PART IV: HEALTH INSURANCE

Employer-Provided Health Insurance

Employer's Deduction

313. May an employer deduct as a business expense the cost of premiums paid for accident and health insurance for employees?

An employer generally can deduct as a business expense all premiums paid for health insurance for one or more employees. This includes premiums for medical expense insurance. Dismemberment and sight loss coverage for the employee, his or her spouse and dependents, disability income for the employee (Q 364), and accidental death coverage. For deductibility of long-term care insurance premiums, see Q 433.

Premiums are deductible by an employer whether coverage is provided under a group policy or under individual policies. The deduction for health insurance is allowable only if benefits are payable to employees or their beneficiaries; it is not allowable if benefits are payable to the employer.[1] Where a spouse of an employer is a bona fide employee and the employer is covered as a family member, the premium is deductible.[2] A corporation can deduct premiums it pays on group hospitalization coverage for commission salespersons, regardless of whether they are employees.[3] Premiums must qualify as additional reasonable compensation to the insured employees.[4]

If a payment is considered made to a fund that is part of an employer plan to provide the benefit, the deduction for amounts paid or accrued may be limited (Q 3963).

An accrual basis employer that provides medical benefits to employees directly instead of through insurance or an intermediary fund may not deduct amounts estimated to be necessary to pay for medical care provided in the year but for which claims have not been filed with the employer by the end of the year if filing a claim is necessary to establish the employer's liability for payment.[5]

In the case of a plan covering stockholder-employees only, see Q 327; in the case of an S corporation, partnership, or sole proprietorship employer, see Q 328.

Where health benefits are provided through a fund, see Q 491.

314. What credit is available for small employers for employee health insurance expenses?

A credit is available for employee health insurance expenses of an eligible small employer for taxable years beginning after December 31, 2009, provided the employer offers health

1. Treas. Reg. §1.162-10(a); Rev. Rul. 58-90, 1958-1 CB 88; Rev. Rul. 56-632, 1956-2 CB 101; Rev. Rul. 210, 1953-2 CB 114.
2. Rev. Rul. 71-588, 1971-2 CB 91; TAM 9409006.
3. Rev. Rul. 56-400, 1956-2 CB 116.
4. *Ernest Holdeman & Collet, Inc. v. Comm.*, TC Memo 1960-10. See Rev. Rul. 58-90, supra.
5. *U.S. v. General Dynamics Corp.*, 481 U.S. 239 (1987).

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insurance to its employees.[1] Beginning in 2014, the credit is available to eligible small employers for two consecutive years.

An eligible small employer is an employer that has no more than twenty-five full time employees, the average annual wages of whom do not exceed $50,000 (in 2010, 2011, 2012, and 2013; the amount is indexed thereafter).[2] The inflation adjusted amount for 2014 is $50,800.[3]

An employer must have a contribution arrangement for each employee who enrolls in the health plan offered by the employer through an exchange that requires that the employer make a non-elective contribution in an amount equal to a uniform percentage, not less than 50 percent, of the premium cost.[4]

Subject to phase-out[5] based on the number of employees and average wages, the amount of the credit is equal to 50 percent, and 35 percent in the case of tax exempts, of the lesser of (1) the aggregate amount of non-elective contributions made by the employer on behalf of its employees for health insurance premiums for health plans offered by the employer to employees through an exchange, or (2) the aggregate amount of non-elective contributions the employer would have made if each employee had been enrolled in a health plan that had a premium equal to the average premium for the small group market in the ratings area.[6]

For years 2010, 2011, 2012, and 2013, the following modifications apply in determining the amount of the credit:

(1) the credit percentage is reduced to 35 percent (25 percent in the case of tax exempts);[7]

(2) the amount under (1) is determined by reference to non-elective contributions for premiums paid for health insurance, and there is no exchange requirement;[8] and

(3) the amount under (2) is determined by the average premium for the state small group market.[9]

The credit also is allowed against the alternative minimum tax.[10]

In 2014 small employers will have exclusive access to an expanded Small Business Healthcare Tax Credit under the Affordable Care Act. This tax credit covers as much as 50 percent of the employer contribution toward premium costs for eligible employers who have low- to moderate-wage workers.

