate
2014	1.0%
2015	2.0%
2016	2.5%

Example 8. Use the same facts as **Example 7.** The Morganstern family's household income is $45,000 and the 2014 filing threshold for Fred and Sheila is assumed to be $21,700.

The amount of income in excess of the filing threshold is $23,300 ($45,000 − $21,700). Because the percentage of income rate for 2014 is 1%, the applicable percentage of income penalty is $233 (1% × $23,300).

The monthly percentage of income penalty is $19.42 ($233 ÷ 12). Because the Morgansterns did not have coverage for 11 months of the year, their percentage of income penalty for 2014 is $213.62 (11 × $19.42).

Step 3. The taxpayer's penalty is the **lesser of:**

- The flat dollar amount penalty or the percentage of income penalty, whichever is greater, **or**
- The national average cost for a "bronze-level" qualified health plan offered on the state exchanges during the tax year for the taxpayer and any family members for whom coverage should have been maintained for the full tax year.

37. IRC §6012(a)(1).

38. IRC §5000A(c)(2)(B).

Example 9. Use the same facts as **Example 8.** The national average cost for bronze-level coverage for the Morganstern family is $4,500.

The **greater** of the calculated flat dollar penalty ($261) and percentage of income penalty ($213.62) is $261.

The individual mandate penalty for the Morganstern family is the **lesser** of:

- $261, or
- $4,500.

Therefore, because the Morgansterns did not have minimum essential coverage for 11 months of the year, their penalty is **$261.** This amount must be reported on Fred and Sheila's 2014 tax return.

Note. Further IRS guidance may change how the above calculations are computed.

Observation. Once these penalty provisions are fully phased in for 2016 and subsequent years, the potential penalties are much greater.

Example 10. Use the same facts as **Example 9,** except that the tax year in which the Morgansterns did not have coverage for 11 months is 2016. Their penalty is calculated as follows.

Step 1. Calculation of flat dollar penalty.

The applicable dollar amount for the household is as follows.

Family Member	Applicable Dollar Amount
Fred	$ 695
Sheila	695
Steven	348
Stephanie	348
Francis	695
Total	$2,781

The monthly flat dollar amount penalty is $231.75 ($2,781 ÷ 12). For the 11 months that the Morgansterns did not have minimum essential coverage, the flat dollar penalty is $2,549.25 (11 months × $231.75).

The flat dollar limit is $2,085 (3 × $695) for the year. The amount of the flat dollar limit attributable to the 11 months for which the Morgansterns did not have coverage is $1,911 ($^{11}/_{12}$ × $2,085). Therefore, the flat dollar penalty for the Morganstern family is $1,911.

Step 2. Calculation of the percentage of income penalty.

The amount of income in excess of the filing threshold is $23,300 ($45,000 − $21,700). Because the percentage of income amount for 2016 is 2.5%, the applicable percentage of income penalty is $582.50 (2.5% × $23,300).

The monthly percentage of income penalty is $48.54 ($582.50 ÷ 12). Because the Morgansterns did not have coverage for 11 months of the year, their percentage of income penalty for 2016 is $533.94 (11 × $48.54).

Step 3. The **greater** of the calculated flat dollar penalty ($1,911) and percentage of income penalty ($533.94) is $1,911.

The individual mandate penalty for the Morganstern family is the **lesser** of:

- $1,911, or
- $4,500.

Because the Morgansterns did not have minimum essential coverage for the year, their penalty is **$1,911.** This amount must be reported on the 2016 tax return filed by Fred and Sheila.

> **Note.** If a **taxpayer and spouse** file a joint return, both individuals are **jointly liable** for the shared-responsibility payment penalty.[39]

Penalty Exceptions

The shared-responsibility payment penalty does not apply in the following situations.

Individual with Household Income below Filing Threshold. The penalty does not apply to applicable individuals who have household incomes for the year below their filing threshold.[40] In order to determine whether the applicable individual has a household income below their filing threshold, it is essential to bear in mind some key definitions.

> **Note.** The filing thresholds that were provided earlier in this chapter under the definition of household income are **2012 amounts.**

First, to measure household income, the **MAGI** (as calculated earlier) of each household member is taken into account.

Household income is the sum of the MAGI amounts for each family member who is taken into account in determining the taxpayer's **family size.**[41] Family size is the number of individuals for whom the taxpayer is able to claim a personal exemption under IRC §151.[42]

> **Note**. This provision compares household income of those within the taxpayer's family to the taxpayer's filing threshold. Note that the filing thresholds are subject to annual inflation adjustments.

39. IRC §5000A(b)(3)(B).
40. IRC §5000A(e)(2).
41. IRC §5000A(c)(4)(A).
42. Ibid.

Coverage Is Unaffordable. The penalty does not apply to applicable individuals for months in which they cannot afford coverage. Coverage is **unaffordable** if the applicable individual's **required contribution** (on an annualized basis) for that month is greater than 8% of the individual's **household income** for the tax year.[43]

The "required contribution" for the individual depends on where the individual can obtain coverage. Some individuals can obtain coverage through an employer, and others must use the state exchange for coverage. The definition of "required contribution" for each group is therefore different[44] and is one of the following.

- The annual premium for minimum essential coverage through an eligible employer-sponsored plan for self-only coverage
- The annual premium for the lowest cost coverage available through the taxpayer's state exchange, less the individual's premium assistance credit for the tax year under IRC §36B

"Household income" for purposes of coverage affordability is determined in the same manner as described in the previous section, with two modifications.

1. The household income used for this provision is that for the most recent tax year for which the Secretary of HHS determines information is available.[45]
2. Household income is increased by any amount of required health plan contribution made through a salary reduction arrangement and excluded from income.[46]

> **Observation**. Although the IRS has taxpayer income information, the manner in which the HHS gains access or obtains this information, which is needed for the affordability determination, remains unknown.

For health plan years commencing after 2014, the Secretary of HHS can adjust the 8% threshold amount if the rate of premium growth exceeds income growth within a specified period.[47]

> **Note.** The general purpose of this provision is to ensure that the individual is not obligated to spend more than 8% of household income for health insurance in order to avoid the penalty.

Native Americans. The penalty does not apply to an applicable individual for any month in which the individual is a member of an Indian tribe. The definition of "Indian tribe" is provided in IRC §45A(c)(6).[48]

Short Periods without Coverage. Generally, a penalty does not apply to an applicable individual when required coverage is not in effect for a continuous period of **less than three months.**[49] Special rules apply to this provision.

- The penalty does not apply for any month if the **last day** of that month occurs during a period in which the applicable individual did not have minimum essential coverage for a period of less than three months.
- The continuous period of less than three months is determined without regard to the duration of the calendar year.
- If the taxpayer's period without required coverage exceeds the allowable 3-month window, a penalty applies for the **entire** period of noncoverage.

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43. IRC 5000A(e)(1)(A).
44. IRC 5000A(e)(1)(B).
45. See IRC §5000A(e)(1)(A), referring to the PPACA §1412(b)(1)(B).
46. IRC §5000A(e)(1)(A).
47. IRC §5000A(e)(1)(D).
48. IRC §5000A(e)(3).
49. IRC §5000A(e)(4)(A).

This 3-month "window" is permitted in each tax year. However, if two or more such periods occur within one year, only the first period occurring in the year is penalty-free.[50] The Code indicates that the IRS will provide rules regarding penalty calculations for continuous periods of less than three months that straddle two tax years.[51]

Hardship. For any month for which the Secretary of HHS determines that an applicable individual has suffered hardship in obtaining required coverage on their state exchange, an exemption from the penalty applies.[52]

This determination by HHS is made under PPACA §1311(d)(4)(H), in which a state exchange must provide certain minimum services (discussed later in this chapter). These minimum services include the granting of certification that an individual is exempt from either the individual mandate or the shared-responsibility penalty either because there is no affordable qualified healthcare plan available to the taxpayer or the taxpayer otherwise qualifies for an exemption.

