Part IX: Tax Increases and Revenue Raisers

Additional Requirements for Nonprofit Hospitals

357. When are health reform's additional requirements for Code section 501(c)(3) hospitals effective?

All of the new requirements, with the exception of the Community Health Needs Assessment (CHNA) requirements (see Q 360), will apply to taxable years after March 23, 2010.[[1]](#footnote-1) The CHNA requirements become effective for taxable years after March 23, 2012.[[2]](#footnote-2)

358. Why were these additional requirements enacted?

Charitable hospital organizations seeking to qualify for federal tax-exempt status must now satisfy not only Code section 501(c)(3) criteria but also health reform’s additional requirements.

Among other things, these requirements impose transparency on hospital organizations and require a level of accountability for providing adequate charity care. Those charitable hospital organizations seeking the benefits of tax-exempt status must prove they are fulfilling their charitable missions.

359. What are the requirements for the establishment of a financial assistance policy?

Health reform imposed additional requirements on charitable hospitals to qualify for Code section 501(c)(3) tax-exempt status. Specifically, tax-exempt hospital organizations must establish a written financial assistance policy, to include:

(a) The criteria for eligibility for financial assistance,

(b) The method for applying for financial assistance,

(c) The basis for calculating amounts charged to patients,

(d) The action to be taken in the event of nonpayment, and

(e) A description of the procedures to publicize the policy.[[3]](#footnote-3)

In addition, the hospitals must establish a written policy concerning emergency medical care, requiring the organization to provide care for emergency medical conditions regardless of the patient’s ability to pay.[[4]](#footnote-4)

Moreover, the organizations must limit the amounts charged for emergency or non-emergency medical care to patients eligible for financial assistance to not more than the amount generally billed and prohibit the use of gross charges.[[5]](#footnote-5)

Finally, nonprofit hospitals must refrain from engaging in extraordinary billing and collection actions until after reasonable efforts have been made to determine whether a patient is eligible for financial assistance.[[6]](#footnote-6)

360. What are the community health needs assessment requirements?

For taxable years after March 23, 2012, tax-exempt hospitals must conduct a “community health needs assessment” (CHNA) every three years and then adopt and implement a strategic plan to meet the community’s health needs identified through the assessment. The CHNA must take into account input from public health experts and individuals in the community who represent the broad interests of the community in the area served by the organization. The CHNA must be made available to the public.[[7]](#footnote-7)

In addition, these hospitals must include on their IRS Form 990 a description of how the organization is addressing the needs identified in the CHNA and a description of any such needs that are not being addressed, together with the reasons why such needs are not being addressed.[[8]](#footnote-8)

Not only must a hospital organization satisfy the above additional requirements, but the organization’s community benefit activities will be subject to review by the Department of the Treasury at least once every three years.[[9]](#footnote-9) Any organization that fails to meet the CHNA requirements for any taxable year will be subject to an excise tax of $50,000.[[10]](#footnote-10) The amount of the excise tax must be reported on the organization’s annual tax return.[[11]](#footnote-11)

Penalty for Lack of Economic Substance

361. What is the economic substance doctrine?

The term “economic substance doctrine” means the common-law doctrine established by court decisions under which income tax benefits are not allowed if the transaction does not have economic substance or lacks a business purpose.[[12]](#footnote-12) As part of health reform, Congress codified the economic substance doctrine in the Internal Revenue Code[[13]](#footnote-13) and imposed penalties for its violation.[[14]](#footnote-14) The law adopts a two-prong test used by most, though not all, of the federal circuit courts. A transaction has economic substance only if:

(i) the transaction changes in a meaningful way (apart from federal income tax effects) the taxpayer's economic position, and

(ii) the taxpayer has a substantial purpose (apart from federal income tax effects) for entering into the transaction.[[15]](#footnote-15)

Additionally, the law adopts a strict liability penalty if the taxpayer violates the doctrine (40 percent if not disclosed; 20 percent if disclosed). This will impose a significant downside risk for those who continue to indulge in tax-shelter transactions because there will be no reasonable cause defense available. However, aggressive positions might be tested in refund actions without risk of the penalty imposed under Code section 6676 on excessive refund claims.[[16]](#footnote-16)

The IRS has announced that there will be no “angel list” (specific transactions to which the penalty does not apply).[[17]](#footnote-17) By avoiding “bright lines,” few rational taxpayers should want to test the “tax lottery” in this area.

362. When are the economic substance penalties effective?

The law applies with respect to transactions entered into on or after March 31, 2010.[[18]](#footnote-18)

Tanning Bed Tax

363. What is the new tanning bed tax?

Effective July 1, 2010, a 10 percent tax on indoor tanning salons' tanning sessions is imposed.[[19]](#footnote-19) Recipients of any indoor tanning service are responsible for paying an excise tax equal to 10 percent of the amount paid for the indoor tanning services, whether or not the amounts to be paid by insurance.[[20]](#footnote-20) The tax is imposed at the time of payment for any indoor tanning service[[21]](#footnote-21) and is collected by the service provider.[[22]](#footnote-22) The tax is 10 percent of the amount of the services and is not grossed up.[[23]](#footnote-23)

364. Which tanning services are covered and which are exempt from the indoor tanning services tax?

An “indoor tanning service” is a service that uses any electronic product designed to incorporate one or more ultraviolet lamps, and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning.[[24]](#footnote-24)

The term “indoor tanning service” excludes any phototherapy service performed by a licensed medical professional, on the medical professional's premises.[[25]](#footnote-25) Phototherapy services performed by a licensed medical professional on the medical professional's premises are exempt from the indoor tanning services excise tax. Phototherapy service means a service that exposes an individual to specific wavelengths of light for treatment of:

* dermatological conditions (e.g., acne, psoriasis, or eczema)[[26]](#footnote-26)
* sleep disorders[[27]](#footnote-27)
* seasonal affective disorder (SAD) or other psychiatric disorder;[[28]](#footnote-28)
* neonatal jaundice[[29]](#footnote-29)
* wound healing;[[30]](#footnote-30) or
* other medical condition determined by a licensed medical professional to be treatable by exposing the individual to specific wavelengths of light[[31]](#footnote-31)

Indoor tanning services also do not include spray tans or topical creams[[32]](#footnote-32) and tanning lotions.[[33]](#footnote-33)

Limits on Reimbursement of Nonprescription Over-the-Counter Drugs

365. How have the rules changed on the ability to reimburse for over-the-counter (OTC) drugs?

Health reform limits the payment for over-the-counter drugs to insulin or those that are prescribed by a physician beginning January 1, 2011.[[34]](#footnote-34) Thus, the cost of OTC medicines cannot be reimbursed with excludable income through a health flexible spending account (FSA), health reimbursement account (HRA), health savings account (HSA), or Archer medical savings account (MSA) unless the medicine is insulin or the non-prescription medicine is, in fact, prescribed by a doctor.

IRS Notice 2011-5 states that health FSA and HRA debit cards may continue to be used after January 15, 2011, to purchase prescribed over-the-counter medicines or drugs at drug stores and pharmacies, at non-healthcare merchants that have pharmacies, and at mail order and Web-based vendors that sell prescription drugs, if:

(1) prior to purchase:

* the prescription for the OTC medicine or drug is presented (in any format) to the pharmacist
* the OTC medicine or drug is dispensed by the pharmacist in accordance with applicable law and regulations; and
* a prescription number is assigned

(2) the pharmacy or other vendor retains, in a manner that meets IRS's recordkeeping requirements:

* the prescription number
* the name of the purchaser or person for whom the prescription applies; and
* the date and amount of the purchase

(3) all of these records are available to the taxpayer's employer or its agent upon request

(4) the debit card system will not accept a charge for an OTC medicine or drug unless a prescription number has been assigned; and

(5) the additional requirements regarding the use of health FSA or HRA debit cards[[35]](#footnote-35) are met.

Use of Debit Cards. After January 15, 2011, health FSA and HRA debit cards may also continue to be used to purchase OTC medicines or drugs from vendors other than those described previously that have healthcare-related “Merchant IRCs,”[[36]](#footnote-36) including physicians, pharmacies, dentists, vision-care offices, hospitals, and other medical care providers. If all other requirements in the previous list are satisfied, then these debit card transactions will be considered fully substantiated at the time and point-of-sale.

Health FSA and HRA debit cards may also be used to purchase OTC medicines and drugs at “90 percent pharmacies” with at least 90 percent of the store's gross receipts during the prior tax year consisting of qualified medical care expenses.[[37]](#footnote-37)

Doubled HSA and MSA Penalty for Spending for Non-Health Care and Nonprescription Over-the-Counter Items

366. How has health reform changed the penalty for a health savings account (HSA) or an Archer medical savings account (MSA) regarding payment for non-medical items?

The health reform law revised the rules with respect to HSAs[[38]](#footnote-38) and MSAs[[39]](#footnote-39) to provide that for amounts paid after December 31, 2010, a distribution for a medicine or drug is a tax-free qualified medical expense only if the medicine or drug is a prescribed drug or insulin. Thus, to be reimbursed, over-the-counter (OTC) drugs must have a prescription or be insulin. Thus, a distribution from an HSA or an Archer MSA for a medicine or drug is a tax-free qualified medical expense only if the medicine or drug:

* requires a prescription,
* is an OTC medicine or drug and the individual obtains a prescription, or
* is insulin

If amounts are distributed from an HSA or Archer MSA for any medicine or drug that does not satisfy this requirement, the amounts will be distributions for nonqualified medical expenses, which are includable in gross income and generally are subject to a 20 percent additional tax.

The IRS has stated that items that are not medicines or drugs -- including equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits -- are not reimbursable[[40]](#footnote-40) unless they qualify for medical care expenses. Such items may qualify if they otherwise meet the definition of medical care, which includes expenses for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body. Expenses for items that are merely beneficial to the general health of an individual, such as expenditures for a vacation, are not expenses for medical care.[[41]](#footnote-41)

367. When were the new HSA and Archer MSA rules effective?

These new rules are effective for items purchased on or after January 1, 2011.[[42]](#footnote-42) This change does not affect HSA or Archer MSA distributions for medicines or drugs made before January 1, 2011, nor does it affect distributions made after December 31, 2010, for medicines or drugs purchased on or before that date.

368. What is a prescription for purposes of these rules?

For the prescription requirement, a “prescription” for a medicine or drug, including one sold over the counter, is a written or electronic order that satisfies the legal requirements for a prescription in the state in which the expense is incurred, including that it be issued by someone who is legally authorized to issue a prescription in that state.[[43]](#footnote-43) In later guidance, the IRS indicated that a prescription could be presented to the pharmacist “in any format.”[[44]](#footnote-44) This modification means that if state law allows oral prescriptions by telephone, then the telephone qualifies as a prescription.

Annual Fee on Manufacturers and Importers of Branded Drugs

369. What is the annual fee on manufacturers and importers of branded drugs?

Health reform[[45]](#footnote-45) imposes an annual flat fee starting at $2.5 billion in 2011, increasing to $4.1 billion by 2018, and $2.8 billion in 2019 and thereafter on the branded pharmaceutical manufacturing sector, including foreign corporations and importers. This nondeductible fee is allocated across the industry according to market share and does not apply to companies with sales of branded pharmaceuticals of $5 million or less or certain orphan drugs.

For sales of branded prescription drugs between $5 million and $125 million, only 10 percent of such sales are taken into account when determining the applicable fee. For sales between $125 million and $225 million, 40 percent of such sales are taken into account; and for sales between $225 and $400 million, 75 percent of such sales are considered. To the extent that a covered entity’s sales of branded prescription drugs to a specified government program exceed $400 million, 100 percent of such excess sales are taken into account to compute the entity’s market share.[[46]](#footnote-46)

This nondeductible excise tax is paid to the Medicare Part B trust fund.[[47]](#footnote-47) The IRS issued guidance on this tax.[[48]](#footnote-48)

370. When is this new tax effective?

The first calculation period is the calendar year beginning January 1, 2011. The fee for 2011 must be paid to the IRS no later than September 30, 2012.

Repeal of Employer-Paid Retiree Prescription Drug Rebate Income Tax Exclusion

371. What was the employer-paid retiree prescription drug rebate income tax exclusion?

Before taxable years beginning in 2013, employers providing retiree drug coverage to their former employees could both exclude from income the federal subsidy they received and also deduct all of the costs of the retiree drug coverage, including the costs paid by the subsidy. This rule was enacted in 2003 when the Medicare Part D drug coverage program was enacted. This double benefit was intended to encourage employers to continue coverage for retirees and lessen the number of people switching to Medicare Part D coverage. Many retirees preferred the employer-provided coverage to the Medicare coverage because it is usually more generous than Medicare Part D and does not have “doughnut holes” in coverage. Doughnut holes are the gaps in prescription drug coverage under Medicare after subscribers reach a certain level of expenses and before coverage kicks in again.