1. IRC Sec. 45R, as added by PPACA 2010.
2. IRC Secs. 45R(d), as added by PPACA 2010; IRC Sec 45R(d)(3)(B), as amended by Section 10105(e)(1) of PPACA 2010.
3. Rev. Rul. 2013-35, 2013-47 IRB 537.
4. IRC Sec. 45R(d)(4), as added by PPACA 2010.
5. IRC Sec. 45R(c), as added by PPACA 2010.
6. IRC Sec. 45(b), as added by PPACA 2010.
7. IRC Sec. 45R(g)(2)(A), as added by PPACA 2010.
8. IRC Secs. 45R(g)(2)(B), 45R(g)(3), as added by PPACA 2010.
9. IRC Sec. 45R(g)(2)(C), as added by PPACA 2010.
10. IRC Sec. 38(c)(4)(B), as amended by PPACA 2010. The IRS has issued guidance; see IRS Notice 2010-44, 2010-22 I.R.B. 717; IRS Notice 2010-82, 2010-51 I.R.B. 1.

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Employee's Income Taxation

315. Is the value of employer-provided coverage under accident or health insurance taxable income to an employee?

Generally, no.

This includes medical expense and dismemberment and sight loss coverage for the employee, his or her spouse and dependents, and coverage providing for disability income for the employee (Q 364). There is no specific limit on the amount of employer-provided coverage that may be excluded from an employee's gross income. Coverage is tax-exempt to an employee whether it is provided under a group or individual insurance policy.[1] Coverage under an uninsured plan is explained in Q 318.

Likewise, the value of critical illness coverage is not taxable income to an employee.

Accidental death coverage is excludable from an employee's gross income under IRC Section 106(a).[2]

In a Private Letter Ruling, the IRS decided that the value of consumer medical cards purchased by a partnership for its employees was excludable from the employees' income under IRC Section 106(a).[3]

Where an employer applies salary reduction amounts to the payment of health insurance premiums for employees, the salary reduction amounts are excludable from gross income under IRC Section 106.[4]

If an employee pays the premiums on his or her personally-owned medical expense insurance and is reimbursed by his or her employer, the reimbursement likewise is excludable from the employee's gross income under IRC Section 106.[5]

Where an employer simply pays an employee or retiree a sum that may be used to pay the premium but that amount is not required to be used for that purpose, the amount is taxable to the employee.[6]

According to the IRS, where an employer, not pursuant to a cafeteria plan under IRC Section 125 (Q 3501), offers an employee a choice between a lower salary and employer-paid health insurance or a higher salary and no health insurance, the employee must include the full amount of the higher salary in income regardless of his or her choice. An employee selecting the health insurance option is considered to have received the higher salary and, in turn, paid a portion of the salary equal to the health insurance premium to the insurance company.[7]

1. IRC Sec. 106(a). See also Treas. Reg. §1.106-1; Rev. Rul. 58-90, 1958-1 CB 88; Rev. Rul. 56-632, 1956-1 CB 101.
2. See Treas. Reg. §1.106-1; Treas. Reg. §1.79-1(f)(3); Let. Ruls. 8801015, 8922048.
3. Let. Rul. 9814023.
4. Rev. Rul. 2002-03, 2002-1 CB 316.
5. See Rev. Rul. 61-146, 1961-2 CB 25; see *Larkin v. Comm.*, 48 TC 629 (1967), Footnote #3; Let. Rul. 9840044.
6. Rev. Rul. 75-241, 1975-1 CB 316, Let. Rul. 9022060. See also Let. Rul. 9104050.
7. Let. Rul. 9406002. See also Let. Rul. 9513027.

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A federal district court faced with a similar fact situation has ruled that for employees who accept employer-paid health insurance coverage, the difference between the higher salary and the lower one is not subject to FICA and FUTA taxes or to income tax withholding.[1]

Where a taxpayer's contribution to a fund providing retiree health benefits is deducted from the taxpayer's after-tax salary, it is considered an employee contribution and is includable in the taxpayer's income under IRC Section 61.

In contrast, where an employer increases or grosses up a taxpayer's salary and then deducts the fund contribution from the taxpayer's after-tax salary, the contribution is considered to be an employer contribution that is excludable from the gross income of the taxpayer under IRC Section 106.[2]

A return of premium rider on a health insurance policy was ruled a benefit in addition to accident and health benefits and the premium paid by the employer was not excludable by the employee.[3]

Employer-provided accident and health coverage for an employee and the employee's spouse and dependents, both before and after retirement, and for the employee's surviving spouse and dependents after the employee's death, does not have to be included in gross income by the active or retired employee or, after the employee's death, by the employee's survivors.[4]

If an employer's accident and health plan continues to provide coverage pursuant to a collective bargaining agreement for an employee who is laid off, the value of the coverage is excluded from the gross income of the laid-off employee.[5] Terminated employees who receive medical coverage under a medical plan that is part of the former employer's severance plan are considered to be employees for purposes of IRC Sections 105 and 106. Thus, an employer's contributions toward medical care for employees are excludable from income under IRC Section 106.[6] Otherwise, the exclusion is available only to active employees.