Dependents. If a taxpayer claims another applicable individual as a dependent, the taxpayer, rather than the dependent, is liable for the shared-responsibility payment penalty.[53]

> **Example 11.** Laurie is a 30-year-old university student who lives with her mother during all of 2014. She is covered under her mother's healthcare plan as long as she remains a university student. Laurie graduates on May 18, 2014, and, effective on that date, she is no longer covered by her mother's policy. For several months during 2014, she obtains three part-time temporary jobs that do not provide her with any healthcare coverage. Finally in November 12, 2014, she obtains full-time employment and enrolls in the employer's healthcare coverage. Because Laurie had no coverage for the five months of June through October, a penalty will be imposed for those five months. Depending on the definition of month that is adopted by the IRS, a penalty may also be imposed for the partial months of noncoverage (May and November). If Laurie's mother claims a dependency exemption for Laurie for 2014, it is Laurie's mother who will be liable for the penalty.

Residence Outside the U.S. An individual is deemed to have minimum essential coverage for the months in which an applicable individual is either:

- A bona fide resident of a U.S. possession, or
- A resident outside the United States for a period during which that individual meets either the bona fide residency test or physical presence test and therefore qualifies for the foreign earned income exclusion.[54]

Accordingly, for those months, the individual is not subject to any shared-responsibility payment penalty.

> **Note**. The **bona fide residency** test and **physical presence** test, which qualify a taxpayer for the foreign earned income exclusion, were discussed in Chapter 9, International Taxation, of the 2011 *University of Illinois Federal Tax Workbook*.

50. IRC §5000A(e)(4)(B)(iii).
51. Ibid.
52. IRC §5000A(e)(5).
53. IRC §5000A(b)(3)(A).
54. IRC §5000A(f)(4).

COST LIMITATIONS

The new healthcare reform legislation provides for subsidization of healthcare costs to certain lower-income individuals.

Premium Assistance Credit

By January 1, 2014, each state must establish a state exchange through which qualified individuals and small business employers can obtain qualified health benefits. Individuals who purchase coverage through a state exchange may be entitled to the premium assistance credit (PAC). The PAC is a refundable income tax credit available on a sliding scale basis to **qualifying taxpayers** with **household incomes** between 100 and 400% of the **federal poverty guidelines** for the family size involved and who do not receive coverage through either the taxpayer's employer or the spouse's employer. Taxpayers with incomes above 400% of the federal poverty guideline do not qualify for the PAC.

Taxpayers with incomes below 100% of the federal poverty guideline may still qualify for the PAC under special rules. A taxpayer with a household income below 100% of the federal poverty guideline for their family size is treated as a qualifying taxpayer if they meet the following conditions.

- The taxpayer or a family member actually enrolls in a qualified health plan purchased through a state exchange.
- At the time of enrollment, the state exchange estimates the taxpayer's household income will be in the 100 to 400% range necessary to qualify for the PAC.
- Advance credits are authorized and paid for one or more months during the year.
- If the taxpayer's income were actually in the 100 to 400% range, that taxpayer would be an applicable individual.

> **Note.** Under the PPACA, taxpayers with incomes under 133% of the federal poverty guidelines will generally be covered by Medicaid. The PAC rules assume that individuals in this lower-income category generally cannot afford health insurance coverage. However, taxpayers with incomes above 100% of the federal poverty guideline who purchase coverage will qualify for the PAC because their income is within the 100%–400% qualifying range.

In order to understand the purpose and the calculation of the PAC, it is first essential to understand some preliminary definitions and concepts, which follow.

Levels of Coverage. Taxpayers who purchase coverage on their respective state exchanges will have the following four basic levels of coverage available, each with their respective actuarial values as shown.

Level of Coverage	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

The actuarial value of coverage generally refers to the percentage of the taxpayer's medical costs that the insurance will pay under the terms of its policies. The taxpayer pays the remaining percentage of the costs not covered by the insurance. For example, a taxpayer with silver-level coverage will pay 30% of their healthcare costs and the insurance will pay 70%.

> **Note**. State exchanges will actually provide more than one type of plan under each of the four basic levels. This provides the taxpayer with different cost options for each of the four categories.

One factor used in the calculation that determines the amount of PAC to which the taxpayer is entitled is the cost of the "**second lowest cost silver plan**" that is available to the taxpayer on the state exchange.[55] The second lowest cost silver plan is referred to as the **applicable benchmark plan.**[56] The applicable benchmark plan is generally self-only coverage for either single taxpayers without dependents or family coverage for taxpayers with a spouse and/or dependents.[57]

Example 12. Monica is a single individual with no dependents. On January 1, 2014, she enrolls in a qualified health plan that she purchased on the state exchange. For purposes of calculating any 2014 PAC, the applicable benchmark plan is the second lowest cost silver plan that is available to her on her state exchange (whether she actually purchases this or another plan). Her PAC is based on the cost of this applicable benchmark plan.

Example 13. Paul and Diane are married and live with Diane's two teenage sons, Duane and Dale. Because Paul has special medical needs, Paul and Diane purchase self-only coverage for Paul and also purchase separate family coverage for Diane, Duane, and Dale. Both policies are purchased on their state exchange. The applicable benchmark plan for Paul and Diane is the second lowest cost silver plan available on their state exchange that covers Paul, Diane, Duane, and Dale.

Note. In order to qualify for the PAC, taxpayers who are married at the end of the tax year must file MFJ.

Example 14. Jennifer enrolls in a new health insurance plan through her state exchange on January 1, 2014. She is single and has no dependents when she enrolls. The birth of her first child, Oscar, takes place on June 1, 2014. She can claim Oscar as a dependent when she files her 2014 tax return. Effective June 1, 2014, Jennifer enrolls in a health insurance plan covering both her and Oscar. Under the PAC rules, the applicable benchmark plan for Jennifer for the period from January 1 through May 31, 2014, is the second lowest cost silver plan for self-only coverage that was available to Jennifer when she obtained her coverage at the beginning of the year. However, from June 1 through the rest of the year, the applicable benchmark plan for her is the second lowest cost silver plan with family coverage that is available to her and Oscar.

Note. The IRS has provided guidance, including some examples, on how to determine the applicable benchmark plan for taxpayers in various family situations. See Treas. Reg. §1.36B-3(f).

Household Income Amount. For purposes of the PAC, "household income" is calculated by adding together **MAGI** amounts for **all** of the taxpayer's applicable family members who are taken into account in determining the taxpayer's family size for the year. The taxpayer's family size is equal to the number of individuals for whom the taxpayer is allowed a personal exemption. For each of these individuals, MAGI is calculated as follows.[58]

	AGI
+	Tax-exempt interest received
+	Foreign earned income exclusion or housing costs excluded from income under IRC §911
+	Any social security or tier 1 railroad retirement benefits excluded from gross income under IRC §86
	MAGI

55. IRC §36B(b)(2)(B)(i).

56. Treas. Reg. §1.36B-3(f).

57. Ibid.

58. IRC §36B(d)(2)(B).

Poverty Income Level. HHS annually updates and publishes poverty income guidelines in the Federal Register. These poverty guidelines (often referred to as the "federal poverty level") are used in determining eligibility for various federal programs, including qualification for the PAC. The poverty income guidelines for 2012 are as follows.[59]

PAC Table 1

Persons in Family or Household	Poverty Guideline		
	48 Contiguous States	Alaska	Hawaii
1	$11,170	$13,970	$12,860
2	15,130	18,920	17,410
3	19,090	23,870	21,960
4	23,050	28,820	26,510
5	27,010	33,770	31,060
6	30,970	38,720	35,610
7	34,930	43,670	40,160
8	38,890	48,620	44,710
Above 8 [a]	3,960	4,950	4,550

[a] Add this amount for each additional person over 8.