For taxable years beginning in 2013 and thereafter, the rule that the exclusion from taxable income for Medicare Part D federal subsidy payments to employers is not taken into account in determining the deduction is allowable for an employer’s retiree prescription drug expenses is eliminated.[[49]](#footnote-49) Thus, the amount otherwise allowable as a deduction for an employer’s retiree prescription drug expenses will be reduced by the amount of the excludible subsidy payments received from the federal government by that employer. Some employers that are losing this double benefit say they will discontinue the retiree drug coverage benefit.

The elimination of the exclusion will result in treating the subsidy the same as most items that may be excluded from income. Thus, for example, while medical insurance reimbursements are not included in a taxpayer's income, they also are not deductible as medical expenses under Code section 213.

**Example:** A company receives a $28 federal subsidy for $100 of eligible drug expenses. The $28 is excludable from income under Code section 139A, and the amount otherwise allowable as a deduction will be reduced by the $28. If the company otherwise meets the Code section 162 requirements for its eligible retiree drug expenses, it is entitled to a $72 ordinary business expense deduction.[[50]](#footnote-50)

Tax on Sale of Medical Devices

372. What is the new tax on the sale of taxable medical devices?

The healthcare reform law amends Chapter 32 of the Internal Revenue Code establishing section 4191 of the Code that imposes a new excise tax on manufacturers or importers of taxable medical devices.[[51]](#footnote-51) The tax is equal to 2.3 percent of the sale price of medical devices sold after December 31, 2012. Certain medical devices, such as contact lenses and hearing aids purchased by the general public at retail stores, are exempt.

373. What is a taxable medical device?

A “taxable medical device” means any device[[52]](#footnote-52) intended for humans.[[53]](#footnote-53) Several specific devices are exempted from the tax, including eyeglasses, contact lenses, hearing aids, and any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use.[[54]](#footnote-54)

In addition, the following sales by a manufacturer are exempt:

* For use by the purchaser for further manufacture, or for resale by the purchaser to a second purchaser for use by such second purchaser in further manufacture.
* For export, or for resale by the purchaser to a second purchaser for export.
* For use by the purchaser as supplies for vessels or aircraft.
* To a state or local government for the exclusive use of the state or local government.
* To a nonprofit educational organization for its exclusive use.
* To a qualified blood collector organization for such organization's exclusive use in the collection, storage, or transportation of blood.[[55]](#footnote-55)

Expanded Medicare Tax on Wages

374. What is the expanded Medicare tax on wages that goes into effect January 1, 2013?

An additional 0.9 percent Medicare tax (called the hospital insurance tax) on wages in excess of the $250,000/$125,000/$200,000 thresholds for married taxpayers filing jointly, married taxpayers filing separately, and all other taxpayers, respectively, is imposed on individuals in 2013. There is a corresponding 0.9 percent increase in the self-employment tax for self-employed individuals, except that the $250,000/$125,000/$200,000 thresholds are reduced (but not below zero) by the taxpayer’s wages.[[56]](#footnote-56) This additional 0.9 percent tax on wages and self-employment income above the applicable thresholds is not deductible for income tax purposes.[[57]](#footnote-57) In this respect, it is like the “employee” portion of the FICA tax, which generally comes out of after-tax wages, as opposed to the “employer” portion of the FICA tax that is deductible by the employer (and not included in the employee’s wages).

The net effect of this new 0.9 percent Medicare tax is to put the higher-income wage earner in roughly the same position as the higher-income passive investor who must pay a 3.8 percent Medicare tax on investment income above the same dollar thresholds. They both will effectively now pay an additional 3.8 percent tax above the “high-income” thresholds.

However, a taxpayer subject to this extra 0.9 percent tax is effectively allowed to “deduct” the 1.45 percent “employer” portion of the FICA tax when applying the increased 3.8 percent rate, even above the income thresholds, whereas the investor subject to the 3.8 percent tax on net investment income cannot deduct it. All wages and self-employment income are subject to the existing 2.9 percent Medicare tax (the 1.45 percent “employer” portion, which is “deductible,” and the 1.45 percent employee portion, which is not), not just the portion of such income above the thresholds.

The new Medicare tax rate structure, including both the new 3.8 percent Medicare tax on investment income, discussed beginning with Q 375, and the 0.9 percent increased FICA/SECA (Self Employment Contributions Act) rate should not have a big impact on most other closely held business tax planning issues. However, it increases the advantage of wages versus dividends from a C corporation. Ironically, a passive investor in a partnership subject to the self-employment tax actually pays tax at a slightly lower marginal rate (43.95 percent) than that same investor in a partnership whose activities are not subject to the self-employment tax (44.59 percent), because of the deductibility of the 1.45 percent amount.[[58]](#footnote-58)

Additionally, an S corporation shareholder receiving a dividend distribution from S corporation trade or business income (as opposed to self-employment income) pays even less (40.79 percent) as this dividend is not subject to either the expanded Medicare tax on wages or the new Medicare tax on investment income, discussed in Q 375. The rates above are based on the maximum 2012 income tax rate of 35 percent. If that increases, the marginal rates above will increase as well.

New 3.8 Percent Medicare Tax on Investment Income

375. What is the new 3.8 percent Medicare tax on investment income, effective in 2013?

For taxable years starting on or after January 1, 2013, the health reform law imposes a new 3.8 percent Medicare tax on “net investment income” (this excludes trade or business income, except from passive activities and trading in financial instruments or commodities) for higher income individuals, estates, and trusts through Code section 1411. For individuals, such “net investment income” is subject to this new tax to the extent that “modified adjusted gross income” exceeds $250,000 in the case of joint returns, $125,000 in the case of married filing separate returns, and $200,000 in all other cases.[[59]](#footnote-59) Modified adjusted gross income is adjusted gross income increased by the net foreign earned income exclusion.[[60]](#footnote-60) Although the new tax is called a “Medicare” tax in the health reform statute, legislative history, and Internal Revenue Code, the IRS refers to this new tax as the “net investment income tax.” Nonresident aliens are not subject to the new tax.

**Example:** A married couple filing jointly has $300,000 of AGI, $100,000 of which is net investment income. They will pay $1,900 in the new tax – i.e., 3.8 percent of the lesser of the amount of net investment income ($100,000) or $50,000 which is the excess of the $300,000 AGI over the $250,000 threshold amount.

**Example:** Same as Example # 1 above, except only $25,000 of the AGI is net investment income. They will pay $950 in the new tax – i.e., 3.8 percent of the lesser of the amount of net investment income ($25,000) or $50,000 which is the excess of the $300,000 AGI over the $250,000 threshold amount.

376. Does this new Medicare tax on investment income apply to estates and trusts also?

Yes. For estates or trusts, this new tax applies to the lesser of (1) undistributed net investment income or (2) the excess of (i) AGI (as defined in Code section 67(e)) over (ii) the dollar amount at which the highest trust/estate tax rate begins.[[61]](#footnote-61) The highest tax bracket in Code section 1(e) for estates and trusts during calendar year 2012 is taxable income over $11,650.[[62]](#footnote-62) Additionally, as explained below, “net investment income” for purposes of this new tax is defined to include passive activity income.[[63]](#footnote-63) No tax is imposed on tax-exempt trusts, however, where principal and income goes to charity.[[64]](#footnote-64)

**Example:** For 2013, a trust has $250,000 in AGI and $100,000 in undistributed net investment income. Assume that the top federal rate for trusts starts at $11,650 in 2013. The trust pays $3,800 in this tax, namely, 3.8 percent of the lesser of its undistributed net investment income ($100,000) or $238,350 which is the excess of its $250,000 AGI over $11,650.

**Example:** Same as above, except that the trust’s AGI equals $100,000. It would pay $3,357 in this tax, namely, 3.8 percent of the lesser of its undistributed net investment income ($100,000) or $88,350 which is the excess of its $100,000 AGI over $11,650.

377. How does this new Medicare tax on investment income apply to S corporation electing small business trusts?

It is not clear how this new Medicare tax should apply to net investment income passed through from an S corporation to a shareholder that is an electing small business trust shareholder. First, such a trust may distribute some or all of this net investment income, even though it is taxed inside the trust at the “highest rate set forth in section 1(e).”[[65]](#footnote-65) Second, for purposes of determining “the distributable net income of the entire trust,” such pass through items are “excluded.”[[66]](#footnote-66)

378. What is “net investment income?”

Net investment income does not include trade or business income except income except from Code section 469 passive activities and trading in financial instruments or commodities.[[67]](#footnote-67) “Net investment income” means the following items, less deductions “properly allocable”[[68]](#footnote-68) to them:

* Interest, Dividends, Annuities, Royalties and Rents.[[69]](#footnote-69) However, these types of income are not subject to this new tax if they are “derived in the ordinary course of a trade or business,” as long as that trade or business does not constitute a passive activity with respect to the taxpayer and does not constitute “trading in financial instruments or commodities.”[[70]](#footnote-70) Thus, interest on customer receivables and interest derived in an active lending business should not be subject to this new tax. Moreover, royalties earned in the active conduct of a software business should be exempt. However, net investment income attributable to working capital will be subject to the tax.[[71]](#footnote-71)
* Passive Activity Income. [[72]](#footnote-72) Until 2013, passive activity income was a favorable tax classification because it, unlike non-passive trade or business income, could be offset by passive losses.[[73]](#footnote-73) Thus, taxpayers often preferred this income classification. This new tax may cause taxpayers to attempt to avoid passive activity classification. Net investment income includes trade or business income that is a passive activity under Code section 469.[[74]](#footnote-74)

For example, an individual might be engaged in 10 separate activities, and actively participate in several of them for less than 500 hours per year. If each of these activities is treated as a separate activity, then those activities in which the taxpayer spends more than 100, but less than 500, hours per year (and which generate an overall net loss), along with those in which the taxpayer spends less than 100 hours per year, should be classified as passive activities generating passive activity income.[[75]](#footnote-75) However, treating all of the activities in which the taxpayer participates as one single activity for passive activity purposes could avoid this new tax on all of the income from the activities in which he or she participates (though probably not for his or her outside passive activities), because the taxpayer’s aggregate material participation in all of these activities totals more than 500 hours.[[76]](#footnote-76)

Such planning considerations are important because the Internal Revenue Service now requires all taxpayers who form new groups of activities or add new activities to existing groups to disclose how they are aggregating or segregating their activities under the passive activity loss rules.[[77]](#footnote-77) These disclosure requirements apply for taxable years beginning after January 15, 2010.[[78]](#footnote-78)

Incorporation of the passive activity rules into this new Medicare Tax structure also creates a number of open issues. For example, the passive activity regulations provide that gross income from each significant participation activity “equal to a ratable portion of the taxpayer’s net passive income from such activity for the taxable year shall be treated as not from a passive activity if the taxpayer experiences net taxable income from such significant participation activities.”[[79]](#footnote-79) Does this mean that such income is not subject to this new Medicare Tax on “net investment income”? There are no clear answers yet.

* The Business of Financial Instruments and Commodities. The “trade or business of trading in financial instruments or commodities (as defined in Code section 475(e)(2)) is “net investment income,” regardless of whether a taxpayer materially participates.[[80]](#footnote-80) This seemingly would include hedge fund income. Although commodities are defined by reference to a specific Code section, the term “financial instruments” will be defined by regulation. Treasury Regulation section 1.1275-6 (b)(3) defines “financial instrument” as “a spot, forward, or future contract, an option, a notional principal contract, a debt instrument, or a similar instrument, or combination or series of financial instruments,” but specifically excludes stock. Similarly, Code section 475(c)(2)(E) and Treasury Regulation section 1.988-1(a)(2)(iii) describe financial instruments in terms of what are commonly considered to be financial derivatives. On the other hand, Code section 731(c)(2)(C) defines financial instrument more broadly as including stocks and other equity investments, evidences of indebtedness, options, forward or futures contracts, notional principal contracts, and derivatives.

Another issue is what constitutes “trading” in financial instruments or commodities? Does the extensive case law relating to the treatment of “dealers” and “traders” come into play, perhaps with individual investors not subject to this new tax?[[81]](#footnote-81)

* Net Gain from Non-Business Property. “Net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business,” is subject to this tax, unless that trade or business is a passive activity with respect to the taxpayer or involves trading in financial instruments or commodities.[[82]](#footnote-82) In general, this is a broad category. This income includes gain from the disposition of nonbusiness assets, such as houses, boats, and airplanes. However, excluded gain from the sale of a personal residence of $250,000 or $500,000[[83]](#footnote-83) is not subject to this Medicare tax on investment income because it is not “taken into account in computing taxable income.”[[84]](#footnote-84) Gain from the disposition of stock in a C corporation should be taxable under this provision unless excluded under Code section 1202.