Full time life insurance salespersons are considered employees if they are employees for Social Security purposes.[7] Coverage for other commission salespersons is taxable income to the salespersons, unless an employer-employee relationship exists.[8] In the case of shareholder-employees owning more than 2 percent of the stock of an S corporation, see Q 328.

Discrimination generally does not affect exclusion of the value of coverage. Even if a self-insured medical expense reimbursement plan discriminates in favor of highly compensated employees, the value of coverage is not taxable; only reimbursements are affected (Q 319).

1. *Express Oil Change, Inc. v. U.S.*, 25 F. Supp. 2d 1313, 78 AFTR2d 96-6764 (N.D. Ala. 1996), *aff'd,166 F. 3d 1290*, 83 AFTR2d 99-302 (11th Cir. 1998).
2. Let. Rul. 9625012.
3. Let. Rul. 8804010.
4. Rev. Rul. 82-196, 1982-2 CB 53; GCM 38917 (11-17-82).
5. See Rev. Rul. 85-121, 1985-2 CB 57.
6. Let. Rul. 9612008.
7. IRC Sec. 7701(a)(20).
8. Rev. Rul. 56-400, 1956-2 CB 116; see also IRC Sec. 3508.

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Beginning in January 2012, The Affordable Care Act requires employers to report the cost of coverage under an employer-sponsored group health plan.

The fact that the cost of an employee's health care benefits is shown on the employee's Form W-2 does not mean that the benefits are taxable to the employee. There is nothing about the reporting requirement that causes or will cause excludable employer-provided health coverage to become taxable. The purpose of the reporting requirement is to provide employees useful and comparable consumer information on the cost of their health care coverage.

316. How does health reform expand the income exclusion for adult children's coverage?

Under the Patient Protection and Affordable Care Act of 2010 ("PPACA 2010"), the exclusion from gross income for amounts expended on medical care (Q 315) is expanded to include employer provided health coverage for any adult child of the taxpayer if the adult child has not attained the age of twenty-seven as of the end of the taxable year. According to Notice 2010-38, the adult child does not have to be eligible to be claimed as a dependent for tax purposes for this income exclusion to apply.[1]

317. What are the tax consequences of payments received by employees under employer-provided accident or health insurance?

Although the amounts that both employers and employees pay for premiums for employer sponsored health and accident insurance plans must now be stated on the employee's Form W-2, the tax consequences of receiving benefits pursuant to those plans have not changed. However, some payments must be included in the employee's gross income, explained below.

Hospital, Surgical, and Medical Expenses

Amounts received by an employee under employer-provided accident or health insurance, group or individual, that reimburse the employee for hospital, surgical, and other medical expenses incurred for care of the employee or his or her spouse and dependents generally are tax-exempt without limit.

Nonetheless, benefits must be included in gross income to the extent that they reimburse an employee for any expenses that the employee deducted in a prior year. Moreover, if reimbursements exceed actual expenses, the excess must be included in gross income to the extent that it is attributable to employer contributions.[2]

Where an employer reimburses employees for salary reduction contributions applied to the payment of health insurance premiums, these amounts are not excludable under IRC Section 105(b) because there are no employee-paid premiums to reimburse.[3]

1. IRC Sec. 105(b), as amended by the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010. Notice 2010-38, 2010-20 IRB 682.
2. IRC Sec. 105(b); Treas. Reg. §1.105-2; Rev. Rul. 69-154, 1969-1 CB 46.
3. Rev. Rul. 2002-3, 2002-1 CB 316.