The determination of the amount of PAC that a qualifying taxpayer is entitled to begins with a sliding scale. The low end of the sliding scale is 100% of the poverty income guideline for the taxpayer, based on the number of persons in the taxpayer's family. The high end of the scale is 400% of the poverty income guideline that applies to the taxpayer based on family size. If the taxpayer's household income is not within these two end points of the sliding scale, the taxpayer does not qualify for the PAC.

The taxpayer's household income is multiplied by the applicable percentage to arrive at the amount of refundable PAC the taxpayer will receive. The applicable percentage depends on where the taxpayer's household income places them on the sliding scale.

The sliding scale is **tiered**. A lower and upper applicable percentage define each tier. The sliding scale's tiers and the applicable percentages for each tier are summarized as follows.

PAC Table 2

Amount of Household Income [a]	Lower Applicable Percentage [b]	Upper Applicable Percentage [c]
100% to 133%	2.00%	2.00%
133% to 150%	3.00%	4.00%
150% to 200%	4.00%	6.30%
200% to 250%	6.30%	8.05%
250% to 300%	8.05%	9.50%
300% to 400%	9.50%	9.50%

[a] Expressed as a percentage of the poverty income guideline for the taxpayer's family size.

[b] Also referred to as the "Initial Premium Percentage."

[c] Also referred to as the "Final Premium Percentage."

59. *2012 HHS Poverty Guidelines*. Feb. 9, 2012. Department of Health and Human Services. [www.aspe.hhs.gov/poverty/12poverty.shtml] Accessed on Jul. 3, 2012. There are separate tables for Alaska and Hawaii.

> **Observation**. The tiered sliding scale has a "**cliff effect**" that may affect many taxpayers. For example, one extra dollar of income may make a taxpayer ineligible for Medicaid and obligated to pay a maximum of 2% of household income for health insurance premiums. In addition, a taxpayer with income at 133% of the poverty income guideline is obligated to pay a maximum 2% of household income in insurance costs, but income of 133.01% subjects that taxpayer to a maximum 3% obligation.

For taxpayers with household incomes within an income tier in the above table, the income and the applicable percentage are **linearly** related. Accordingly, a taxpayer with household income of 141.5% of the poverty income guideline falls into the second tier and is exactly at the midpoint between 133% and 150%. That taxpayer's applicable percentage is therefore at the midpoint between the lower 3% and upper 4% applicable percentages (which is 3.5%).

Maximum Premiums Payable by Qualifying Taxpayers. A qualifying taxpayer's applicable percentage of income, (based on that taxpayer's household income and family size as determined by Table 2) represents the maximum amount that the taxpayer will be required to pay for coverage.

Example 15. Chloe is a single taxpayer with no dependents. She lives in Illinois. Her annual income is $22,340 (exactly 200% of the federal poverty income guideline of $11,170 for a single individual within the contiguous 48 states). This places Chloe at the very bottom of the fourth tier in Table 2. Her applicable percentage is therefore 6.30%. The maximum premium Chloe is required to pay for coverage is $1,407 ($22,340 × 6.30%).

Calculation of the PAC. Generally, the PAC that a taxpayer will qualify for is the cost of the applicable benchmark plan available to the taxpayer minus the maximum premium the taxpayer is expected to pay. This is expressed by the following formula:

Amount of PAC available = **Cost of applicable benchmark plan available to the taxpayer** − **Maximum premium taxpayer is expected to pay**

> **Observation**. The above formula illustrates how the PAC available to the taxpayer is tied to the cost of the applicable benchmark plan available to that taxpayer on the state exchange. In addition, the maximum premium the taxpayer is expected to pay is based on income and family size, which also have an impact on the PAC for which a taxpayer qualifies.

Example 16. Use the same facts as **Example 15.** The annual premium for the second lowest cost silver plan available to Chloe on the Illinois exchange is $5,907. The amount of PAC available to Chloe is $4,500 ($5,907 − $1,407).

Administration. The taxpayer generally purchases their desired coverage on their state exchange. The PAC, as calculated on that year's tax return, offsets some of the cost of this coverage. However, paying the entire cost of the coverage "up-front" and waiting until the next tax return is filed to receive the tax credit may prove financially difficult for many taxpayers. Accordingly, when the PAC is implemented for the first time commencing with 2014, it will be administered as an **advance credit.** Generally, the following steps will occur.

1. The taxpayer purchasing coverage on their state exchange will provide the exchange with the amount of their income and number of dependents for which a personal exemption deduction will be claimed for that year.

> **Note**. IRS guidance suggests that the state exchange can use income amounts obtained from the taxpayer or it can also use income estimates based on the taxpayer's family size and geographic area. These geographic areas are referred to as "rating areas."

2. The state exchange uses the income amount to calculate the taxpayer's PAC for the year.
3. The PAC calculated by the state exchange is paid directly to the insurance provider to offset some of the plan's cost on an immediate basis for the taxpayer.
4. The taxpayer pays the cost of their desired coverage minus the amount of calculated PAC.
5. When the taxpayer later files their return for the year in which the coverage was in effect, the tax return will include a **reconciliation** between the state exchange-calculated PAC applied against the cost of coverage and the actual PAC that will be calculated and shown on the tax return for that year.[60]
6. Any amount of state exchange-calculated PAC paid to the insurance plan that was over and above the actual tax return PAC that the taxpayer qualifies for will be **recovered** in the form of an **additional tax liability.**[61]
7. This additional tax liability has some applicable caps for taxpayers with incomes below 400% of the poverty income guidelines (as shown earlier).

Tax Reporting. The taxpayer is responsible for reconciling the advance credit payments for all family members' coverage purchased through a state exchange. If the taxpayer indicates to the state exchange that they will be entitled to claim personal exemptions for dependents for which the taxpayer is not actually entitled, the taxpayer must still reconcile the advance credit payments that were used to reduce the cost of coverage for the year.[62]

> **Note**. The IRS is currently developing the forms and schedules that will be used in connection with the annual tax return reconciliation of advance PAC payments and the qualifying PAC amount. The IRS is specifically authorized to publish the regulations to administer the PAC and reconcile the annual tax return.[63]

Every health insurance issuer, sponsor, or government agency administering a government health insurance program must file an annual information return that reports information for each individual for whom minimum essential coverage is provided.[64] This obligation exists whether the coverage is purchased through a state exchange or through an employer.[65]

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60. Treas. Reg. §1.36B-3(a).
61. Treas. Reg. §1.36B-3(a)(i).
62. Treas. Reg. §1.36B-3(a)(ii).
63. IRC §36B(g).
64. IRC §6055(b)(1).
65. IRS Notice 2012-32, 2012-20 IRB 910.

The state exchanges are specifically required to provide information to the IRS in connection with a taxpayer's PAC and health insurance coverage information.[66] The annual information return that reports details regarding minimum essential coverage must include the following items.[67]

1. The name, address, and TIN of the primary person insured under the plan and every other individual covered under the plan
2. The total premium for the coverage in which the taxpayer enrolled
3. The cost of the applicable benchmark plan that was used to calculate the advance credit payments for the taxpayer for the period of time that the coverage was in effect
4. The dates that each individual had minimum essential coverage during the year
5. Whether the coverage is a qualified health insurance plan offered through a state exchange
6. The amount of any advance PAC payment made on behalf of the taxpayer
7. Any other information the IRS may require

The issuer of information returns must provide a written statement to each person that shows the information that is disclosed to the IRS.[68]

Because the first year that the individual mandate will become effective is 2014, the first information returns will be issued in 2015. Presumably, key amounts from the information returns will be reported on Form 1040 using new schedules or forms reconciling the taxpayer's PAC with any advance PAC payments made through the state exchange.