Significantly, “property held in a trade or business” is excluded unless the trade or business does not fall within the disfavored passive activity or trading category.[[85]](#footnote-85) There is also an exception for the disposition of interests in partnerships and S corporations (*i.e.*, pass-through entities), which provides that gain on such dispositions will be taken into account “only to the extent of the net gain which would be so taken into account by the transferor if all property of the partnership or S corporation were sold for fair market value immediately before the disposition of such interest.”[[86]](#footnote-86) The Technical Explanation concludes that “[t]hus only net gain or loss attributable to property held by the entity which is not properly attributable to an active trade or business is taken into account.”[[87]](#footnote-87)

379. How does the Medicare tax on investment income apply to pass-through entities?

The tax is not intended to apply at all to non-passive, non-trading businesses conducted by S corporations, partnerships, or sole proprietorships.[[88]](#footnote-88) Thus, for pass-through entities that do not have passive investors and do not engage in any financial instrument or commodity trading business, “net investment income” will include only non-business income from interest, dividends, annuities, royalties, rents, and capital gains, minus the allocable deductions. Therefore, business income earned or distributed by such pass-through entities will not be subject to the new Medicare tax.

An S corporation shareholder’s allocable share of trade or business income is not net earnings from self-employment and will not be subject to the extra 0.9 percent Medicare tax on wages nor to the 3.8 percent on net investment income.[[89]](#footnote-89) One technique that clearly does not work is for a professional to form a partnership or LLC “with himself or herself.” or otherwise try to “fractionalize” personal services into a large “passive” component and a small “residual” component, and then claim that the income flowing through the “passive” or limited liability ownership is not subject to SECA.[[90]](#footnote-90)

380. What items are not subject to the Medicare tax on net investment income?

Active Trade or Business Income. Active trade or business income is not subject to the 3.8 percent Medicare net investment income tax. The net investment income tax makes extremely important the distinction between activities that are a trade or business on the one hand and not so characterized on the other hand. Activities entered into for profit are not necessarily trade or business activities.[[91]](#footnote-91)

IRA and Qualified Plan Distributions. “Net investment income” does not include any distribution from a plan or arrangement described in Code sections 401(a) (pension, profit-sharing, 401(k) and stock bonus plans), 403(a) or 403(b) (employee annuity plans), 408 (IRAs), 408A (Roth IRAs), or 457(b) (state and local government and tax-exempt organization deferred compensation plans).[[92]](#footnote-92) Distributions from such plans also do not constitute “wages” for purposes of FICA taxes and withholding,[[93]](#footnote-93) However, distributions from these plans (except for Roth IRAs) enter into a taxpayer’s adjusted gross income (AGI) and, therefore, increase AGI above the applicable threshold amount for purposes of determining tax on net investment income from taxable mutual funds and other non-sheltered sources.

Other Exempt Income. The explanation of the Joint Committee on Taxation states that gross income for purposes of computing net investment income does not include items excluded from gross income for income tax purposes, such as interest on tax-exempt bonds or gain excluded under Code section 121 from the sale of a principal residence.[[94]](#footnote-94) Similarly, proceeds from a life insurance policy (subject to the “transfer-for-value” rules of Code section 101), and the “inside buildup” in a life insurance policy, should be exempt from the new tax.

Cafeteria Plan Changes

$2,500 Cap on Employee FSA Contributions

381. What are the cafeteria plan changes enacted in health reform?

For tax years beginning in 2011, the new SIMPLE cafeteria plan, discussed earlier in Part V (Small Business Provisions) is an option for smaller employers.

In taxable years beginning after 2012, health reform limits annual employee contributions to a health flexible spending account (FSA) offered under a cafeteria plan to $2,500 (adjusted for inflation).[[95]](#footnote-95)

In addition, effective beginning in 2014, Code section 125(f)(3) permits a qualified employer to offer employees the opportunity to enroll in a qualified health insurance plan of a health exchange through the employer's cafeteria plan, even though reimbursement of expenses paid to a health exchange-participating qualified health plan otherwise is not a permissible benefit under a cafeteria plan.

382. To what does the new $2,500 FSA limit apply?

The $2,500 cap is for employee contributions to health flexible spending accounts (FSAs) for plan years beginning in 2013 and thereafter.[[96]](#footnote-96) Health FSAs are used to reimburse medical and dental expenses not paid by insurance, whether due to copays, deductibles, or otherwise. The $2,500 health FSA limit does not apply to a cafeteria plan health insurance premium conversion (Premium Only Plans or “POP”) option and other various options in a cafeteria plan, such as dependent care FSAs and adoption assistance FSAs. The limit also does not apply to employer contributions (“flex credits”) to cafeteria plan health FSAs.

383. What clarifications has the IRS made regarding issues relating to the $2,500 health FSA employee deferral limit?

IRS Notice 2012-40 provides:

* The $2,500 limit applies only to salary reduction contributions under a health FSA, and does not apply to certain employer non-elective contributions (flex credits) or to any types of contributions or amounts available for reimbursement under other types of FSAs, health savings accounts, or reimbursement arrangements, including salary reduction contributions used to pay an employee’s share of health coverage (insured or self-insured) dependent care, or adoption assistance
* The cap applies to health FSA plan years that begin on or after January 1, 2013. Thus, the new cap will not apply to non-calendar year plans until the plan year beginning in 2013. However, a plan sponsor cannot change from a calendar year to a non-calendar plan year to postpone the new cap without a *bona fide* business reason for the change
* For plans that have adopted the optional cafeteria plan two-and-a-half month grace period,[[97]](#footnote-97) amounts carried over during the grace period do not count toward the cap
* The employer can correct employee deferral contributions that exceed the limit if due to a reasonable mistake and not willful misconduct as long as the cafeteria plan is not under IRS audit. To correct the error, the employer pays the excess amount to the employee, which is reported as wages for income tax withholding and employment taxes on the employee’s Form W-2 for the employee’s taxable year that ends with or after the cafeteria plan year in which the correction is made.
* The relief provided for erroneous excess contributions is not available for an employer if a federal tax return of the employer is under examination with respect to benefits provided under a cafeteria plan
* If both spouses have an FSA, whether at the same or different employers, each can fund his/her health FSA to the full amount of the $2,500 limit
* An individual employed by separate employers that are not members of the same controlled group or affiliated service group may establish and fund an FSA at each employer up to the $2,500 limit
* If a cafeteria plan has a short plan year (fewer than twelve months) that begins after 2012, the $2,500 limit is prorated based on the number of months in that short plan year

384. What is the deadline to amend a cafeteria plan to limit employee deferrals into health FSAs?

Employers have until the end of 2014 to amend their plan documents to incorporate the $2,500 limit, but this change must be effective for the plan year beginning in 2013.[[98]](#footnote-98)

385. What is the penalty if a cafeteria plan is not timely amended or does not comply with the $2,500 employee deferral limit?

A cafeteria plan that fails to comply with Code section 125(i) for plan years beginning in 2013 is not a valid Code section 125 cafeteria plan and the value of the taxable benefits that an employee could have elected to receive under the plan during the plan year is includible in employee’s gross income, regardless of the benefit elected by the employee.[[99]](#footnote-99)

Health Insurers Executive Compensation

386. How does health reform increase taxes on executive compensation for health insurance companies?

The law limits the amount that certain health insurers may deduct for a tax year starting after 2012 for compensation to any employee in excess of $500,000. Congress enacted this limitation as part of the Patient Protection and Affordable Care Act of 2010, which, among many other things, essentially requires every individual to be covered by health insurance. Congress included the $500,000 cap to ensure that companies providing mandatory coverage do not utilize premiums received for this coverage to overcompensate executives.

Although the law only applies to certain healthcare insurers, it otherwise has a broader impact than the general deduction limit under Code section 162(m). section 162(m) limits the amount a publicly held corporation may deduct for compensation paid to a narrow group of executives to $1 million per year per executive, makes an exception for performance-based compensation and commissions, and excludes the compensation paid to former covered executives once they are no longer covered.

However, the new health insurance company provision applies regardless of whether the health insurer’s stock is publicly traded, limits the deduction to $500,000 per individual, and makes no exception for performance-based compensation or commissions. In addition, the limit applies to compensation, including deferred compensation, paid to all current and former employees and most independent contractors, not just to compensation paid to a narrow group of current top executives.

387. What is a covered health insurance provider?

The $500,000 cap only applies to an employer for a “disqualified taxable year,”[[100]](#footnote-100) which is a taxable year during which the employer is a “covered health insurance provider.”[[101]](#footnote-101) A covered health insurance provider is a “health insurance issuer” that writes “minimum essential coverage” and receives premiums for this coverage that account for at least 25 percent of its gross premiums from providing health insurance coverage.[[102]](#footnote-102) A “health insurance issuer” is an insurance company, service, or organization (including a health maintenance organization (HMO)) that is licensed to engage in the business of insurance in a U.S. state and is subject to state law regulating insurance.[[103]](#footnote-103) “Minimum essential coverage” is coverage satisfying the individual mandate, applicable for years after 2013, that every individual have health insurance coverage.[[104]](#footnote-104) For example, employer-sponsored health insurance satisfies the mandate for covered employees and is therefore minimum essential coverage.[[105]](#footnote-105)

Aggregation Rules for Related Employers. A broad range of related persons are aggregated in applying the definition of “covered health insurance provider” by controlled group and affiliated service group rules.[[106]](#footnote-106) Assume an insurance company writes health insurance through two subsidiaries, one of which issues primarily minimum essential coverage and the other of which only issues health insurance that is not minimum essential coverage. The two subsidiaries (and all other members of the corporate group) are treated as one employer for this purpose. Thus, if premiums for minimum essential coverage are at least 25 percent of the gross health insurance premiums received by the group, the $500,000 cap applies to both of the health insurance subsidiaries, including the subsidiary that writes no minimum essential coverage.

388. What is applicable individual remuneration for purposes of the $500,000 annual limit?

The $500,000 cap generally applies to an employer's deductions for “applicable individual remuneration” for services performed by an “applicable individual” during a disqualified taxable year beginning after 2012.[[107]](#footnote-107) The term “applicable individual” includes all employees, officers, and directors of a covered health insurance provider, and it also includes any other person “who provides services for or on behalf of such covered health insurance provider.”[[108]](#footnote-108) An individual performing services as an independent contractor can therefore be an applicable individual.[[109]](#footnote-109)

“Applicable individual remuneration” includes “the aggregate amount” that would, but for the $500,000 cap, be allowed as a deduction for remuneration for services performed by an applicable individual for a disqualified taxable year, whether or not the services were performed during the taxable year.[[110]](#footnote-110) Remuneration paid on a commission basis and other performance-based compensation may be applicable individual remuneration.

Applicable individual remuneration does not include “deferred deduction remuneration,” which is remuneration for services performed during one disqualified taxable year that is deductible for a later disqualified taxable year.[[111]](#footnote-111) Deferred deduction remuneration is taken into account for the year of the deduction (usually the year during which the compensation is paid), not the year during which the services are performed. Deferred deduction remuneration may include remuneration, otherwise deductible for a disqualified taxable year beginning after 2012 that is paid for services performed during any disqualified year beginning after 2009.

389. How is the $500,000 cap applied? Does it make any difference if compensation is earned and paid later as deferred compensation?

The cap applies separately to “deferred deduction remuneration” and applicable individual remuneration. For applicable individual remuneration (compensation that is deductible for the year during which the services are performed), remuneration in excess of $500,000 for any individual is not deductible for the current year or at any other time.[[112]](#footnote-112)

The rule for deferred deduction remuneration applies to any such remuneration that is attributable to services performed by an applicable individual during a disqualified taxable year beginning after 2009, but deductible for a disqualified year after 2012. For such compensation otherwise deductible for a particular year, the maximum deduction is the excess of $500,000 over the sum of (1) the applicable individual remuneration for the year during which the services were performed, and (2) any portion of the deferred deduction remuneration for such services that was taken into account under this rule for a preceding post-2009 taxable year.[[113]](#footnote-113)

In other words, deferred deduction remuneration is taken into account for the year for which it is otherwise deductible, but the deduction is only allowed to the extent of the unused cap for the individual from the year during which the services were performed.

**Example:** Assume an employee's compensation for disqualified taxable year 1 is cash compensation of $400,000 plus nonqualified deferred compensation of $300,000, which the employer may only deduct when paid; the deferred compensation is paid to the employee in two installments: $150,000 during disqualified taxable year 2 and $150,000 during disqualified taxable year 3.

Taxable years 1, 2, and 3 all begin after 2012. The cash compensation is fully deductible for year 1 because it does not exceed $500,000. The deferred compensation would normally be deductible for years 2 and 3 in the amounts paid during each of those years. The maximum deduction for the deferred compensation paid during year 2 is $100,000: the excess of $500,000 over the amount deductible for the year during which the services were performed ($400,000).

The employer is allowed no deduction for the deferred compensation paid during year 3 because the cap is $500,000, less the amount deductible for the year the services were performed ($400,000) and less amounts deductible before year 3 for compensation deferred from year 1 ($100,000 deducted for year 2).