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Likewise, where an employer applies salary reduction contributions to the payment of health insurance premiums and then pays the amount of the salary reduction to employees regardless of whether the employee incurs expenses for medical care, these so-called advance reimbursements or loans are not excludable from gross income under IRC Section 105(b) and are subject to FICA and FUTA taxes.[1]

Sight Loss and Dismemberment Benefits

Payments not related to absence from work for the permanent loss, or loss of use, of a member or function of a body or permanent disfigurement of the employee or spouse or a dependent are excluded from income if the amounts paid are computed with reference to the nature of the injury.[2]

A lump-sum payment for incurable cancer under a group life-and-disability policy qualified for tax exemption under this provision.[3]

Benefits determined by length of service rather than type and severity of injury did not qualify for the exemption.[4]

Benefits determined as a percentage of a disabled employee's salary rather than the nature of the employee's injury were not excludable from income.[5] An employee who has permanently lost a bodily member or function but is working and drawing a salary cannot exclude a portion of that salary as payment for loss of the member or function if that portion was not computed with reference to the loss.[6]

Critical Illness Benefits

Amounts received by an employee under employer-provided critical illness policies where the value of the coverage was not includable in the employee's gross income are includable in the employee's gross income. The exclusion from gross income under IRC Section 105(b) applies only to amounts paid specifically to reimburse medical care expenses. Because critical illness insurance policies pay a benefit irrespective of whether medical expenses are incurred, these amounts are not excludable under IRC Section 105(b).[7]

Wage Continuation and Disability Income

Sick pay, wage continuation payments, and disability income payments, both preretirement and postretirement, generally are fully includable in gross income and taxable to an employee (Q 364).[8]

1. Rev. Rul. 2002-80, 2002-2 CB 925.
2. IRC Sec. 105(c).
3. Rev. Rul. 63-181, 1963-2 CB 74.
4. *Beisler v. Comm.*, 814 F.2d 1304 (9th Cir. 1987); *West v. Comm.*, TC Memo 1992-617. See also *Rosen v. U.S.*, 829 F.2d 506 (4th Cir. 1987).
5. *Colton v. Comm.*, TC Memo 1995-275; *Webster v. Comm.*, 870 F. Supp 202, 94-2 USTC ¶50,586 (M.D. Tenn. 1994).
6. *Laverty v. Comm.*, 61 TC 160 (1973) *aff'd*, 523 F.2d 479, 75-2 USTC ¶9712 (9th Cir. 1975).
7. See Treas. Regs. §§1.105-2, 1.213-1(e).
8. See Let. Ruls. 9103043, 9036049.

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Accidental Death Benefit

Accidental death benefits under an employer's plan are received income tax-free by an employee's beneficiary under IRC Section 101(a) as life insurance proceeds payable by reason of the insured's death.[1] Death benefits payable under life insurance contracts issued after December 31, 1984, are excludable only if the contract meets the statutory definition of a life insurance contract in IRC Section 7702 (Q 64).

Survivors' Benefits

Benefits paid to a surviving spouse and dependents under an employer accident and health plan that provided coverage for an employee and the employee's spouse and dependents both before and after retirement, and to the employee's surviving spouse and dependents after the employee's death, are excludable to the extent that they would be if paid to the employee.[2]

318. Are benefits provided under an employer's noninsured accident and health plan excludable from an employee's income?

To be tax-exempt on the same basis as insured plans (Q 315, Q 317), uninsured benefits must be received under an accident and health plan for employees.[3] Although there must be a plan for uninsured payments, the plan need not follow a particular legal form. According to an Ohio federal District Court[4], there is no legal magic to a form; the essence of the arrangement must determine its legal character. The fact that there is no formal contract of insurance is immaterial, if it is clear that, for an adequate consideration, the company has agreed and has become liable to pay and has paid sickness benefits based upon a reasonable plan of protection of its employees.

Thus, a provision for disability pay in an employment contract has been held to satisfy the condition.[5]

It is not necessary for tax purposes that a plan be in writing or that an employee's rights to benefits under the plan be enforceable. For example, an employer's custom or policy of continuing wages during disability, generally known to employees, has been held to constitute a plan.[6]

If an employee's rights are not enforceable, the employee must have been covered by a plan or a program, policy, or custom having the effect of a plan when the employee became sick or injured, and notice or knowledge of the plan must have been readily available to the employee.[7] For there to be a plan, an employer must commit to certain rules and regulations governing payment and these rules must be made known to employees as a definite policy before accident

1. Treas. Reg. §1.101-1(a).
2. Rev. Rul. 82-196, 1982-2 CB 53; GCM 38917 (11-17-82).
3. IRC Sec. 105(e).
4. *Epmeier v. U.S.*, 199 F.2d 508 (7th Cir., 1959).
5. *Andress v. U.S.*, 198 F. Supp. 371 (N.D. Ohio, 1961).
6. *Niekamp v. U.S.*, 240 F. Supp. 195 (E.D. Mo. 1965); *Pickle*, TC Memo 1971-304.
7. Treas. Reg. §1.105-5(a).