Recovery of Excess Advance Credit Payments. If it is found that advance credit payments exceed the PAC amount for which the taxpayer actually qualifies, the excess is recovered in the form of an additional tax liability on the taxpayer's return for the year.[69]

However, for those taxpayers with household incomes of **less than 400%** of the poverty income guidelines for their family size, there is a cap on the amount of additional tax liability that will be imposed in order to recover any excess advance credit payments. The cap for these taxpayers is implemented along the following 3-tiered guideline.

PAC Table 3

Household Income Percentage of Poverty Income Guideline	Maximum Additional Tax Liability for Single Taxpayers[70] (Except Surviving Spouses and Head of Household Filers)	Maximum Additional Tax Liability for All Other Taxpayers
Less than 200%	$ 300	$ 600
At least 200% but less than 300%	750	1,500
At least 300% but less than 400%	1,250	2,500

Note. The amounts in the above table will be subject to inflation indexing, rounded to the next lowest $50 increment, commencing with tax years after 2014.

66. IRC §36B(f)(3).
67. IRC §6055(b)(1); Treas. Reg. §1.36B-5.
68. IRC §6055(c)(1).
69. Treas. Reg. §1.36B-4(a)(1)(i).
70. This category applies to those taxpayers covered under IRC §1(c).

Example 17. Marvin is a single individual with no dependents. Based on Marvin's family size and his rating area, the state exchange estimates Marvin's household income for the year as $27,925. Using PAC Table 1, the poverty income guideline for Marvin is $11,170. The state exchange estimates Marvin's household income at 250% of the poverty income guideline ($11,170 × 250% = $27,925).

When Marvin enrolls in his new health insurance plan effective January 1 of the tax year, the state exchange completes an estimated calculation of his PAC and uses this amount to determine the advance credit payments that Marvin can use to offset the cost of the coverage he selects for the year. The state exchange initially calculates Marvin's estimated PAC as follows.

The **estimated maximum premium** Marvin is expected to pay for the year is calculated by multiplying his estimated household income by his applicable percentage rate. Using PAC Table 2 (shown before **Example 15** in this chapter), the state exchange's income estimate for Marvin places him at the top of the fourth tier (the 200 to 250% tier) with an applicable percentage of 8.05%. Following is the estimated maximum premium Marvin is expected to pay for the year for purposes of the estimated PAC calculation by the state exchange.

Estimated maximum = Income estimate × Applicable percentage rate
= $27,925 × 8.05%
= $2,248

The annual cost of the **applicable benchmark coverage** for Marvin is $5,600. The state exchange completes an estimated calculation of Marvin's PAC as follows.

Estimated PAC = Cost of benchmark coverage − Maximum premium Marvin is expected to pay
= $5,600 − $2,248
= $3,352

Marvin is entitled to an advance credit payment of $3,352 for the year. This amount is credited against the total annual cost of the coverage Marvin selects. He purchases self-only coverage on his state exchange with a total cost of $6,200. Marvin pays the amount of the total cost in excess of his advance credit payment. The advance credit payment subsidizes his premium and is paid directly to the insurance carrier for the coverage he selects. Marvin's out-of-pocket cost is therefore $2,848 ($6,200 − $3,352).

When Marvin files his return for the year, he must **reconcile** the advance credit payment of $3,352 with the PAC tax credit that he actually qualifies for based on his income and the number of dependent exemptions that he can claim for the year. These amounts may be different than the amounts estimated by the state exchange in the calculations used to arrive at the $3,352 advance credit payment amount.

Marvin's actual household income for the year is $39,095. When Marvin's actual PAC for the year is calculated, he finds that his income equates to 350% of the poverty income guideline for his family size of one. Referring to Table 2, Marvin's applicable percentage rate for the year is 9.5% because he falls into the last tier (300 to 400%) of the table. Marvin's maximum premium that he is expected to pay is calculated as follows.

Maximum premium = Household income × Applicable percentage rate
= $39,095 × 9.5%
= $3,714

Marvin's actual PAC, based on his income and family size, is calculated as follows.

Actual PAC = Cost of benchmark coverage − Maximum premium Marvin is expected to pay
= $5,600 − $3,714
= $1,886

Therefore, Marvin received advance payments of $3,352 but qualifies for an actual PAC, as shown on his return for the year, of only $1,886. The excess of the advance payments over the actual PAC is $1,466 ($3,352 − $1,886), which will be **recovered** as an additional tax liability on Marvin's tax return.

However, because Marvin's $39,095 income is less than 400% of the poverty income guideline for his family size of one, the **tax cap** outlined in Treas. Reg. §1.36B-4(a)(3) applies to him. Under these rules, Marvin's additional tax liability for excess advance payments cannot exceed $1,250, which is the applicable cap for a single individual at Marvin's income level (PAC Table 3). Even though Marvin received excess payments of $1,466, his additional tax liability will be only $1,250 for the year.

Note. This example illustrates a taxpayer with qualified health insurance coverage in effect for the full tax year. The regulations[71] provide a definition of "coverage month" so that appropriate calculations may be completed for taxpayers who had qualifying coverage for less than the entire calendar year.

Implementation. Beginning January 1, 2014, when the individual mandate becomes effective, initial eligibility for the PAC and any advance payments of the credit for state exchange-purchased coverage will be based on the taxpayer's household income two years prior to the enrollment year.

According to the Joint Committee on Taxation,[72] an eligible taxpayer purchasing a health insurance plan through a state exchange will report their income to the exchange. The advance credits are paid to the taxpayer's insurance carrier directly from the federal Treasury. Taxpayers may update eligibility information or request a redetermination of their tax credit eligibility under the following circumstances.

- A change in marital status or other household circumstance
- A decrease in income of more than 20%
- A receipt of unemployment insurance

Note. It appears that the IRS is still developing appropriate guidance on how information will be conveyed by the taxpayer to the state exchange for a determination or redetermination of advance credit payments. Presumably, guidance on this subject will be published before the January 1, 2014, effective date of the individual mandate.

71. Treas. Reg. §1.36B-3(c).

72. Joint Committee on Taxation report JCX-18-10, March 30, 2010, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010" as Amended, in Combination with the "Patient Protection and Affordable Care Act."*

Subsidizing Healthcare Costs

The PPACA is concerned with ensuring that once coverage is obtained by low- to moderate-income taxpayers, that coverage is not too expensive to actually use because of the necessary out-of-pocket costs, such as deductibles, copayments, qualified medical expenses, and coinsurance.

The PPACA provides two cost-sharing reduction measures.

- Cost sharing for low- to moderate-income eligible taxpayers with household incomes in the range of 100 to 400% of the poverty income guideline
- An additional cost-sharing reduction for lower-income insured taxpayers

These cost-sharing reductions are available to taxpayers who obtain coverage through their state exchange as well as for taxpayers with employer-provided coverage. Taxpayers obtaining coverage through their state exchange may qualify for the PAC in addition to one or both of these cost-sharing reduction measures.

Cost Sharing Subsidization for Low- to Moderate-Income Taxpayers. There is an overall out-of-pocket limitation mandated by the PPACA. For 2014, this limit adopts the same dollar amount that serves as the overall limit on out-of-pocket expenses for high deductible health plans (HDHP).[73] These HDHP limits are subject to possible adjustments for inflation each year. For 2011 and 2012, these amounts are as follows.