390. What rules apply to a covered health insurance provider for compensation earned in 2010 through 2012?

The application of Code section 162(m)(6) to deferred compensation earned prior to 2013 but paid out after 2012 is different because the law defines a “covered health insurance provider” in broader terms for 2010, 2011, and 2012 than for 2013 and later. Starting in 2013, a health insurance provider is “covered” only if 25 percent or more of its gross premiums received from providing health insurance coverage is from “minimum essential coverage,” which, as defined in Code section 5000A(f), generally means group or individual medical coverage needed to satisfy the individual coverage. The pre-2013 definition of covered health insurance provider (receiving any premium) applies to more employers than the post-2012 definition (receiving at least 25 percent of premiums from offering minimum essential coverage).

For a taxable year beginning during the years 2010 through 2012, an employer is a covered health insurance provider, and the year is therefore disqualified, if the employer is a health insurer and receives premiums from providing health insurance coverage.[[114]](#footnote-114) For such a year, in other words, the portion of the gross premiums received from providing minimum essential coverage is not relevant. The cap never applies to compensation that is deductible for a year beginning before 2013. An employer's status as a covered health insurance provider for a year during the period 2010 through 2012 is only relevant for the purpose of tainting remuneration for services performed during those years but is not deductible by the employer (e.g., is not paid) until a year after 2012.

If an employer is a health insurance issuer for all years after 2009, it is a covered health insurance provider for the years 2010 through 2012. If at least 25 percent of its gross premiums from health insurance coverage for years after 2012 is for minimum essential coverage, it is also a covered health insurance provider for post-2012 years. The cap can apply to remuneration for services performed during the years 2010 through 2012, but paid during a post-2012 year.[[115]](#footnote-115) In contrast, if premiums for minimum essential coverage are less than 25 percent of the employer's gross premiums for each post-2012 year, it is not a health insurance issuer for any such year, and the cap cannot apply to any remuneration that it pays, regardless of when the services are performed.[[116]](#footnote-116)

The cap applies to deferred deduction remuneration only if the employer is a covered health insurance provider for both the year during which the services are performed and the year for which the remuneration would normally be deductible (e.g., the year of payment), but the employer's status for other years is not relevant. An entity that was not a covered health insurance provider after 2012 does not have its deductions limited if compensation deferred from 2010, 2011, or 2012 was paid out after 2012.[[117]](#footnote-117)

**Example:** An employer is a health insurance issuer for all years after 2009, and premiums for minimum essential coverage are less than 25 percent of the employer's gross premiums for the years 2013 through 2015. These premiums account for at least 25 percent of gross premiums for 2016 and later years.[[118]](#footnote-118) The employer is a covered health insurance provider for 2010 through 2012 and for years after 2015, but not for the years 2013 through 2015. The cap applies to deferred deduction remuneration for services performed during a 2010–2012 year if the remuneration becomes deductible for a year after 2015, but not if the deduction is allowed for a year during the period 2013 through 2015.

De Minimis Rule. The IRS has administratively provided a *de minimis* rule not found in the statute.[[119]](#footnote-119) An employer is deemed not to be a covered health insurance provider for a taxable year beginning during the period 2010 through 2012 if the premiums it receives for providing health insurance coverage are less than 2 percent of its gross revenues for the year.[[120]](#footnote-120) For a taxable year beginning after 2012, an employer is not considered a covered health insurance provider if health insurance premiums received for providing minimum essential coverage are less than 2 percent of its gross revenues for the year.

**390.01 Healthcare reform & executive physical / executive diagnostic reimbursement plans; do they still work?**

Diagnostic reimbursement plans for executives have been common for over thirty years. They allow an employer to pay for or reimburse such employees these expenses with dollars that are deductible to the employer and not taxed to the executive[[121]](#footnote-121). This exception to the self-insured health plan nondiscrimination rules is allowed by Reg. 1.105-11(g). However, IRS Notice 2013-54[[122]](#footnote-122) provides that so-called Health Reimbursement Accounts cannot be offered by employers (except solely to retirees or single participant plans) unless the participants are also enrolled in a major medical plan of the employer or the employer’s spouse. The question then is whether the executive physical plan is an HRA for this purpose. While not free from doubt, the better answer is that such a plan is not an HRA.

There is a good basis to feel comfortable that an HRA as described in Notice 2013-54 does not include an HRA based on prior guidance issued by the IRS. The “executive physical” plan promotes diagnostic services, one of the objectives of healthcare reform, and is not the type of plan where the healthcare reform on the prohibition on annual limits in health plans would seem important.

Notice 2013-54 defines HRA as an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Code § 213(d)) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. Notice 2013-54 references IRS Notice 2002-45 and Revenue Ruling 2002-41.  It notes that HRAs are exempt from the prohibition on annual dollar limits and cost sharing for preventive benefits if it is integrated with the employer’s group health plan, of that of a spouse’s employer, which meet these rules. Absent this interpretation, HRAs would generally be impossible to maintain.

An executive physical reimbursement plan under Reg. 1.105-11(g) is limited solely to employees and cannot include dependents or spouses. It is not subject to the tax rules governing self-insured medical expense reimbursement plans.  On the other hand, Notice 2002-45 says that “to the extent an HRA is a self-insured medical expense reimbursement plan, the nondiscrimination rules under § 105(h) apply to the HRA.”  Thus, Notice 2013-54 distinguishes between HRAs that are medical expense reimbursement plans and the executive physical reimbursement plan.

In addition, the IRS differentiates diagnostic services in defining health care services, likely because compared to treatment expenses, they are minor and do not provide significant medical benefits in the treatment of a disease.  Notice 2004-23 provides a safe harbor for preventive care benefits allowed to be provided by a high deductible health plan (HDHP) without satisfying the minimum deductible under section 223(c)(2) of the Code.  Indeed, Notice 2004-50 Q&A 26 indicates that preventive care benefits are defined broadly and that it even includes the treatment of a related condition during that procedure comes within the safe harbor for preventive care in Notice 2004-23 where it would be unreasonable or impracticable to perform another procedure to treat the condition. For example, removal of polyps during a diagnostic colonoscopy is preventive care that can be provided before the deductible in an HDHP has been satisfied.

Finally, Notice 2013-54 does not alter Rev. Rul. 61-146, which allows the payment of medical expenses income tax-free to employees with employer deductible dollars. Additionally, the logic of Notice 2013-54[[123]](#footnote-123) is helpful because it provides that Employee Assistance Plans are not subject to healthcare reform as long as they do not provide significant benefits in the nature of medical care or treatment. Excluding executive diagnostic and physical programs from healthcare reform requirements is therefore consistent with the treatment of EAPs under Notice 2013-54.

Increase Threshold for Personal Deduction for Medical Expenses

391. How does health reform limit individual income tax deductions for health care?

In 2013 and thereafter, individual itemized deductions for unreimbursed medical care expenses, including premiums for health, long-term-care, and dental insurance are only deductible to the extent they exceed 10 percent of adjusted gross income. In 2012 and before, the threshold was 7.5 percent.[[124]](#footnote-124) However, through 2016, taxpayers age 65 and older will continue to be able to use the old 7.5 percent threshold.[[125]](#footnote-125)

These taxpayers could claim an itemized deduction to the extent that their unreimbursed medical expenses exceeded 7.5 percent of adjusted gross income. Use of this deduction requires taxpayers to itemize deductions and forgo the standard deduction, and the 7.5 percent threshold made the deduction of minimal value for most taxpayers. The Joint Committee on Taxation estimated the value of this limited itemized deduction for medical expenses to be only $8.7 billion in 2007, as compared to the combined value of $250.9 billion for the exclusion for employer-provided health insurance and the self-employed health insurance deduction.[[126]](#footnote-126)

Further, many taxpayers will receive a tax subsidy for buying insurance on a health insurance exchange beginning in 2014.[[127]](#footnote-127)

The Individual Mandate

392. What is the individual mandate?

As discussed in detail in Part I of this book, the individual mandate requires individuals, unless excluded, to have minimum essential health coverage through their employer or individually or pay a tax penalty.

If an “applicable individual” does not have “minimum essential coverage” for that individual or dependents who also are an “applicable individual,” a tax “penalty”[[128]](#footnote-128) equal to the greater of:

(i) the “applicable dollar amount” for the individual and all such dependents (up to a maximum of three applicable dollar amounts) or

(ii) a specified percentage of the applicable individual’s “household income,” but in no event more than “the national average premium for qualified health plans which have a bronze level (see Q 67) of coverage with coverage for the applicable family size involved, that are offered through exchanges.”[[129]](#footnote-129)

The minimum penalty ranges from $95 in calendar year 2014 up to $695 in calendar year 2016, and is inflation-adjusted thereafter.[[130]](#footnote-130) Moreover, the applicable percentage of income increases from 1 percent in calendar year 2014, to 2 percent in calendar year 2015, and to 2.5 percent for calendar year 2016 and thereafter.[[131]](#footnote-131)

For low-income employees, the minimum penalty is small in comparison to the actual cost of coverage, thereby increasing the likelihood that an individual without minimum essential coverage will not purchase health insurance, although the tax credit subsidies will make the insurance less expensive.

Applicable Individual. The individual mandate tax penalty applies only to “applicable individuals,” and the definition of that term excludes designated categories of individuals, including:

* members of certain religious faiths already exempt from self-employment tax,
* members of healthcare-sharing ministries which, among other things, share medical expenses among members and have been in continuous existence since December 31, 1999
* illegal aliens, and
* incarcerated individuals after they have been convicted[[132]](#footnote-132)

Affordability. Another major exemption is the one for applicable individuals whose “required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual’s household income for the taxable year.”[[133]](#footnote-133) For this exemption, the “required contribution” for an individual eligible to participate in an employer-sponsored plan is equal to “the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage.”[[134]](#footnote-134)

Taxpayers whose household income for a taxable year is less than the gross income necessary to trigger an income tax return filing requirement[[135]](#footnote-135) are also not applicable individuals and are not subject to the employee mandate. These gross income levels are unlikely to exempt many applicable individuals who are not already exempt under the 8 percent affordability exemption discussed above. However, many such individuals are also likely to be eligible for Medicaid and thus exempt from the penalty as long as they apply to procure such coverage.

The Administration has now clarified the deadline, stating that individuals who sign up for insurance on the Exchange within the open enrollment period won't face a penalty. The Administration, as well as the Department of Health and Human Services (HHS), have emphasized that this “clarification” isn't a substantive modification and that the start date for benefits and overall deadline for enrolling remain unchanged. This clarification is viewed by many as welcome news as it effectively gives individuals more time than originally thought to obtain coverage and not face a penalty. On the other hand, a number of politicians are calling for even more change such as extending the open enrollment period or delaying the individual mandate penalty for a year.

393. What is the purpose of the individual mandate?

One purpose is to provide incentives to individuals to have health coverage to reduce the burdens imposed by free medical care. If they do not have minimum essential coverage, unless exempt, they must pay a tax penalty. Additionally, a primary goal of health reform was to fix the problems in the market for individual health insurance policies.

Most critically, the law imposes open enrollment[[136]](#footnote-136) and guaranteed renewal[[137]](#footnote-137) requirements on all health insurance plans offered in the individual and small group markets so that these plans must accept all applicants for health insurance. The law will further limit insurance issuers’ ability to charge applicants different prices based on their expected health risks. The law will only allow health insurance issuers to vary their prices based on four factors:

* the size of the applicant’s family (for applicants seeking family coverage)
* the geographic region in which the applicant resides
* the applicant’s age, and
* whether the applicant uses tobacco[[138]](#footnote-138)

Even with respect to these factors, insurance issuers will be limited to charging their oldest applicants no more than three times the prices charged to their youngest applicants and to charging tobacco users no more than one and a half times the prices charged to non-smokers.[[139]](#footnote-139) In effect, the law prevents insurance plans from discriminating against applicants with preexisting health conditions.

These provisions of the law that will significantly limit insurers’ ability to engage in risk classification could undermine the individual market. However, health reform does several things to bolster this market, including penalties and incentives, such as:

* the individual mandate tax penalty
* state-based health insurance exchanges
* generous tax subsidies for those lower income individuals purchasing insurance, and
* the expansion of state Medicaid programs (in effect made optional by the U.S. Supreme Court)

If these provisions are effective, insurance policies offered on the exchanges could potentially be of better quality and lower cost than employer-provided offerings. Perhaps more likely, if the provisions are only partially effective, employer-provided insurance might retain its advantages over insurance policies offered on the exchanges, but with the advantages of employer-provided insurance being significantly reduced as compared to the advantages employer-provided insurance previously enjoyed over the insurance policies available on the individual market due to income tax advantages as well as bargaining power.

The Employer Mandate

394. How does the employer mandate improve health care?

The details of the employer mandate, which potentially affects employers (including related employers) with fifty or more full-time equivalent employees, are discussed in Part I and in detail in Part XI. It is designed to induce employers to offer affordable coverage for essential health benefits.