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or sickness arises; *ad hoc* payments at the complete discretion of an employer do not qualify as a plan.[1]

The plan must be for employees. A plan may cover one or more employees and there may be different plans for different employees or classes of employees.[2] A plan that is found to cover individuals in a capacity other than their employee status, even though they are employees, is not a plan for employees (Q 327). Self-employed individuals and certain shareholders owning more than 2 percent of the stock of an S corporation are not treated as employees for the purpose of determining the excludability of employer-provided accident and health benefits (Q 328).[3]

In addition, uninsured medical expense reimbursement plans for employees must meet nondiscrimination requirements for medical expense reimbursements to be tax-free to highly compensated employees (Q 319).

Planning Point: The most important concept surrounding Section 105 Plans is *legitimate employment* between spouses or any other named employee. This issue is closely scrutinized by the IRS, and it is absolutely vital that the relationship be in existence. Fabricated relationships are absolutely discouraged. Therefore, having the following items in place helps to ensure the plan operates smoothly and the tax advantages are maximized:

Written employment agreements

1. Logs of hours worked by employees
2. Established cash (salary) compensation payment amounts and schedules

In addition, it is recommended to:

1. Name the insured (it is preferred that the insurance policy be in the employee's name).
2. Maintain separate checking accounts (one for business use and the second for personal use).
3. Pay for medical expenses (all medical expenses for the family should be paid by the employee from his or her personal account), and the employee should document all payments.

319. What nondiscrimination requirements apply to employer provided health insurance plans?

Editor's note: Under current law, other than rules concerning discrimination based on health status under HIPAA '96 that generally apply to both insured and uninsured plans (Q 353, Q 355), a plan that provides health benefits through an accident or health insurance policy need not meet the nondiscrimination requirements of IRC Section 105(h) for covered employees to enjoy the tax benefits described in Q 317. For plan years beginning on or after September 23,

1. *Est. of Kaufman*, 35 TC 663 (1961), *aff'd*, 300 F.2d 128 (6th Cir. 1962); *Lang*, 41 TC 352 (1963); *Levine*, 50 TC 422 (1968); *Est. of Chism*, TC Memo 1962-6, *aff'd*, 322 F.2d 956 (9th Cir. 1963); *Burr*, TC Memo 1966-112; *Frazier v. Comm.*, TC Memo 1994-358; *Harris*, 77-1 USTC ¶9414 (E.D. Va. 1977).
2. Treas. Reg. §1.105-5(a); *Andress v. U.S.*, supra.
3. IRC Sec. 105(g); Treas. Reg. §1.105-5(b).

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2010, which was six months after the date of enactment of PPACA 2010, insured plans that are not grandfathered were expected to be subject to the same nondiscrimination requirements as self-insured plans. On December 22, 2010, however, the IRS announced in Notice 2011-1 that compliance with nondiscrimination rules for health insurance plans will be delayed until regulations or other administrative guidance has been issued. The IRS indicated that the guidance will not apply until plan years beginning a specified period after guidance is issued.

PPACA Rules

Under PPACA 2010, a group health plan other than a self-insured plan must satisfy the requirements of IRC Section 105(h)(2). More specifically, PPACA 2010 states that rules similar to the rules in IRC Section 105(h)(3) (nondiscriminatory eligibility classifications), Section 105(h)(4) (nondiscriminatory benefits), and Section 105(h)(8) (certain controlled groups) apply to insured plans. The term highly compensated individual has the meaning given that term by IRC Section 105(h)(5).[1]

An accident or health insurance policy may be an individual or a group policy issued by a licensed insurance company, or an arrangement in the nature of a prepaid health care plan regulated under federal or state law including an HMO. Unless a policy involves shifting of risk to an unrelated third party, a plan will be considered self-insured.

A plan is not considered self-insured merely because prior claims experience is one factor in determining the premium.[2] Furthermore, a policy of a captive insurance company is not considered self-insurance if, for the plan year, premiums paid to a captive insurer by unrelated companies are at least one-half of the total premiums received and the policy is similar to those sold to unrelated companies.[3]

Likewise, a plan that reimburses employees for premiums paid under an insured plan does not have to satisfy nondiscrimination requirements.