	2011	2012
Individual limit	$ 5,950	$ 6,050
Family limit	11,900	12,100

Note. For 2015 and subsequent years, these limits are adjusted using a percentage of average per capita health insurance premium increases.

Once the above amounts are increased by any additional inflation adjustments for 2014, those 2014 amounts will serve as the out-of-pocket limit for taxpayer health insurance costs when the individual mandate of the PPACA becomes effective for the first time on January 1, 2014.

Taxpayers with household incomes in the range of 100 to 400% of the poverty income guideline for their family size may qualify for a **cost-sharing reduction, or subsidization,** of their out-of-pocket costs. To qualify, the taxpayer must enroll in a qualified health plan at the silver level that was purchased on their state exchange. The cost-sharing reduction lowers the out-of-pocket limit for these low- to moderate-income taxpayers by using a sliding scale as follows.

Income Range as a Percentage of Poverty Income Guideline for Taxpayer's Family Size	Amount of HDHP Limit Amount That Applies as Health Insurance Out-of-Pocket Cost Limitation
Greater than 100% up to 200%	1/3
Greater than 200% up to 300%	1/2
Greater than 300% up to 400%	2/3

Using the above table, the PPACA places a cap on the amount that the insurance company can require the taxpayer to pay in out-of-pocket expenses.

[73] The high deductible health plan out-of-pocket limits are mandated by IRC §223(c)(2)(A)(ii).

Example 18. The 2012 federal poverty guideline for a family of four living in the contiguous United States is $23,050. Assume this amount is $25,000 for 2014. In addition, the 2012 HDHP limit for a family is $12,100. Assume this amount is $13,000 for 2014.

Louis and his wife Norma have two dependent children and live in Illinois. In 2014, Louis earns $62,500 and was the only income earner in the family. Louis's income is 250% of the federal poverty guideline for a family of four in the contiguous United States. He has silver-level coverage for his entire family that he purchased on his state exchange. This places him in the second tier of the 3-tiered cost sharing reduction table (for incomes greater than 200% up to 300% of the poverty income guideline). The corresponding amount of the HDHP limit that will serve as Louis's cap on out-of-pocket costs in 2014 is 1/2. Therefore, the cap on Louis' out-of-pocket costs is $6,500 (1/2 × $13,000).

Further Reduction for Lower-Income Taxpayers. Under current legislation, the HHS Secretary will establish specific procedures for qualified health insurance companies to further reduce cost-sharing so that the plan's actuarial value percentage (reflected by the plan's share of allowed costs and benefits) is increased as follows.

Income Range as a Percentage of Poverty Income Guideline for Taxpayer's Family Size	Required Actuarial Value of Plan
From 100% up to 150%	94%
Greater than 150% up to 200%	87%
Greater than 200% up to 250%	73%

Procedures. Procedures for these subsidies are currently being developed. It appears that the HHS Secretary will provide the insurance companies with details on taxpayers who qualify for a cost-sharing reduction so the companies can implement these measures. These cost reductions are subsidized by the federal government with funds that will be paid directly to the insurance companies which, in turn, will reduce the costs to the eligible taxpayer under their plan.

Note. Currently, there is no provision to apply for these cost-sharing reductions on a tax return or other IRS form or procedure.

In addition, for taxpayers with employer-provided coverage, an employer must be notified if an employee is determined as eligible for a cost-sharing reduction. The notice must provide the employer with information about the employer's potential liability for payments under the employer health coverage mandate[74] (discussed later in this chapter).

The employer must be notified that terminating, or otherwise discriminating against an employee because the employee received a credit or subsidy, violates the Fair Labor Standards Act. Although an employer is generally not entitled to information about employees who qualify for the PAC or cost-sharing reduction, the employer may be notified of the qualifying employee's name and whether that employee's income is above or below the threshold used to measure the affordability of the employer's health insurance coverage.

Note. These cost-sharing reductions are mandated by the PPACA §1402. Under this provision, special rules apply to the following.

- Benefits beyond the essential health benefits that the healthcare coverage is required to provide to the taxpayer[75]
- Pediatric dental benefits
- Native Americans

74. See IRC §4980H.

75. PPACA §1402(c)(4).

EMPLOYER MANDATE

In addition to the individual mandate that places obligations on individual taxpayers, the PPACA also provides for an employer mandate.

Although the PPACA does not require employers to offer health insurance coverage to employees, **applicable large employers** are subject to a **shared-responsibility mandate** effective January 1, 2014. This is the same date that the individual mandate for applicable individuals, discussed earlier, becomes effective.

APPLICABLE LARGE EMPLOYERS

An "applicable large employer" (ALE) is an employer that employed an average of at least 50 full-time employees on business days during the previous calendar year.[76] However, there is an **exemption** available if the employer meets both of the following conditions.

- The workforce exceeds 50 full-time employees for 120 or fewer days during the calendar year.
- The employees in excess of 50 employees were seasonal workers.[77]

Counting Employees

A full-time employee is an employee who is employed an average of at least 30 hours per week.[78]

> **Note**. Further IRS guidance is expected on how to determine an employee's hours of service.[79] The Code authorizes the IRS to confer with the Department of Labor in publishing regulations on the application of this provision, including rules relating to employees who are not compensated on an hourly basis.[80]

The definition of **seasonal worker** is the same as that used by the Department of Labor in its Migrant and Seasonal Agricultural Worker Protection law.[81] This definition is as follows.

> *On a seasonal or other temporary basis means:*
>
> *Labor is performed on a seasonal basis where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year. A worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year.*[82]

In addition, workers employed exclusively during holiday seasons are also included in the definition of seasonal worker for purposes of the ALE exemption.

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76. IRC §4980H(c)(2).
77. IRC §4890H(c)(2)(B).
78. IRC §4980H(c)(4).
79. IRS Notice 2012-17, 2012-9 IRB 430.
80. IRC §4980H(c)(4)(B).
81. 29 CFR §500.20(s)(1) as referenced by IRC §4980H(c)(2)(B)(ii).
82. 29 CFR §500.20(s)(1).

Commonly Controlled or New Employers

Generally, commonly controlled employers are treated as a single employer for purposes of counting employees.[83]

> **Note.** The common control rules in IRC §§414(b), (c), (m), and (o) determine whether one or more controlled employers is considered a common employer for purposes of the definition of ALE. The IRS has provided substantial guidance in the form of regulations under §414 to assist in this determination.

In addition, if the employer is **new** (and thus had no workforce in the previous year), a special rule is used to determine whether the employer is an ALE. For a new employer, the determination is made using the average number of employees that the new employer is **reasonably expected** to employ on business days within the **current calendar year.**[84]

Part-Time Employees

In addition to counting all full-time employees, the employer must also take into account its part-time employees. Part-time employees are counted by adding up the total number of service hours for the month for all part-time employees and dividing that sum by 120.[85]

> **Note**. The Code indicates that this part-time calculation is done for "any month." Presumably, 12 monthly calculations for the previous year must be completed in this fashion in order to determine the full-time equivalent of any part-time employees for the previous year.

> **Observation.** It appears that further IRS guidance is necessary on the subject of counting part-time employees. In addition, further guidance is expected on how to account for newly hired employees.

Example 19. ChronoTime Watchmakers, Inc., employs seven part-time people in addition to its full-time staff for the month of January 2013. For that month, the seven part-time employees worked a total of 360 hours. Those seven part-time employees are counted as three (360 ÷ 120) FTE employees for January. Similar calculations are needed for February through December 2013 to determine the total number of ChronoTime's FTE employees for 2013. If ChronoTime falls under the definition of an ALE, it is subject to the PPACA's employer shared-responsibility mandate.