Maintaining the previous system of employer-sponsored coverage for lower-income employees was critically important for realizing health reform’s financial targets because additional lower-income employees qualifying for the exchange subsidies drive up federal costs. Thus, the employer mandate, coupled with the health insurance nondiscrimination rules and the grandfathered plan rules were designed to induce employers to provide care to employees and their families.

395. What are the incentives created by health reform for employers, including but not limited to the employer mandate?

An employer avoids the Code section 4980H(a) “all employee” $2,000 penalty by offering health insurance to all full-time employees regardless of how much the employees would be charged for that insurance. The Code section 4980H(b) penalty will be triggered when an employer does offer health insurance, but when that insurance is “unaffordable” or fails the minimum value test, namely, that the employer’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.[[140]](#footnote-140)

An employer with few low- and moderate-income employees could face the full Code section 4980H(b) penalty of $3,000 annually per employee that qualifies for the exchange subsidies. An employer with many low- and moderate-income employees is more likely to have the Code section 4980H(b) assessable payments limited to the Code section 4980H(a) penalty amount of $2,000 times the total number of full-time employees over thirty.

The Code section 4980H(a) penalty will not prevent employers from providing health insurance to their higher-income employees while sending their lower-income employees to the exchanges. The employers can avoid the Code section 4980H(a) penalty by offering their lower income employees “unaffordable” health insurance. Only the Code section 4980H(b) penalties will apply to an employer who offers “unaffordable” health insurance to its lower-income employees. Although employers often may not know a family’s household income, nevertheless, the law somewhat encourages an employer to offer the tax benefits of employer coverage for high earners and provide unaffordable coverage to lower income employees to allow them to benefit from the exchange subsidies. A critical question is whether the health insurance nondiscrimination rules will result in the additional $100 per day per affected (nonhighly compensated) employee.

An offer of “affordable” employer-sponsored health insurance will result in an employee’s entire family being ineligible for the premium tax credits, not just the employee.[[141]](#footnote-141) Moreover, whether an employer’s offer of family coverage is considered “affordable” is determined based on the cost the employee would need to contribute for self-only coverage.[[142]](#footnote-142) In other words, if an employer offers an insurance policy with an option for family coverage, and if the amount an employee would need to contribute to pay for the portion of the policy covering only the employee (and not also the other members of the employee’s family) is less than 9.5 percent of the employee’s household income, then the employee’s entire family is ineligible for the premium tax credits.

Comparing just the exchange subsidies (tax credits for lower income individuals) to the tax exclusions (employer tax deduction and individual exclusion from income and payroll taxes) based on the Tax Policy Center’s estimates for 2016, the breakeven point for an individual is when household income is somewhere between 350 percent and 375 percent of the federal poverty line. The breakeven point for a family of four is when household income reaches 400 percent of the federal poverty line.[[143]](#footnote-143)

For household incomes below these breakeven points, the exchange subsidies will generally offer more value than the tax exclusions. Conversely, for household incomes above these breakeven points, the tax exclusions will generally offer more value than the exchange subsidies. These breakeven analyses assume that the health-insurance policies offered on the exchanges will be of equivalent cost and quality to employer-sponsored health insurance policies. If all of the exchange coverage options are inferior to employer-sponsored options, then the breakeven thresholds would need to be adjusted.

These breakeven analyses assume that employers offer their employees subsidized health insurance as a form of employee compensation. When comparing the premiums they must pay for exchange coverage against the premiums they must pay for employer-sponsored coverage, many employees will prefer employer-sponsored coverage to the extent that employers continue to subsidize this coverage. Yet, in effect, these employer subsidies come out of the employees’ income.

Health Insurance Premium Tax

396. What is the health insurance premium “tax” that begins in 2014?

Beginning in 2014, Americans will indirectly start paying a new fee on health insurance that will be assessed against health insurers but likely will be paid through increased premium rates. Health reform[[144]](#footnote-144) requires individuals, families, and others to help pay a total of $73 billion over five years. The tax is not deductible.[[145]](#footnote-145) This means that health insurers must pay the tax and then pay federal, state, and local taxes on the taxed amount, which increases the amount by which they must increase premiums to break even.

The health insurance (HI) premium tax is an annual fee on insurers beginning in 2014. The fee (equivalent to a sales tax) applies to U.S. health insurance providers and is intended to collect roughly $90 billion in revenue through 2020. A predetermined amount of revenue will be collected each year:

* $8 billion in 2014
* $11.3 billion in 2015 and 2016
* $13.9 billion in 2017, and
* $14.3 billion or more annually in years 2018 and beyond

After 2018, the HI tax in any particular year will equal the fee levied during the previous year, increased by the rate of premium growth for the preceding calendar year. The aggregate fee is apportioned among the providers based on a ratio designed to reflect relative market share of U.S. health insurance business.

A study by former Congressional Budget Office Director Douglas Holtz-Eakin released in March 2011 found that the HI tax can be expected to raise premiums for employer-sponsored insurance by as much as 3 percent, a price increase that is nearly $475 per family per year and $5,000 per family over the first decade. [[146]](#footnote-146) Additionally, the Joint Committee on Taxation estimated that repealing the tax would reduce premiums of insurance plans offered by covered entities by 2.0 percent to 2.5 percent.[[147]](#footnote-147)

The new tax is not assessed on self-funded ERISA health plans, nonprofit insurers that meet specific criteria, and certain voluntary employee beneficiaries associations (VEBAs).

Tax on “Cadillac” Policies

397. Why did Congress decide to tax generous health plans?

Beginning in 2018, health reform imposes a tax on high-cost health plans. In addition to being a revenue raiser, the reason for this provision is to reduce the demand for high-cost (“Cadillac”) coverage where the individual has little out-of-pocket cost so as to encourage employers, providers, and consumers to control health costs.

398. What type of plans are taxed?

For purposes of the excise tax on employer-sponsored health insurance, coverage is health coverage under any group health plan offered by an employer to an employee (plus any former employee, surviving spouse, and any other primary insured individual[[148]](#footnote-148)) without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee's income) or the employee pays for the coverage with after-tax dollars.[[149]](#footnote-149)

Employer-sponsored health insurance coverage includes coverage under any group health plan established and maintained primarily for the civilian employees of the federal government or any of its agencies or instrumentalities and, generally, of any state government or political subdivision or any state agencies or instrumentalities. [[150]](#footnote-150)

Employer-sponsored health insurance coverage includes both fully insured and self-insured health coverage excludable from the employee's gross income, including, in the self-insured context, on-site medical clinics that offer more than a minimal amount of medical care to employees and executive physical programs. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for any portion of which a deduction is allowable to the self-employed individual under Code section 162(l).

399. How does the Cadillac tax on expensive health plans work?

Beginning in 2018, a 40 percent nondeductible excise tax is imposed on “coverage providers” that provide high-cost health care coverage to the employer’s employees. Coverage providers include:

* health insurer for fully insured plans
* the employer with respect to self-insured plans, HSA or Archer MSA contributions, and
* in all other cases, the “person that administers the plan.”

The tax applies to “applicable employer-sponsored coverage,” which is coverage under a group health plan:

* that is made available to an employee by an employer, and
* that either
* is actually excludable from gross income under Code section 106, or
* would be excludable if it were employer-provided coverage within the meaning of Code section 106[[151]](#footnote-151)

The excise tax is imposed on the “excess benefit” provided to the employees.

There is no exception to the tax for grandfathered plans.

Excess benefit is determined by comparing the cost of the actual coverage provided (calculated using rules similar to those for determining COBRA premiums) that exceeds annual limits. For 2018, the annual limit for employee-only coverage is $10,200 per year (as adjusted by a “health cost adjustment percentage” or HCAP) and $27,500 per year (as adjusted by the HCAP) for coverage other than employee-only.

The HCAP takes into account year-to-year increases in the cost of health care coverage, including increases attributable to age and gender differences.

400. What is the effect on the excise tax if the employee pays for all or part of the coverage?

Whether the employer or the employee pays for coverage does not impact the determination of whether it is “applicable employer-sponsored coverage.”[[152]](#footnote-152) However, it can affect the cost of that coverage when the amount of an employee’s excess benefit is calculated, which affects the amount of excise tax payable.

401. What coverage is not subject to the excise tax on high-cost employer-sponsored coverage?

In determining whether the value of health coverage exceeds the threshold amount, the following items are not included.[[153]](#footnote-153)

* The value of employer sponsored coverage for long term care and the following benefits described in Code section 9832(c)(1) that are excepted benefits and exempt from the portability, access and renewability requirements of the Health Insurance Portability and Accountability Act (HIPAA), namely:
* coverage only for accident or disability income insurance, or any combination of these coverages
* coverage issued as a supplement to liability insurance
* liability insurance, including general liability insurance and automobile liability insurance
* workers' compensation or similar insurance
* automobile medical payment insurance
* credit-only insurance; and
* other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits
* The value of independent, noncoordinated coverage described in Code section 9832(c)(3) if that coverage is purchased exclusively by the employee with after-tax dollars (or, in the case of a self-employed individual, for which a deduction under Code section 162(l) is not allowable). Such Code section 9832(c)(3) coverage includes coverage only for a specified disease or illness, as well as hospital indemnity or other fixed indemnity insurance. Fixed indemnity health coverage pays fixed dollar amounts based on the occurrence of qualifying events, including but not limited to the diagnosis of a specific disease, an accidental injury or a hospitalization, and no coordination with other health coverage. The value of employer-sponsored health insurance coverage does include the value of such coverage if any portion of the coverage is employer-provided or, in the case of a self-employed individual, if a deduction is allowable for any portion of the payment for the coverage.
* Any coverage under a separate policy, certificate, or contract of insurance that provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye.

402. Is there any relief in the Cadillac tax rules for people whose health coverage is expensive because their occupation is dangerous?

Yes. The annual limits noted in Q 399 are increased by $1,650 and $3,450, respectively, for employees in high-risk professions (e.g., law enforcement, EMT/paramedics, construction, mining, longshoremen, and so forth).

403. How is the tax calculated and paid?

Liability for the excise tax is determined on a monthly basis. Employers are required to calculate the amount of the excess benefit subject to the excise tax for each taxable period and to determine each coverage provider’s “applicable share” of the excess benefit. A coverage provider’s applicable share of an employee’s excess benefit is determined by multiplying the aggregate excess benefit for the employee by the ratio obtained by comparing (i) the cost of the coverage provided to the employee by the coverage provider to (ii) the aggregate cost of all applicable coverage.[[154]](#footnote-154)

The amount subject to the excise tax on high-cost employer-sponsored health insurance coverage for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a health flexible spending account (FSA) for the tax year, and the dollar amount of employer contributions to a health savings account (HSA) or an Archer medical savings account (MSA), minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer sponsored health insurance coverage including coverage for any supplementary health insurance coverage. The applicable premium for health coverage provided through health reimbursement account (HRA) is also included in this aggregate amount.[[155]](#footnote-155)

The tax is equal to 40 percent of the aggregate value of the health insurance coverage that exceeds:

(1) the threshold dollar amount[[156]](#footnote-156)

(2) multiplied by the health cost adjustment percentage, and

(3) increased by the age and gender adjusted excess premium amount[[157]](#footnote-157)

For 2018, the threshold dollar amount is $10,200 for individual coverage and $27,500 for family coverage.[[158]](#footnote-158) However, increased thresholds apply for certain classes of taxpayers. The threshold amounts are increased for an individual who has attained age 55, is not Medicare eligible, and is receiving employer-sponsored retiree health coverage, or is covered by a plan sponsored by an employer, the majority of whose employees covered by the plan are engaged in a high-risk profession[[159]](#footnote-159) or employed to repair or install electrical and telecommunications lines. For these individuals, the threshold amount in 2018 is increased by:

(1) $1,650 for individual coverage or $3,450 for family coverage, and

(2) the age and gender-adjusted excess premium amount.[[160]](#footnote-160)

The basic thresholds are also adjusted by the health cost adjustment percentage for growth in the cost of U.S. healthcare between 2010 and 2018 that exceeds the projected growth for that period. The health cost adjustment percentage is equal to 100 percent plus the excess, if any, of

(1) the percentage by which the per employee cost of coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (standard FEHBP coverage) for plan year 2018 (as determined using the benefit package for standard FEHBP coverage for plan year 2010) exceeds the per employee cost of standard FEHBP coverage for plan year 2010; over

(2) 55 percent.[[161]](#footnote-161)

In 2019, the threshold amounts, after application of the health cost adjustment percentage in 2018, if any, are indexed to the Consumer Price Index for All Urban Consumers (CPI-U), as determined by the Department of Labor, plus one percentage point, rounded to the nearest $50. In 2020 and thereafter, the threshold amounts are indexed to the CPI-U as determined by the Department of Labor, rounded to the nearest $50. For each employee (other than for certain retirees and employees in high-risk professions, whose thresholds are adjusted under rules described below), the age and gender adjusted excess premium amount is equal to the excess, if any, of:

(1) the premium cost of standard FEHBP coverage for the type of coverage provided to the individual if priced for the age and gender characteristics of all employees of the individual's employer, over

(2) the premium cost, determined under procedures proscribed by IRS, for that coverage if priced for the age and gender characteristics of the national workforce[[162]](#footnote-162)

In 2019, the primary threshold amounts and additional $1,650 and $3,450 amounts are indexed to the CPI-U, plus one percentage point, rounded to the nearest $50. In 2020 and thereafter, the additional threshold amounts are indexed to the CPI-U, rounded to the nearest $50.[[163]](#footnote-163)

404. Who pays the excise tax and how it is allocated?

The excise tax is imposed pro rata on the issuers of the insurance. Presumably, that cost will be passed along to the insureds. For a self-insured group health plan, a health FSA or an HRA, the excise tax is paid by the entity that administers benefits under the plan or arrangement (the “plan administrator”). The excise tax is paid by the employer if it acts as plan administrator to a self-insured group health plan, a health FSA or an HRA. Where an employer contributes to an HSA or an Archer MSA, the employer is responsible for payment of the excise tax, as the insurer.[[164]](#footnote-164)

The excise tax is allocated pro rata among the insurers, with each insurer responsible for payment of the excise tax on an amount equal to the amount subject to the total excise tax multiplied by a fraction, having as the numerator the amount of employer-sponsored health insurance coverage provided by that insurer to the employee and having as the denominator the aggregate value of all employer-sponsored health insurance coverage provided to the employee.[[165]](#footnote-165)

For a self-insured group health plan, a health FSA or an HRA, the excise tax is allocated to the plan administrator.[[166]](#footnote-166)

The employer is responsible for calculating the amount subject to the excise tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer, plan administrator and IRS, in the form and at the time that IRS may set. Each insurer and plan administrator is then responsible for calculating, reporting, and paying the excise tax to IRS on such forms and at such time as IRS may set.[[167]](#footnote-167)

**Example:** In 2018, an employee elects family coverage under a fully insured healthcare policy covering major medical and dental with a value of $32,000. The health cost adjustment percentage for that year is 100 percent, and the age and gender adjusted excess premium amount for the employee is $600. On these facts, the amount subject to the excise tax is $3,900 ($32,000 less the threshold of $28,100, which is the $27,500 threshold multiplied by 100 percent and increased by $600.) The employer reports $3,900 as taxable to the insurer, which calculates and remits the excise tax of $1,560 (40 percent of 3900) to the IRS.

405. What is the sanction on the employer for underreporting liability for the tax?

A penalty applies to an employer that reports to insurers, plan administrators and IRS a lower amount of insurance cost subject to the excise tax than required. The penalty is the sum of any additional excise tax that each such insurer and administrator would have owed if the employer had reported correctly plus interest[[168]](#footnote-168) attributable to that additional excise tax from the date that the tax was otherwise due to the date paid by the employer.[[169]](#footnote-169)

The penalty does not apply if it is established to IRS's satisfaction that the employer neither knew, nor by exercising reasonable diligence would have known, that the failure existed. In addition, no penalty will be imposed on any failure corrected within the thirty-day period beginning on the first date that the employer knew, or exercising reasonable diligence, would have known, that the failure existed, so long as the failure is due to reasonable cause and not to willful neglect. All or part of the penalty may be waived by IRS in the case of any failure due to reasonable cause and not to willful neglect, to the extent that the payment of the penalty would be excessive or otherwise inequitable relative to the failure involved.[[170]](#footnote-170)

Patient Centered Outcomes Research Institute (PCORI) and PCORI Fees

406. What is the Patient Centered Outcomes Research Institute?

The Patient-Centered Outcomes Research Institute (PCORI) is authorized by Congress to conduct research to provide information about the best available evidence to help patients and their health care providers make more informed decisions. PCORI’s research is intended to give patients a better understanding of the prevention, treatment, and care options available, as well as the science that supports those options.

407. What are PCORI fees?

The ACA imposes a Patient Centered Outcomes Research Institute (PCORI) fee on plan sponsors and issuers of individual and group policies. The "PCORI fee" or the "Section 4376[[171]](#footnote-171) fee" is intended to fund partially the Patient-Centered Outcomes Research Institute created by healthcare reform.

The fee applies to certain "specified health insurance" policies and includes medical policies, retiree-only policies, and any accident or health insurance policy (including a policy under a group health benefit plan) issued to individuals residing in the United States. This does not include:

* "Excepted benefits," as defined under HIPAA, such as stand-alone vision or dental plans;
* Employee Assistance Programs (EAP) or wellness programs
* FSA plans, when they meet the excepted benefits test; or
* HRA, when it meets the excepted benefits test
* Expatriate coverage (those working outside the United States and their spouses and dependents)
* Stop loss, where the issuer is liable for all losses in excess of a specified amount and where the plan sponsor retains its liability for losses
* Indemnity reinsurance policies, where the reinsuring company accepts all or part of the risk of loss under the policy and the issuing company retains its liability for covered lives
* Medicare
* Medicaid
* CHIP
* TRICARE
* Non-insurance health programs for members (spouses or dependents) of the Armed Forces or veterans
* Federally recognized Indian Health Services and programs under the Indian Health Care Improvement Act

408. How are PCORI fees to be paid?

IRS Form 720, Part II, line 133, and its voucher are used to report and remit the Patient Centered Outcomes Research Institute Fee ("PCORI fee") to the IRS by July 31 for the preceding year. The fee must be paid no later than July 31 of the year following the last day of the plan year.[[172]](#footnote-172) The fee is a tax deductible business expense.[[173]](#footnote-173)

The PCORI fee for the second year will increase to $2.00 times the average number of covered lives in the group health plan and is indexed for increases in national health expenditures for the following years.

409. When are PCORI fees due?

The "PCORI fee" is intended to fund partially the Patient-Centered Outcomes Research Institute created by healthcare reform. The PCORI fee is applicable to plan years ending after Sept. 30, 2012, and extends through plan years ending before October 1, 2019. The fee must be paid no later than July 31 of the year following the last day of the plan year.[[174]](#footnote-174) Therefore, the first PCORI fees are due for 2012 calendar year self-insured plans and certain fiscal year plans by July 31, 2013. So, for example, if the fiscal year end is March 31, 2013, the calendar year in which that plan year ends is 2013, and the tax and return would be due July 31, 2014.

PCORI fee for the first year for plan years ending on or after October 1, 2012, and before October 1, 2013 is equal to $1.00 multiplied by the average number of covered lives in the group health plan. The PCORI fee for the second year will increase to $2.00 times the average number of covered lives in the group health plan and is indexed for increases in national health expenditures for the following years.

410. Who pays the PCORI fees?

Insurers file and pay the fee for insured plans.[[175]](#footnote-175) The PCORI fee must be paid by employers that sponsor self-insured health plans (including many employer funded health reimbursement accounts (“HRAs”) and medical expense reimbursement plans (“MERPs”) by July 31, 2013, and each year thereafter.[[176]](#footnote-176) The fee paid by insurers applies to certain "specified health insurance" policies and includes medical policies, retiree-only policies, and any accident or health insurance policy (including a policy under a group health benefit plan) issued to individuals residing in the United States.

The self-insured plan that is taxed is the “self-insured health plan.” This is not tied to the definition of and exemptions from the term “group health plan.” However, the regulations provide an exemption for an employer self-funded plan that provides benefits substantially all of which are excepted benefits.“[[177]](#footnote-177) On the other hand, plans that are not ERISA plans (covering only partners, for example) or retiree-only plans are not exempted.

Health reimbursement arrangements (HRAs) and medical expense reimbursement plans (“MERPs”) are self-funded group health plans and are subject to the PCORI fee unless the employer also sponsors a *self-insured* group health plan, and both plans have the same plan year. If the plan sponsor maintains a self-funded medical plan with the same plan year, the medical plan and HRA may be treated as one plan for purposes of the PCORI fee if all participants participate in both plans. As discussed below, for an HRA or health care FSA, you only count employee/participants, not dependents. However, any other medical plan that is self-funded and not an excepted benefit counts all individuals covered by the plan, whether stand-alone or within a regular or simple cafeteria plan.

However, if the medical plan is fully insured, the medical plan and HRA must be treated as separate plans for purposes of the PCORI fee, with the insurer paying the fee for the medical plan and the employer/plan sponsor paying the fee for the HRA. Treas. Reg. §46.4376-1(b)(1) provides the definition of self-insured plans that are subject to the tax, and includes medical expense reimbursement plans. It only excludes only health FSAs that are excepted benefits. A rule allows counting only the covered employees for purposes of determining the number of covered lives.

411. Can plan sponsors delegate the PCORI filing and fee payment to third parties?

No. Plan sponsors[[178]](#footnote-178) of self-insured health plans[[179]](#footnote-179) must make arrangements to complete and file the Form and pay the annual PCORI fees to the IRS, as the PCORI regulations directly prohibit using "third-party reporting" arrangements with respect to the Form 720. Plan sponsors are also advised that the fee must be paid by the plan sponsor and cannot be paid by the plan or from plan assets.

412. Are any plans excluded from being subject to the PCORI fees?

Yes, a number of employee benefit plans are excluded. They are

* "Excepted benefits," as defined under HIPAA, such as stand-alone vision or stand-alone dental plans. If the benefits covered under the FSA are limited to “excepted benefits,” that FSA is also exempt from the PCORI payment even if FSA participants have no other health plan or the payments exceed the dollar limits described above.[[180]](#footnote-180) Excepted benefits include but are not limited to:
* coverage for only accident or disability income insurance
* liability insurance and coverage issued as a supplement to liability insurance
* workers’ compensation or similar insurance
* automobile medical payment insurance, and
* coverage for onsite medical clinics
* Employee Assistance Programs (EAP) or wellness programs.
* Health FSA plans, when they meet the excepted benefits test. An excepted benefit FSA provides that the maximum benefit payable by the FSA to the participant for a year does not exceed the greater of:
* two times the participant’s salary reduction election under the FSA for the year, or
* $500 plus the amount of the participant’s salary reduction election, meaning a $3000 benefit from a $2500 salary reduction election and an employer paid flex credit of $500 is possible. Most FSAs also meet the second requirement
* Excepted Benefit FSA. If the benefits covered under the FSA are limited to “excepted benefits,” that FSA is also exempt from the PCORI payment even if FSA participants have no other health plan or the payments exceed the dollar limits described above. Excepted benefits include but are not limited to:
* coverage for only accident or disability income insurance
* liability insurance and coverage issued as a supplement to liability insurance
* workers’ compensation or similar insurance
* automobile medical payment insurance, and
* coverage for onsite medical clinics
* Employer funded HRA and MERP plans where employer’s *self-insured* group health plan if both plans have the same plan year.
* Expatriate coverage (those working outside the United States and their spouses and dependents).
* Long-term care, home health care, and nursing home care
* Stop loss, where the issuer is liable for all losses in excess of a specified amount and where the plan sponsor retains its liability for losses
* Hospital and other indemnity insurance policies
* Medicare
* Medicaid
* CHIP and TRICARE.
* Non-insurance health programs for members (spouses or dependents) of the Armed Forces or veterans.
* Federally recognized Indian Health Services and programs under the Indian Health Care Improvement Act.

413. How are the average number of lives determined and the fees calculated?

***Fully Insured Plans***

There are four optional methods for determining the average number of covered lives. Issuers must use the same method consistently for the duration of any year and the same method for all policies subject to the fee. (The insurance carrier is responsible for paying the required PCORI fee in the case of fully insured coverage.)

**Actual Count** – Count the total number of covered lives for each day of the policy year and divide by the number of days in a year.

**Snapshot Method** – Count the number of members on a single day (or days if consistent for each quarter) during a quarter and divide the total by the number of dates on which a count was made. The date used for each quarter must be the same (i.e., the first day, the last day)

**NAIC Member Months Method** – The issuer determines the average number of covered lives based on member months reported to the National Association of Insurance Commissioners (NAIC) on the Supplemental Health Care Exhibit for the calendar year. The average number of lives in effect for the calendar year equals member months divided by twelve.

**State Form Method** – This method is for issuers that are not required to file the NAIC Exhibit. These issuers may determine the number of covered lives using a form that is filed with the issuer's state of domicile, if the form reports the number of covered lives in the same manner as the NAIC Supplemental Exhibit.

***Self-funded Plans***

Self-funded plans may determine the average number of covered lives by using any of the following methods. Like fully insured plans, plan sponsors must use the same method consistently for the duration of any year and the same method for all policies subject to the fee.

**Actual Count** – Count the total covered lives for each day of the plan year and divide by the number of days in the plan year.