320. What nondiscrimination requirements apply to self-insured health plans?

Nondiscrimination requirements apply to self-insured health benefits, although the IRS announced in Notice 2011-1 on December 22, 2010, that compliance with nondiscrimination rules for health insurance plans will be delayed until regulations or other administrative guidance has been issued. This guidance remains pending. The IRS indicated that the guidance will not apply until plan years beginning in specified periods after guidance is issued. Some plans will be grandfathered.

Benefits under a self-insured plan generally are excludable from an employee's gross income (Q 318). If a self-insured medical expense reimbursement plan or the self-insured part of a partly-insured medical expense reimbursement plan discriminates in favor of highly compensated individuals, certain amounts paid to highly compensated individuals are taxable to them.

1. Secs. 2716 of the Public Health Service Act, as added by Section 1001(5) of PPACA 2010, as amended by Section 10101(d) of PPACA 2010.
2. See, for example, Let. Rul. 8235047.
3. Treas. Reg. §1.105-11(b).

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A self-insured plan is one in which reimbursement of medical expenses is not provided under a policy of accident and health insurance.[1] According to regulations, a plan underwritten by a cost-plus policy or a policy that, in effect, merely provides administrative or bookkeeping services is considered self-insured.[2]

A medical expense reimbursement plan cannot be implemented retroactively. To allow this would render meaningless the nondiscrimination requirements of IRC Section 105.[3]

A self-insured plan may not discriminate in favor of highly compensated individuals either with respect to eligibility to participate or benefits.

Eligibility

A plan discriminates as to eligibility to participate unless the plan benefits the following:

(1) 70 percent or more of all employees, or 80 percent or more of all the employees who are eligible to benefit under the plan if 70 percent or more of all employees are eligible to benefit under the plan; or

(2) Employees who qualify under a classification set up by the employer and found by the IRS not to be discriminatory in favor of highly compensated individuals.[4]

Excludable Employees

For purposes of these eligibility requirements, an employer may exclude from consideration those employees who:

(1) have not completed three years of service at the beginning of the plan year; years of service during which an individual was ineligible under (2), (3), (4), or (5) below must be counted for this purpose;

(2) have not attained age twenty-five at the beginning of the plan year;

(3) are part-time or seasonal employees;

(4) are covered by a collective bargaining agreement if health benefits were the subject of good faith bargaining; or

(5) are nonresident aliens with no U.S.-source earned income.[5]

1. See IRC Sec. 105(h)(6).
2. Treas. Reg. §1.105-11(b).
3. *Wollenburg v. U.S.*, 75 F. Supp. 2d 1032 (DC Neb. 1999); *American Family Mut. Ins. Co. v. U.S.*, 815 F. Supp. 1206 (WD Wisc. 1992). See also Rev. Rul. 2002-58, 2002-38 IRB 541.
4. IRC Sec. 105(h)(3)(A).
5. IRC Sec. 105(h)(3)(B).

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Part-time and Seasonal Workers

Employees customarily employed for fewer than thirty-five hours per week are considered part-time and employees customarily employed for fewer than nine months per year are considered seasonal if similarly situated employees of the employer or in the same industry or location are employed for substantially more hours or months, as applicable. Employees customarily employed for fewer than twenty-five hours per week or seven months per year are considered part-time or seasonal under a safe harbor rule.[1]

Benefits

A plan discriminates as to benefits unless all benefits provided for participants who are highly compensated individuals are provided for all other participants.[2] Benefits are not available to all participants if some participants become eligible immediately and others after a waiting period.[3] Benefits available to dependents of highly compensated employees must be equally available to dependents of all other participating employees. The test is applied to benefits subject to reimbursement, rather than to actual benefit payments or claims.

Any maximum limit on the amount of reimbursement must be uniform for all participants and for all dependents, regardless of years of service or age. Further, a plan will be considered discriminatory if the type or amount of benefits subject to reimbursement is offered in proportion to compensation and highly compensated employees are covered by the plan. A plan will not be considered discriminatory in operation merely because highly compensated participants use a broad range of plan benefits to a greater extent than other participants.[4]

An employer's plan will not violate nondiscrimination rules merely because benefits under the plan are offset by benefits paid under a self-insured or insured plan of the employer or of another employer or by benefits paid under Medicare or other federal or state law. A self-insured plan may take into account benefits provided under another plan only to the extent that the benefit is the same under both plans.[5] Benefits provided to a retired employee who was highly compensated must be the same as benefits provided to all other retired participants.