83. IRC §4980H(c)(2)(C)(i).

84. IRC §4980H(c)(2)(C)(ii).

85. IRC §4980H(c)(2)(E).

ALE REPORTING REQUIREMENTS

The PPACA imposes additional reporting requirements on ALEs. Additional information about the employer health insurance plan (or its absence) must be reported to the IRS each year. In addition, the ALE must notify each employee of the information disclosed about that employee in the IRS health insurance report.

Employer Health Insurance Coverage Reporting

ALEs are subject to special reporting requirements under the PPACA. An ALE is required to report the following information to the IRS.

1. The name and EIN of the employer
2. A certification as to whether the employer offers its full-time employees the opportunity to enroll in minimum essential coverage under an **eligible employer-sponsored plan**
3. The number of full-time employees for each month during the calendar year
4. The name, address, and TIN of each full-time employee during the calendar year and the number of months each employee was covered by a health plan
5. Any other information the IRS may require[86]

Furthermore, if the employer provides coverage for its employees, the ALE must disclose many details regarding the coverage offered, including factors such as waiting periods, the lowest cost option, and the total cost of benefits allowed under the plan.[87]

> **Note**. IRS guidance and new forms are anticipated in connection with this new annual employer reporting requirement.

An "eligible employer-sponsored plan" is defined as a group health insurance plan offered by an employer to an employee which is one of the following.

1. Governmental plan under the Public Health Service Act
2. Any other plan or coverage offered in the group market within a state
3. A grandfathered health insurance plan[88]

Some group health insurance plans and health insurance coverage existing as of March 23, 2010 (the date of PPACA enactment), are **grandfathered plans** that are not subject to many of the PPACA provisions and can continue in place. Grandfathered plans must include a statement notifying the enrollees that they have grandfathered status as permitted by the PPACA. Making certain changes to a grandfathered plan can result in the termination of its grandfathered status.

> **Note.** For more information on grandfathered plans, see PPACA §1251 and Temp. Treas. Reg. §54.9815-1251T, which address the various rules and eligibility for grandfathered plans.

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86. IRC §6056(b).
87. Ibid.
88. IRC §5000A(f)(2).

Written Statements to Employees

Employers who are subject to the health insurance coverage reporting requirement must also furnish to each employee named in the report a written statement indicating the following.

- The name, address, and telephone number of the person who compiled the report
- The particular details about the employee that are shown in the report

These disclosures are due to employees on **January 31** of the year following the calendar year for which the report to the IRS regarding health insurance coverage was made.[89] Although January 31 is stated in the Code as the deadline for the required disclosure to employees, there is no due date yet indicated for filing reports with the IRS regarding the employer's health insurance coverage or the individual employee disclosures. Further guidance is anticipated.

Penalties

The health insurance report that employers are required to file with the IRS is included under the definition of "information return."[90] In addition, the written statements that the employer is required to provide to each employee are also considered information returns. Categorizing these employer reports as information returns is significant because this means that a failure to timely file the returns subjects the employer to potential penalties under IRC §6721.

Generally, the amount of the penalty under §6721 depends on the number of information returns that were not filed on a timely basis or were incomplete and how soon the taxpayer provided or corrected the information. The following table summarizes the penalties that apply under §6721.

	Description	Penalty per Information Return	Maximum Penalty per Calendar Year	Maximum Small Business Penalty
First tier penalty	Taxpayer files accurate and complete information return(s) within 30 days of due date.	$ 30	$ 250,000	$ 75,000
Second tier penalty	Taxpayer files accurate and complete information return(s) more than 30 days after due date but on or before August 1 of the year due	60	500,000	200,000
Third tier penalty	Taxpayer does not file correct information return(s) by August 1 of the year due	100	1,500,000	500,000

Note. There is an equivalent penalty under IRC §6722 for failure to furnish information returns to employees. For more information, see 2012 Volume B, Chapter 4: Information Reporting.

Note. All the above amounts are subject to possible inflation adjustments every fifth calendar year after 2012.[91]

89. IRC §6056(c)(2).
90. IRC §6724(d)(1)(B)(xxv).
91. IRC §6721(f).

The small business maximum penalty applies to a business with gross receipts of no more than $5 million in each of the last three years ending before the tax year in which the penalty is assessed. The $5 million gross receipts test used to define a small business is the same as the $5 million gross receipts test in connection with the limitation on the use of the cash method of accounting.[92]

> **Caution.** A failure to timely file an information return includes failure to file it in the required manner. If upcoming IRS guidance regarding the filing of reports by employers requires such reports to be filed either electronically or by another method, it will be essential to file these reports using the required method in order to avoid penalties.

If an employer shows **reasonable cause** for a late filing or nonfiling of the information returns required by the PPACA, it may avoid the penalty.[93] Other grounds for a penalty waiver include the presence of **inconsequential** errors or **de minimis** errors on the required information returns. Such errors do not make an information return inaccurate or incomplete.[94]

If the employer's required healthcare filings are late, inaccurate, or incomplete because of **intentional disregard** for the filing requirements, special rules apply to the penalty. Intentional disregard exists if the employer knowingly or willfully fails to timely file the information return or fails to include accurate and correct information. All the facts and circumstances are considered in determining intentional disregard. Some of the facts considered are the following.

- Whether the employer has a pattern of repeated failures to comply with information return requirements
- Whether the employer promptly corrected an error after it was discovered
- Whether the employer corrected an error within 30 days of being advised of the error by the IRS
- Whether the cost in penalties is less than the cost of timely, correct, or accurate filing of the information return[95]

Generally, if intentional disregard exists on the part of the employer, the penalty is increased to the greater of:

1. $250 per information return, or
2. The "statutory percentage," which is either 5% or 10% of the dollar amount shown on certain specified information returns when filed correctly.[96]

Under current rules, neither the employer report on health insurance required to be filed annually with the IRS nor the information returns to be provided to employees are included in the list of items subject to the statutory percentage. Accordingly, intentional disregard will cause the per-information-return penalty to increase to $250 without application of the statutory percentage provision.

> **Example 20.** MGT Instruments, Inc., is an ALE subject to the employer mandate. It must file an information return to the IRS regarding the health insurance coverage it offers to its 62 full-time employees. In addition, MGT must file copies of the written disclosure required to be furnished to each individual employee with the IRS. The total number of information returns is 63 (62 individual employee disclosures plus the healthcare coverage statement filed with the IRS). Assume that the deadline for 2014 for all of these information returns is January 31, 2015. MGT does not file these information returns until May 15, 2015. Because the returns were filed more than 30 days after the due date and before August 1, the penalty is $60 per information return. For 63 information returns, the penalty is $3,780 (63 information returns × $60 per return).

A showing of reasonable cause is not available to an employer that intentionally disregarded the filing requirements.[97]

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92. See IRC §448(c) and Temp. Treas. Reg. §1.448-1T(f)(1).
93. See IRC §6724(a) and Treas. Reg. §301.6724-1 for further details on showing reasonable cause.
94. See Treas. Reg. §301.6721-1 for a discussion of inconsequential and de minimis information return errors.
95. Treas. Reg. §301.6721-1(f)(3).
96. See Treas. Reg. §301.6721-1.
97. Treas. Reg. §301.6724-1(a)(1).

EMPLOYERS NOT OFFERING COVERAGE

The PPACA **does not** require employers to offer coverage to employees. However, starting January 1, 2014, ALEs will be subject to shared-responsibility payments if:

- The employer **fails to offer** its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month, and
- At least one full-time employee has been certified to the employer as having enrolled in a state exchange and receives a PAC or qualifies for cost sharing.

These employers are subject to a shared-responsibility payment, which is calculated on a monthly basis using the following steps.

1. Subtract 30 employees from the total number of FTE employees **for the month.**
2. Multiply that reduced number of employees by $166.67.