**Snapshot Dates** – Count the total number of covered lives on a single day in a quarter (or more than one day) and divide the total by the number of dates on which a count was made. (The date or dates must be consistent for each quarter.)

**Snapshot Factor** – In the case of self-only coverage, determine the sum of: (1) the number of participants with self-only coverage, and (2) the number of participants with other than self-only coverage multiplied by 2.35.

**Form 5500 Method** – For self-only coverage, determine the average number of participants by combining the total number of participants at the beginning of the plan year with the total number of participants at the end of the plan year as reported on the Form 5500 and divide by two. In the case of plans with self-only and other coverage, the average number of total lives is the sum of total participants covered at the beginning and the end of the plan year, as reported on the Form 5500.

414. How are multiple self-funded plans counted for purposes of the fee?

Under the final rule, if the plan sponsor of a self-funded plan has more than one self-funded plan (e.g., one for medical, another for pharmacy) it may treat them as a single self-funded plan for purposes of this fee to avoid double counting of the members. This special counting rule only applies to self-funded plans in the proposed rule.

415. How are the number of covered lives determined in the first year?

For the first year of the fee, plan years beginning before July 11, 2012, and ending on or after Oct. 1, 2012, a plan sponsor may determine the average number of covered lives using any reasonable method. In the first year, fully insured plans, for example, may report only 25 percent of the number of lives it reported on the NAIC form in 2012.

416. Are there special rules for health FSAs and HRAs?

If a plan sponsor only maintains a flexible spending account or a health reimbursement arrangement, the plan sponsor may treat each participant's account as covering a single life. (The plan sponsor is not required to count spouses or other dependents.)

If the FSA/HRA is sponsored by a plan sponsor that also has an applicable self-funded health plan (that is not a FSA or HRA), the two arrangements may be treated as one plan.