For purposes of applying the nondiscrimination rules, all employees of a controlled group of corporations, or employers under common control, and of members of an affiliated service group (Q 3830, Q 3832) are treated as employed by a single employer.[6]

321. Who is a highly compensated individual for purposes of determining whether a health plan is discriminatory?

An employee is a highly compensated individual if the employee falls into any one of the following three classifications:

1. Treas. Reg. §1.105-11(c).
2. IRC Sec. 105(h)(4).
3. Let. Ruls. 8411050, 8336065.
4. Treas. Reg. §1.105-11(c)(3).
5. Treas. Reg. §1.105-11(c)(1).
6. IRC Sec. 105(h).

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(1) The employee is one of the five highest paid officers;

(2) The employee is a shareholder who owns, either actually or constructively through application of the attribution rules (Q 286), more than 10 percent in value of the employer's stock; or

(3) The employee is among the highest paid 25 percent, rounded to the nearest higher whole number, of all employees other than excludable employees who are not participants and not including retired participants.[1] Fiscal year plans may determine compensation on the basis of the calendar year ending in the plan year.

Planning Point: These requirements are not mutually exclusive. The five highest paid officers may also be among the highest 25 percent of all employees. However, if one of the top five officers is not in that pay range, that officer still needs to be included in the highly compensated individual category.

A participant's status as officer or stockholder with respect to a particular benefit is determined at the time when the benefit is provided.[2]

322. What are the tax consequences for amounts paid by an employer to highly compensated employees under a discriminatory self-insured medical expense reimbursement plan?

The taxable amount of payments made to a highly compensated individual from a discriminatory self-insured medical expense reimbursement plan is the excess reimbursement.[3] Two situations produce an excess reimbursement.

The first situation occurs when a benefit is available to a highly compensated individual but not to all other participants, or that otherwise discriminates in favor of highly compensated individuals. In this situation, the total amount reimbursed under the plan to the employee with respect to that benefit is an excess reimbursement.

The second situation occurs when benefits are available to all other participants and are not otherwise discriminatory and where a plan discriminates as to participation. Here, excess reimbursement is determined by multiplying the total amount reimbursed to the highly compensated individual for the plan year by a fraction. The numerator is the total amount reimbursed to all participants who are highly compensated individuals under the plan for the plan year; the denominator is the total amount reimbursed to all employees under the plan for such plan year. In determining the fraction, no account is taken of any reimbursement attributable to a benefit not available to all other participants.[4]

Multiple plans may be designated as a single plan for purposes of satisfying nondiscrimination requirements. An employee who elects to participate in an optional HMO offered by the

1. IRC Sec. 105(h)(5).
2. Treas. Reg. §1.105-11(d).
3. IRC Sec. 105(h)(1).
4. IRC Sec. 105(h)(7).

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plan is considered benefited by the plan only if the employer's contributions with respect to the employee are at least equal to what would have been made to the self-insured plan and the HMO is designated, with the self-insured plan, as a single plan. Regulations do not suggest how to determine contributions to a self-insured plan.

Unless a plan provides otherwise, reimbursements will be attributed to the plan year in which payment is made; thus, they will be taxed in an individual's tax year in which a plan year ends.

Amounts reimbursed for medical diagnostic procedures for employees, but not dependents, performed at a facility that provides only medical services are not considered a part of a plan and do not come within these rules requiring nondiscriminatory treatment.[1]

Contributory Plan

Reimbursements attributable to employee contributions are received tax-free, subject to inclusion if the expense was previously deducted (Q 317). Amounts attributable to employer contributions are determined in the ratio that employer contributions bear to total contributions for the calendar years immediately preceding the year of receipt, up to three years; if a plan has been in effect for less than a year, then such determination may be based upon the portion of the year of receipt preceding the time when the determination is made, or such determination may be made periodically (such as monthly or quarterly) and used throughout the succeeding period. [2] For example, if an employee terminates his services on April 15, 2014, and 2014 is the first year the plan has been in effect, such determination may be based upon the contributions of the employer and the employees during the period beginning with January 1 and ending with April 15, or during the month of March, or during the quarter consisting of January, February, and March.