> **Note.** This shared-responsibility payment for employers **not** offering coverage is referred to as the §**4980H(a)** penalty in this chapter. This penalty is **not deductible** by the employer.

Example 21. During all of 2014, Eastern Materials and Production Engineering, Inc., did not offer minimum essential coverage to its full-time employees. Taking into account all full-time and part-time employees, Eastern's FTE employee count for each month was 127. Eastern is therefore an ALE subject to the shared-responsibility mandate. Because several employees qualified for the PAC and cost sharing for every month of the year, Eastern must make a shared-responsibility payment for all 12 months of 2014.

To calculate the §4980H(a) penalty, Eastern first reduces the 127 FTE employee count by 30. This results in an adjusted employee count of 97 (127 – 30 employees).

The §4980H(a) penalty for one month is $166.67 × 97 employees = $16,167. Because Eastern had the same number of full-time employees each month, the total shared-responsibility payment for the year is $194,004 ($16,167 × 12 months).

> **Observation**. Although a 30-employee reduction is permitted in the calculation of the shared-responsibility payment made by the employer, this same reduction is **not** permitted when calculating the number of employees for the purpose of determining whether the employer is an ALE subject to the employer mandate.

The $166.67 monthly amount is **indexed** for inflation for years after 2014.[98]

> **Note**. The Code specifically authorizes the IRS to mandate that shared-responsibility payments are payable by employers on either an annual, monthly, or other periodic basis.[99] Further guidance and forms are anticipated in this area.

98. IRC §4980H(c)(5).
99. IRC §4980H(d)(2).

EMPLOYERS OFFERING COVERAGE

Employers that offer coverage to employees have specific requirements that must be met under the PPACA. Three of the most important requirements are as follows:

1. The employer must provide insurance that covers **at least 60%** of the employees' healthcare costs.
2. The employer cannot offer coverage **to some** employees and not others.
3. The employer must offer **affordable** coverage to employees.

Under a minimum value test, the employer plan must pay at least 60% of total costs for allowed benefits.[100] This means that the employee's copayments, deductibles, and other out-of-pocket costs cannot exceed 40% of the total benefit costs under the plan offered by the employer.

> **Note**. Further IRS guidance is expected on the nature of the minimum value test to be used in determining whether the 60% cost requirement is met by an employer's coverage. IRS Notice 2012-31,[101] issued on April 26, 2012, described some possible alternatives and requested comments on this subject, with a submission deadline of June 11, 2012. Actuarial calculations and safe-harbor checklists are two of the options discussed in the notice.

If full-time employees pay 9.5% or less of household income for healthcare coverage, the coverage is deemed affordable.

If the employer offers coverage but the coverage does not have sufficient minimum value or if the coverage is not affordable, the employer exposes itself to liability for shared-responsibility payments. If coverage is offered but does not meet the minimum value or affordability requirement, employees may be eligible to purchase coverage on a state exchange and, therefore, may be eligible for the PAC and/or cost-sharing reduction. After a taxpayer applies for premium assistance credits to purchase coverage in a state exchange, HHS will inform the exchange whether the taxpayer is eligible because the taxpayer's (or related individual's) employer does not provide minimum essential coverage or affordable coverage. The state exchange in turn notifies the employer that it may be liable for a penalty.

The penalty may be assessed by the IRS at this point. The IRS must establish a separate appeals process for these employers, giving them the opportunity to present information for review and granting them access to the data used in determining that the coverage offered did not meet the requirements. This process is in addition to any appeal rights the employer already has under the Code.[102]

> **Note.** The PPACA §1411 outlines the procedures for determining whether an employee taxpayer is eligible to purchase coverage on the state exchange (possibly qualifying for the PAC or cost-sharing reduction if their income and family size allow). Further guidance from HHS and/or the IRS is expected on the information flow between these agencies and the taxpayer's state exchange and the specific procedures that will be used to implement this part of the PPACA.

Mandatory Notice to Employees

Effective March 1, 2013, employers must provide written notice to employees regarding the upcoming state exchanges and the employees' potential eligibility to purchase coverage through the state exchange in the event that the employer's coverage does not meet the requirements. This notice must also be provided to newly hired employees in subsequent years.[103]

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100. IRC §36B(c)(2)(C)(ii).
101. IRS Notice 2012-31, 2012-20 IRB 906.
102. See PPACA §1411(e) and (f).
103. PPACA §1512.

ALEs that offer coverage are also subject to shared-responsibility payments if:

- They offer their full-time employees the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month, but
- They have one or more full-time employees who have been certified for the month as having enrolled in a qualified health plan offered through a state exchange which makes that employee eligible for the PAC or cost-sharing reduction.[104]

An employee offered **affordable** minimum essential coverage by an employer is **not eligible** for the PAC or cost-sharing reduction. Moreover, a Medicaid-eligible employee can leave the employer's insurance program and enroll in Medicaid without exposing the employer to shared-responsibility payments.[105]

> **Observation.** The purpose behind this provision is to prevent an employer from discriminating against certain employees by offering insurance to only selected employees, offering insurance that is not affordable, or offering insurance that does not pay at least 60% of the employee's healthcare cost. If no employee is eligible for the PAC or cost-sharing reduction, the employer will have no shared-responsibility payment.

The shared-responsibility payments are calculated for only those full-time employees that qualify for the PAC or cost-sharing reduction. The §4980H(b) penalty is $250 per month for each employee who qualifies for the PAC or cost-sharing reduction. The $250 monthly penalty is subject to annual inflation adjustments after 2014. In addition, the employer's shared-responsibility payment cannot be larger than the penalty that would be incurred if the employer did not offer coverage to its employees (discussed in the last section). Accordingly, the cap on the §4980H(b) penalty to the employer offering coverage is the amount of the §4980H(a) penalty the employer would incur, calculated as if that employer did not offer coverage.

Example 22. During 2014, Sigma Six Brewing Company has 90 full-time employees. The company offers minimum essential coverage only to some of its employees. Eight of the employees receive a PAC because they enrolled in a plan obtained through the state exchange. These eight employees qualified for the PAC and/or cost-sharing reduction for all 12 months of 2014. For each of these eight employees, Sigma Six owes a §4980H(b) penalty of $250 per month, or $2,000 per month ($250 × 8). The annual penalty is $24,000 ($2,000 × 12 months). However, the cap on Sigma's §4980H(b) penalty is the amount of §4980H(a) penalty Sigma would pay had it **not** offered coverage to employees. This §4980H(a) maximum cap on the §4980H(b) penalty is calculated as follows.

1. 90 employees – 30 employees = 60 employees
2. Monthly shared-responsibility payment = $10,000 ($166.67 per month × 60 employees)
3. Maximum annual shared-responsibility payment = $120,000 ($10,000 × 12 months)

Therefore, while the maximum §4980H(b) penalty is $120,000, Sigma Six is liable for the $24,000 penalty as calculated above.

> **Note**. The 30-employee reduction that is allowed in the calculation of the §4980H(a) penalty is not provided in the calculations for the §4980H(b) penalty.

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104. IRC §4980H(b)(1).

105. Joint Committee on Taxation report JCX-18-10, March 30, 2010, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010" as Amended, in Combination with the "Patient Protection and Affordable Care Act."*

2018 CHANGES

EXCISE TAX ON "CADILLAC" HEALTH PLANS

Starting in 2018, the PPACA mandates a 40% excise tax on the amount of higher-cost employee health plans. The excise tax applies to the costs that exceed the following amounts after several potential adjustments.

- $10,200 for single coverage
- $27,500 for family coverage

This excise tax is assessed if one or more employees is covered under any applicable employer-sponsored coverage at any time during the tax year. For purpose of this excise tax, the definition of "employee" includes existing and former employees, surviving spouses, or other primary insured individuals.[106]

The above threshold amounts are subject to several adjustments before arriving at the applicable tax thresholds actually used to calculate the excise tax. These adjustments are as follows.