1. . PPACA §§9007(f), 10903; IRC Sec. 501(r). [↑](#footnote-ref-1)
2. . PPACA §9007(f)(2); IRC Sec. 501(r). [↑](#footnote-ref-2)
3. . PPACA §9007(a)(1)(4)(A); IRC Sec. 501(r). [↑](#footnote-ref-3)
4. . PPACA §9007(a)(1)(4)(B); IRC Sec. 501(r). [↑](#footnote-ref-4)
5. . PPACA §§9007(a)(1)(5), 10903(a); IRC Sec. 501(r). [↑](#footnote-ref-5)
6. . PPACA §9007(a)(1)(6); IRC Sec. 501(r). [↑](#footnote-ref-6)
7. . PPACA §9007(a)(1)(3); IRC Sec. 501(r). [↑](#footnote-ref-7)
8. . PPACA §9007(d); IRC Sec. 501(r). [↑](#footnote-ref-8)
9. . PPACA §9007(c); IRC Sec. 501(r). [↑](#footnote-ref-9)
10. . IRC Sec. 4959. [↑](#footnote-ref-10)
11. . IRC Sec. 6033(b)(10). [↑](#footnote-ref-11)
12. . IRC Sec. 7701(o)(5)(A). [↑](#footnote-ref-12)
13. . IRC Sec. 7701(o). [↑](#footnote-ref-13)
14. . IRC Secs. 6662, 6662A, 6664, and 6676. [↑](#footnote-ref-14)
15. . IRC Sec. 7701(o)(1). [↑](#footnote-ref-15)
16. . Susswein, “Is There a Disclosure Exception to The Economic Substance Penalty?” 133 Tax Notes 871 (Nov. 14, 2011), which discusses the ability to obtain administrative or judicial review of economic substance issues without risk of penalty via refund claims. [↑](#footnote-ref-16)
17. . IRS Notice 2010-62. [↑](#footnote-ref-17)
18. . IRS Notice 2010-62. [↑](#footnote-ref-18)
19. . PPACA §10907. [↑](#footnote-ref-19)
20. . IRC Sec. 5000B(a); Reg. §49.5000B-1T(d)(1). [↑](#footnote-ref-20)
21. . Reg. §49.5000B-1T(b)(1). [↑](#footnote-ref-21)
22. . “Excise Tax on Indoor Tanning Services Frequently Asked Questions,” (June 30, 2010) at www.irs.gov. [↑](#footnote-ref-22)
23. . IRC Sec. 5000B(a). [↑](#footnote-ref-23)
24. . IRC Sec. 5000B(b)(1); Reg. §49.5000B-1T(c)(1). [↑](#footnote-ref-24)
25. . IRC Sec. 5000B(b)(1); Reg. §49.5000B-1T(c)(1). [↑](#footnote-ref-25)
26. . Reg. §49.5000B-1T(c)(3)(i). [↑](#footnote-ref-26)
27. . Reg. §49.5000B-1T(c)(3)(ii). [↑](#footnote-ref-27)
28. . Reg. §49.5000B-1T(c)(3)(iii). [↑](#footnote-ref-28)
29. . Reg. §49.5000B-1T(c)(3)(iv). [↑](#footnote-ref-29)
30. . Reg. §49.5000B-1T(c)(3)(v). [↑](#footnote-ref-30)
31. . Reg. §49.5000B-1T(c)(3)(vi). [↑](#footnote-ref-31)
32. . “Excise Tax on Indoor Tanning Services Frequently Asked Questions,” (June 30, 2010) at www.irs.gov. [↑](#footnote-ref-32)
33. . Reg. §49.5000B-1T(c)(2). [↑](#footnote-ref-33)
34. . See IRC Secs. 106(f), 220(d)(2)(A), and 223(d)(2)(A), as amended by PPACA §9003. [↑](#footnote-ref-34)
35. . Prop. Reg. §1.125-6, Rev. Rul. 2003-43, Notices 2006-69, 2007-2, and 2008-104. [↑](#footnote-ref-35)
36. . Described in Rev. Rul. 2003-43. [↑](#footnote-ref-36)
37. . IRC Sec. 213(d). [↑](#footnote-ref-37)
38. . IRC Sec. 223(d)(2)(A). [↑](#footnote-ref-38)
39. . IRC Sec. 220(d)(2)(A). [↑](#footnote-ref-39)
40. . IRS Notice 2010-59. [↑](#footnote-ref-40)
41. . IRC Sec. 213(d)(1); Treas. Reg. §1.213-1(e)(1)(ii). [↑](#footnote-ref-41)
42. . PPACA §9003(d)(2). [↑](#footnote-ref-42)
43. . IRS Notice 2010-59. [↑](#footnote-ref-43)
44. . IRS Notice 2011-5. [↑](#footnote-ref-44)
45. . PPACA §9008. [↑](#footnote-ref-45)
46. . PPACA §9008(b). [↑](#footnote-ref-46)
47. . PPACA §9008(c). [↑](#footnote-ref-47)
48. . Notices 2010-71 and 2011-9 and Rev. Proc. 2011-24. [↑](#footnote-ref-48)
49. . IRC Sec.139A as amended by PPACA §9012(a). [↑](#footnote-ref-49)
50. . Joint Comm. Staff, Tech Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as Amended, in Combination With the Patient Protection and Affordable Care Act (JCX-18-10), p. 95 (3/21/2010). [↑](#footnote-ref-50)
51. . IRC Sec. 4191(a). [↑](#footnote-ref-51)
52. . Federal Food, Drug and Cosmetic Act (FFDCA) §201(h). [↑](#footnote-ref-52)
53. . IRC Sec. 4191(b). [↑](#footnote-ref-53)
54. . IRC Sec. 4191(c). [↑](#footnote-ref-54)
55. . IRC Sec. 4221. [↑](#footnote-ref-55)
56. . IRC Sec. 1401(b)(2). [↑](#footnote-ref-56)
57. . IRC Sec. 164(f). [↑](#footnote-ref-57)
58. . IRC Sec. 1411(c)(6), Illustration #4. [↑](#footnote-ref-58)
59. . IRC Sec. 1411(a)(1), (b). [↑](#footnote-ref-59)
60. . IRC Sec. 1411(d). Unlike the definition of “modified adjusted gross income” for purposes of the individual premium tax credit, this definition makes no adjustment for tax-exempt interest. [↑](#footnote-ref-60)
61. . IRC Sec. 1411(c)(6). The tax brackets are in IRC Sec. 1(e) for estates and complex trusts. [↑](#footnote-ref-61)
62. . IRC Secs. 1411(a)(2)(i); 1(e). *See* Rev. Proc. 2011-52 (providing tax brackets for calendar year 2012). [↑](#footnote-ref-62)
63. . *See* IRC Sec. 469(a)(2)(A); Treas. Reg. §1.469-8. [↑](#footnote-ref-63)
64. . IRC Sec. 1141(e)(2). [↑](#footnote-ref-64)
65. . IRC Sec. 641(c)(2)(A), (C). [↑](#footnote-ref-65)
66. . IRC Sec. 641(c)(3). [↑](#footnote-ref-66)
67. . IRC Sec. 1411(c)(2). [↑](#footnote-ref-67)
68. . Taxpayers are entitled to subtract “deductions allowed by this subtitle which are properly allocable to such gross income.” For many taxpayers some or all “properly allocable” investment expenses are not “allowed by this subtitle” because they are only deductible to the extent that they exceed 2 percent of adjusted gross income. [↑](#footnote-ref-68)
69. . IRC Sec. 1411(c)(1)(A)(i). [↑](#footnote-ref-69)
70. . IRC Sec. 1411(c)(1)(A)(i), (2). [↑](#footnote-ref-70)
71. . *See* IRC Secs. 1411(c)(3); 469(e)(1)(b). [↑](#footnote-ref-71)
72. . IRC Sec. 1411(c)(1)(A)(ii), (B); (2)(A). [↑](#footnote-ref-72)
73. . IRC Sec. 469(d)(1)(B). [↑](#footnote-ref-73)
74. . IRC Sec. 1411(c)(2)(A). [↑](#footnote-ref-74)
75. . Treas. Reg. §1.469-5T(a)(1), (3), (c). [↑](#footnote-ref-75)
76. . Treas. Reg. §1.469-5T(a)(1). [↑](#footnote-ref-76)
77. . Rev. Proc. 2010-13. [↑](#footnote-ref-77)
78. . Rev. Proc. 2010-13. Taxpayers who do not add new activities or alter their existing activity groups are grandfathered in, and do not need to disclose their existing grouping decisions. [↑](#footnote-ref-78)
79. . Treas. Reg. §1.469-2T(f)(2). [↑](#footnote-ref-79)
80. . IRC Sec. 1411(c)(1)(A)(ii), (2)(B). [↑](#footnote-ref-80)
81. . *See, e.g.,* *Holsinger v. Comm’r*, T.C. Memo 2008-191 (married couple not traders due to insubstantial trading activity and lack of profit motive); *George R. Kemon*, 16 T.C. 1026 (1951) (partnership found to be a trader); *United States v. Diamond*, 788 F.2d 1025 (4th Cir. 1986) (recognizing the difference between “dealers” who sell to customers and “traders” who do not). [↑](#footnote-ref-81)
82. . IRC Sec. 1411(c)(1)(A)(iii). [↑](#footnote-ref-82)
83. . IRC Sec. 121. [↑](#footnote-ref-83)
84. . *See* IRC Sec. 121; Joint Committee On Taxation, Technical Explanation Of The Revenue Provisions Of The Reconciliation Act Of 2010, As Amended In Combination With The Patient Protection And Affordable Care Act, p. 135 n. 285 (Mar. 21, 2010) at http://www.jct.gov/publications.html?func=startdown&id=3673). [↑](#footnote-ref-84)
85. . IRC Sec. 1411(c)(1)(A)(iii). [↑](#footnote-ref-85)
86. . IRC Sec. 1411(c)(4). [↑](#footnote-ref-86)
87. . Technical Explanation, at 135. [↑](#footnote-ref-87)
88. . Technical Explanation, at 135. [↑](#footnote-ref-88)
89. . Rev. Rul. 59-221; see also IRC Sec. 1402(a)(2) (excluding “dividends on shares of stock issued by a corporation” from “net earnings from self-employment); Letter Ruling 871606 (Jan. 21, 1987) (income derived by a shareholder-employee from an “S” corporation did not constitute net earnings from self-employment for self-employment tax purposes and taxpayer was not eligible to adopt a qualified pension plan based on the income derived from “S” corporation since such income did not constitute earned income). [↑](#footnote-ref-89)
90. . *Robucci v. Comm'r.*, 101 T.C. Memo. (CCH) 1060 (Jan. 24, 2011), a psychiatrist on the advice of his CPA set up a structure whereby he formed an LLC between himself and his wholly-owned professional corporation. The Tax Court held that the professional corporation had no business purpose and should be ignored (meaning that the LLC had only one member (the taxpayer) and therefore that all income passed through was subject to SECA) and further upheld the IRS’s imposition of negligence penalties. In *Renkemeyer, Campbell & Weaver LLP v. Comm'r.*, 136 T.C. 137 (2011), three attorneys were partners in an LLP. Initially, 10 percent of the LLP was owned by an “S” corporation owned by an ESOP of which the three attorneys were beneficiaries; later, the “S” corporation was eliminated and, in an apparent attempt to come under the Proposed Section 1402 Regulations, the partners split their interests into de minimis general managing partner interests and the remainder into “investing partner” interests. The bulk of the LLP’s income was allocated to the “investing” interests and the partners did not pay SECA tax on the amounts so allocated. The Tax Court agreed with the IRS’s contention that all income was subject to SECA and that the partners’ active involvement in and performance of legal services for the LLP was inconsistent with what Congress had intended in enacting relief under Code section 1402(a)(13) for limited partners as passive investors. [↑](#footnote-ref-90)
91. . See, e.g. *Estate of Roger Stangeland v. Comm'r.,* T.C. Memo. 2010-185, 100 T.C. Memo. (CCH) 156 (Aug. 16, 2010) (consulting enterprise operated by petitioners to manage petitioner’s other business interests was not itself a trade or business; instead, its purpose and the nature of its operations was to increase the investment value of petitioners’ other businesses); cf. *Wilbur Langford v.* *Comm’r.*, T.C. Memo. 1988-300, 55 T.C. Memo. (CCH) 1267 (July 19, 1988) (college professor’s royalties from co-authorship of one textbook were “royalties” not subject to SECA tax because petitioner’s activities did not rise to the level of a “trade or business”; citing Rev. Rul. 55-385 and Rev. Rul. 68-498. [↑](#footnote-ref-91)
92. . IRC Sec. 1411(c)(5). [↑](#footnote-ref-92)
93. . IRC Sec. 3121(a)(5). [↑](#footnote-ref-93)
94. . Joint Committee On Taxation, Technical Explanation Of The Revenue Provisions Of The Reconciliation Act Of 2010, As Amended In Combination With The Patient Protection And Affordable Care Act, p. 135 n. 285 (Mar. 21, 2010) at http://www.jct.gov/publications.html?func=startdown&id=3673). [↑](#footnote-ref-94)
95. . IRC Sec.125(i). [↑](#footnote-ref-95)
96. . IRC Sec.125(i). [↑](#footnote-ref-96)
97. . See Notice 2005-42, 2005-1 C.B. 1204, and Prop. Treas. Reg. §1.125-1(e). [↑](#footnote-ref-97)
98. . IRS Notice 2012-40. Cafeteria plan amendments generally must be effective only prospectively. See Prop. Treas. Reg. §1.125-1(c). [↑](#footnote-ref-98)
99. . IRS Notice 2012-40. See also Prop. Treas. Reg. §1.125-1(b). [↑](#footnote-ref-99)
100. . IRC Sec. 162(m)(6)(A). [↑](#footnote-ref-100)
101. . IRC Sec. 162(m)(6)(B). [↑](#footnote-ref-101)
102. . IRC Sec. 162(m)(6)(C)(i)(II). This definition applies for years beginning after 2012. Another definition applies for years beginning during the period 2010 through 2012. IRC Sec. 162(m)(6)(C)(i)(I). “Solely for purposes of determining whether a taxpayer is a ‘covered health insurance provider,'…premiums received under an indemnity reinsurance contract are not treated as premiums from providing health insurance coverage.” Notice 2011-2, III.D. [↑](#footnote-ref-102)
103. . IRC Sec. 9832(b)(2). A “group health plan” is not a health insurance issuer. For the term HMO, see Code Section 9832(b)(3). [↑](#footnote-ref-103)
104. . IRC Sec. 5000A(f). [↑](#footnote-ref-104)
105. . IRC Sec. 5000A(f)(1)(B). [↑](#footnote-ref-105)
106. . IRC Sec. 162(m)(6)(C)(ii). Specifically, two or more persons are treated as a single employer for this purpose if they are so treated under Code sections 414(b), 414(c), 414(m), or 414(o). [↑](#footnote-ref-106)
107. . IRC Sec. 162(m)(6)(A)(i). [↑](#footnote-ref-107)
108. . IRC Sec. 162(m)(6)(F). [↑](#footnote-ref-108)
109. . An independent contractor is not, however, an applicable individual if he or she provides substantial services to multiple unrelated customers, as described in Reg. §1.409A-1(f)(2). Notice 2011-2, 2011-2 IRB 260, III.C. [↑](#footnote-ref-109)
110. . IRC Sec. 162(m)(6)(D). [↑](#footnote-ref-110)
111. . IRC Secs. 162(m)(6)(D), 162(m)(6)(E). [↑](#footnote-ref-111)
112. . IRC Sec. 162(m)(6)(A)(i). [↑](#footnote-ref-112)
113. . IRC Sec. 162(m)(6)(A)(ii). [↑](#footnote-ref-113)
114. . IRC Sec. 162(m)(6)(C)(i)(I). [↑](#footnote-ref-114)
115. . Notice 2011-2,, III.A, Ex. 1. [↑](#footnote-ref-115)
116. . Notice 2011-2, III.A, Ex. 2. [↑](#footnote-ref-116)
117. . Notice 2011-02. [↑](#footnote-ref-117)
118. . Notice 2011-2, III.A, Ex. 3. [↑](#footnote-ref-118)
119. . IRC Sec. 162(m)(6)(H) (Treasury “may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph”). [↑](#footnote-ref-119)
120. . Notice 2011-2, III.B. [↑](#footnote-ref-120)
121. So long as the executive is an “employee” and not a self-employed individual, such as a proprietor, partner, or more than 2% shareholder of an S corporation. [↑](#footnote-ref-121)
122. Notice 2013-54, II.A. [↑](#footnote-ref-122)
123. Q&A-9. [↑](#footnote-ref-123)
124. . PPACA §9013(d) amended IRC Sec. 213(a). [↑](#footnote-ref-124)
125. . IRC Sec. 213(f). [↑](#footnote-ref-125)
126. . Joint Committee on Taxation, Tax Expenditures for Health Care, JCX-66-08, pp. 22-24, (July 30, 2008) at http://www.jct.gov/publications.html?func=startdown&id=1193. [↑](#footnote-ref-126)
127. . IRC Sec. 36B. [↑](#footnote-ref-127)
128. . IRC Sec. 5000A(f). [↑](#footnote-ref-128)
129. . IRC Sec. 5000A(b)(1), (c)(1), (2). Use of the national average for bronze coverage means that calculation might not bear much relationship to the actual cost of coverage available in a specific location. However, the premium amounts likely will not be lower than the penalty. [↑](#footnote-ref-129)
130. . IRC Sec. 5000A(c)(3)(A), (B), (D). [↑](#footnote-ref-130)
131. . IRC Sec. 5000A(c)(2)(B). The net effect of these percentage increases for taxpayers who do not procure minimum essential coverage and whose income is sufficient to be above the minimum penalty is an increase in their marginal tax rate by 1% in calendar year 2014 rising to a 2.5 percent marginal tax rate increase for subsequent years. [↑](#footnote-ref-131)
132. . IRC Sec. 5000A(d)(2), (3), (4). [↑](#footnote-ref-132)
133. . IRC Sec. 5000A(e)(1)(A). It is not clear why the "affordability test "for employers is 9.5 percent whereas this individual "affordability test” is 8 percent. [↑](#footnote-ref-133)
134. . IRC Sec. 5000A(e)(1)(B)(i). This affordability test based on the premium for “self-only coverage” will be integrated into the penalty calculation under which an individual may also be responsible for providing coverage for a spouse and/or dependents. *See* Preamble to Proposed Regulations for Code section 36B. [↑](#footnote-ref-134)
135. . IRC Sec. 5000A(e)(2). [↑](#footnote-ref-135)
136. . PPACA §1201. [↑](#footnote-ref-136)
137. . PPACA §1201. [↑](#footnote-ref-137)
138. . PPACA §1201. [↑](#footnote-ref-138)
139. . PPACA §1201. [↑](#footnote-ref-139)
140. . IRC Sec. 36B(c)(2)(C)(ii). [↑](#footnote-ref-140)
141. . IRC Sec. 36B(c)(2)(C)(i)(II); Prop. Treas. Reg. §36B, 76 Fed. Reg. 50931, 50935 (Aug. 17, 2011). [↑](#footnote-ref-141)
142. . IRC Sec. 36B(c)(2)(C)(i)(II); Prop. Treas. Reg. §36B, 76 Fed. Reg. 50931, 50935 (Aug. 17, 2011). [↑](#footnote-ref-142)
143. . Stephanie Rennane & C. Eugene Steurle, Health Reform: A Two-Subsidy System, Urban Institute and Brookings Institution: Tax Policy Center S10-001, (2010), at http://www.taxpolicycenter.org/library/displayatab.cfm?Docid=2699. [↑](#footnote-ref-143)
144. . PPACA §9010. [↑](#footnote-ref-144)
145. . PPACA §9010(f), providing that the tax is nondeductible under IRC Sec. 275(A)(6). [↑](#footnote-ref-145)
146. . Douglas Holtz-Eakin, “Higher Costs and the Affordable Care Act: The Case of the Premium Tax”, American Action Forum ( March 9, 2011) at http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf. [↑](#footnote-ref-146)
147. . Thomas A. Barthold, letter to Senator Jon Kyl, Joint Committee on Taxation, Washington, DC, 3 June 3, 2011 at http://www.ahipcoverage.com/wp-content/uploads/2011/11/Premium-Tax-JCT-Letter-to-Kyl-060311-2.pdf**.** [↑](#footnote-ref-147)
148. . IRC Sec. 4980I(d)(3). [↑](#footnote-ref-148)
149. . IRC Sec. 4980I(d)(1)(A). [↑](#footnote-ref-149)
150. . IRC Sec. 4980I(d)(1)(E). [↑](#footnote-ref-150)
151. . IRC Sec. 4980I(d)(1)(A). [↑](#footnote-ref-151)
152. . IRC Sec. 4980I(d)(1)(C). [↑](#footnote-ref-152)
153. . IRC Sec. 4980I(d)(1). [↑](#footnote-ref-153)
154. . IRC Sec. 4980I(d). [↑](#footnote-ref-154)
155. . IRC Sec. 4980I(d). [↑](#footnote-ref-155)
156. . IRC Sec. 4980I(b)(3)(C). [↑](#footnote-ref-156)
157. . IRC Sec. 4980I(b)(3). [↑](#footnote-ref-157)
158. . IRC Sec. 4980I(b)(3)(C). [↑](#footnote-ref-158)
159. . Law enforcement officers; those engaged in fire protection activities; providers of out-of-hospital emergency medical care (e.g., emergency medical technicians); those whose primary work is longshore work; and those engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. A retiree with at least twenty years of employment in a high-risk profession is also eligible for the increased threshold. IRC Sec. 4980I 4980I(f). [↑](#footnote-ref-159)
160. . IRC Sec. 4980I(b)(3)(C)(iii) and (iv). [↑](#footnote-ref-160)
161. . IRC Sec. 4980I(b)(3)(C)(ii). [↑](#footnote-ref-161)
162. . IRC Sec. 4980I(b)(3)(C)(iii). [↑](#footnote-ref-162)
163. . IRC Sec. 4980I(b)(3)(C)(v). [↑](#footnote-ref-163)
164. . IRC Sec. 4980I(c)(1) and (2). [↑](#footnote-ref-164)
165. . IRC Sec. 4980I(c)(3). [↑](#footnote-ref-165)
166. . IRC Sec. 4980I(c)(2)(C). [↑](#footnote-ref-166)
167. . IRC Sec. 4980I(c)(4). [↑](#footnote-ref-167)
168. . Calculated under IRC Sec. 6621. [↑](#footnote-ref-168)
169. . IRC Sec. 4980I(e). [↑](#footnote-ref-169)
170. . IRC Sec. 4980I(e). [↑](#footnote-ref-170)
171. . PPACA § 4376. [↑](#footnote-ref-171)
172. . 26 CFR § 6071(a)-1. [↑](#footnote-ref-172)
173. . IRS Chief Counsel Memo (June 7, 2013) available at http://www.irs.gov/pub/irs-utl/AM2013-002.pdf. [↑](#footnote-ref-173)
174. . 26 CFR § 6071(a)-1. [↑](#footnote-ref-174)
175. . 26 CFR § 4375-1. [↑](#footnote-ref-175)
176. . IRC § 4376(b)(1) and Reg § 46.4376 provide that the fee imposed by section 4376(a) shall be paid by the plan sponsor. [↑](#footnote-ref-176)
177. . Reg § 46.4376-1(b)(ii). [↑](#footnote-ref-177)
178. . PPACA § 4376(b)(2). [↑](#footnote-ref-178)
179. . 26 CFR § 4375-2. [↑](#footnote-ref-179)
180. . Treas. Reg. § 46.4376–1(b)(1)(ii); IRS, Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377), Q&A-9 at http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers. [↑](#footnote-ref-180)