1. Increase the thresholds by the **health cost adjustment percentage.** This is a possible one-time adjustment to update healthcare costs from 2010 to 2018 levels, but only if the adjustment is large enough.

   The benchmark coverage to be used is the Blue Cross/Blue Shield standard benefit option of the Federal Employees Health Benefits Plan. If the cost increase from 2010 to 2018 is more than 55%, the $10,200 and $27,500 amounts will be increased by the amount of the price increase over 55%. If the cost increase from 2010 to 2018 is less than 55%, no initial adjustment will occur. After determining whether this initial adjustment takes place, further employer-specific adjustments, as outlined below, may take place.

2. Increase the thresholds by the employer-specific **age and gender** adjustments**.** Each year, the employer makes adjustments to take into account the specific gender and age of its workforce. This adjustment is calculated each year by comparing the following.

   - Premiums for the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the particular employees of the employer
   - The cost of the same Blue Cross/Blue Shield option for the national workforce

> **Note.** This adjustment is intended to make certain that an employer with a workforce that is more expensive to insure because of gender or age is not at a disadvantage.

3. Increase the thresholds to account for **retirees and high-risk workforces.** For retired employees covered under the employer's health plan that have attained age 55 and are not eligible for Medicare, the thresholds are increased. If the majority of the employer's workforce is engaged in high-risk professions, similar increases to the threshold amounts are provided. For these situations, the thresholds increase as follows.

   - The $10,200 single coverage threshold is increased by $1,650.
   - The $27,500 family coverage threshold is increased by $3,450.

Only one increase in the threshold is available for an individual over age 55 that is in a high-risk profession.

High-risk job areas include law enforcement, firefighting, rescue or ambulance crews, longshore workers, electrical or telecommunication line repair or installation, construction, mining, forestry, fishing, and agriculture (with the exception of food processing).

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106. IRC §4980I(d)(3).

After the thresholds have been adjusted, the excess of the actual cost of employee coverage over the adjusted thresholds is the **excess benefit** that is subject to the excise tax.

Coverage Subject to the Excise Tax

Generally, the excise tax applies to employer-sponsored coverage under any group health plan with a cost that is excludable from gross income of the employee under the general exclusion rule of IRC §106.[107] It also applies to coverage that would be excludable from the employee's gross income if the coverage were employer-provided. Items subject to the excise tax include the following.

- Reimbursements under an FSA or health reimbursement arrangement (HRA)
- Employer HSA contributions
- Dental, vision, and other supplementary health coverage

The excise tax is not assessed on the following.

- Separate dental or vision coverage
- Fixed indemnity health coverage that the employee buys with after-tax dollars
- Disability benefits or long-term care coverage under an accident or health plan
- Liability insurance, such as general liability and automobile liability coverage
- Coverage issued as a supplement to liability insurance
- Workers' compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Other similar insurance coverage if medical care benefits are secondary or incidental to other insurance benefits

Payment of the Excise Tax

The excise tax is payable by the coverage provider, which is one of the following.

- The **health insurance company,** if the employer-sponsored coverage is a group health plan
- The **employer,** if the employer-sponsored coverage consists of an arrangement under which the employer makes HSA or MSA contributions
- If neither of the above two applies, the **plan administrator** that administers the benefits under the employer-sponsored coverage[108]

Although the taxable period for purposes of the excise tax is the calendar year, the IRS may provide regulations or other guidance mandating taxable periods of shorter duration or use different taxable periods for different employers.[109]

This excise tax is not deductible to the coverage provider that pays the tax.[110]

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107. IRC §4980I(d)(1).
108. IRC §4980I(c).
109. IRC §4980I(f)(8).
110. IRC §§4980I(f)(10) and 275(a)(6).

Employer Responsibility

Under the excise tax rules, the employer must calculate the amount of **excess benefit** that is subject to the tax. The excess benefit is the amount of actual coverage cost for employees that exceeds the adjusted thresholds for the tax period. In addition, the employer must notify the IRS of the excess amount.

> **Note**. Further guidance is anticipated in connection with the calculation of the excise tax and the compliance expected of an employer, including how the employer will provide the IRS with the information necessary to assess the tax.

Example 23. In 2018, Core Central Industries has 10 employees with single coverage that has an annual cost of $12,200. The health insurance coverage is applicable employer-sponsored coverage and is subject to the excise tax. Assume that after all potential threshold adjustments are calculated, Core Central's threshold amounts for excise tax calculation purposes remain at $10,200 for single coverage. The excise tax is assessed on the actual cost of the coverage for 10 employees over the $10,200 threshold. The excess on each of the 10 employees' coverage is $2,000 ($12,200 actual cost − $10,200 threshold). The excess benefit subject to the excise tax is $20,000 ($2,000 excess cost × 10 employees). The excise tax is $8,000 (40% tax × $20,000 excess benefit).

HEALTHCARE REFORM IMPLEMENTATION

Insurance companies that are found to have excessive administration costs relative to the coverage benefits provided must refund a portion of premiums paid to its policyholders. These payments may be taxable income and/or represent a reduction in allowable healthcare expense for the recipient in 2012.

Since the 2010 enactment of the PPACA and HCERA, many provisions of the new healthcare reform legislation have become effective as both Acts are gradually phased in. The table on the following page lists some of the more important tax-related provisions that have already been phased in and those that will become effective in the future.

2010	Medicaid expansion	Additional funding for states to provide Medicaid coverage to parents and childless adults with household incomes up to 133% of the federal poverty income guideline.	PPACA §2001
	Small Business Health Insurance Tax Credit	Tax credit for small businesses to make employer coverage more affordable. Credit of up to 35% of premiums paid (25% for nonprofit organizations). For tax years after 2013, employer participation in a state exchange is necessary to obtain the credit.	IRC §45R IRS Notice 2010-44 IRS Notice 2010-82
	Excise tax on indoor tanning services	10% excise tax applies to indoor tanning services performed on or after July 1, 2010. Salon owners must collect the tax from customers and remit to the IRS quarterly.	IRC §5000B
2011	Health insurance company public disclosure requirements	Individual and small group plans to spend 80% of premium dollars on clinical services and quality activities; 85% for large group plans. Starting in 2011, rebates to policyholders begin from plans not meeting these requirements.	Public Service Health Act §2718(b)(1)(A)
2012	Employer Form W-2 disclosure	Beginning with the 2012 tax year, large employers (250 or more employees) begin to disclose the value of health benefits on employee Forms W-2.	IRC §6051(a)(14) IRS Notice 2012-9
2013	Health FSA contribution cap	FSA plans must have written amendment prohibiting more than $2,500 in contributions.	IRC §125(i)
	Itemized medical expense rules change	Qualified medical expenses are subject to new 10% AGI threshold which replaces previous 7.5% threshold.	IRC §213(a)
	Employers lose deduction for retiree prescription drug plans	Employer deduction for expenses allocable to Medicare Part D subsidy is repealed.	IRC §139A repealed
2014	Individual and employer mandates become effective	Individual taxpayers and employers become subject to their respective obligations under healthcare reform and are subject to penalties.	IRC §5000A IRC §4980H
	Second phase of Small Business Health Insurance Tax Credit	Maximum credit increases to 50% of premiums paid (35% for nonprofit organizations). Employer must participate in a state exchange before qualifying.	IRC §45R
	State exchanges	States must have established exchanges to facilitate the purchase of qualified health plans for individuals and small group markets.	PPACA §1321(b)
2018	Excise tax on "Cadillac" plans	Excise tax of 40% applies to excess amount for high-cost plans.	IRC §4980I