Withholding

An employer does not have to withhold income tax on an amount paid for any medical care reimbursement made to or for the benefit of an employee under a self-insured medical reimbursement plan within the meaning of IRC Section 105(h)(6).[3]

323. Are premiums paid for personal health insurance deductible as medical expenses?

Premiums paid for medical care insurance, that is, hospital, surgical, and medical expense reimbursement coverage, is deductible as a medical expense to the extent that, when added to all other unreimbursed medical expenses, the total exceeds 10 percent of a taxpayer's adjusted gross income (7.5 percent for tax years beginning before 2013). The threshold is also 10 percent for alternative minimum tax purposes.

1. Treas. Reg. §1.105-11(g).
2. Treas. Reg. §1.105-11(i).
3. IRC Sec. 3401(a)(20).

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The Patient Protection and Affordable Care Act increased the threshold to 10 percent of a taxpayer's adjusted gross income for taxpayers who are under the age of sixty-five effective in tax years beginning January 1, 2013. Taxpayers over the age of sixty-five will be temporarily excluded from this provision and the threshold for deductibility for these taxpayers will remain at the 7.5 percent level from years 2013 to 2016.

No deduction may be taken for medical care premiums or any other medical expenses unless a taxpayer itemizes his or her deductions.[1] The limit on itemized deductions for certain high-income individuals is not applicable to medical expenses deductible under IRC Section 213.[2]

Premiums for only medical care insurance are deductible as a medical expense. Premiums for non-medical benefits, including disability income (Q 366), accidental death and dismemberment, and waiver of premium under a life insurance policy, are not deductible.

Amounts paid for any qualified long-term care insurance contract or for qualified long-term care services generally are included in the definition of medical care and, thus, are eligible for income tax deduction, subject to certain limitations (Q 430).[3]

Compulsory contributions to a state disability benefits fund are not deductible as medical expenses but are deductible as taxes.[4] Employee contributions to an alternative employer plan providing disability benefits required by state law are nondeductible personal expenses.[5]

If a policy provides both medical and non-medical benefits, a deduction will be allowed for the medical portion of the premium only if the medical charge is reasonable in relation to the total premium and is stated separately in either the policy or in a statement furnished by the insurance company.[6]

Similarly, because the deduction is limited to expenses of the taxpayer, his or her spouse and dependents, where a premium provides medical care for others as well (as in automobile insurance) without separately stating the portion applicable to the taxpayer, spouse and dependents, no deduction is allowed.[7]

If a policy provides only indemnity for hospital and surgical expenses, premiums qualify as medical care premiums even though the benefits are stated amounts that will be paid without regard to the actual amount of expense incurred (Q 325).[8] Premiums paid for a hospital insurance policy that provides a stated payment for each week an insured is hospitalized, not to exceed a specified number of weeks, regardless of whether the insured receives other payments for reimbursement, do not qualify as medical care premiums and hence are not deductible.[9]

1. IRC Sec. 213(a).
2. IRC Sec. 68(c).
3. IRC Sec. 213(d)(1).
4. *McGowan v. Comm.*, 67 TC 599 (1976); *Trujillo v. Comm.*, 68 TC 670 (1977).
5. Rev. Rul. 81-192 (N.Y.), 1981-2 CB 50; Rev. Rul. 81-193 (N.J.), 1981-2 CB 52; Rev. Rul. 81-194 (Cal.), 1981-2 CB 54.
6. IRC Sec. 213(d)(6).
7. Rev. Rul. 73-483, 1973-2 CB 75.
8. Rev. Rul. 58-602, 1958-2 CB 109, modified by Rev. Rul. 68-212, 1968-1 CB 91.
9. Rev. Rul. 68-451, 1968-2 CB 111.

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Premiums paid for a stand-alone critical illness policy are considered capital outlays and are not deductible.

A deduction will also be denied for employees' contributions to a plan that provides that employees absent from work because of sickness are to be paid a percentage of wages earned on that day by co-employees.[1]

Premiums paid for a policy that provides reimbursement for the cost of prescription drugs are deductible as medical care insurance premiums.[2]

Medicare premiums, paid by persons age sixty-five or older, under the supplementary medical insurance or prescription drug programs are deductible as medical care insurance premiums. Taxes paid by employees and self-employed persons for basic hospital insurance under Medicare are not deductible.[3]

Premiums prepaid by a taxpayer before the taxpayer is sixty-five for insurance covering medical care for the taxpayer, his or her spouse, and his or her dependents after the taxpayer is sixty-five are deductible when paid provided they are payable on a level-premium basis for ten years or more or until age sixty-five, but in no case for fewer than five years.[4]

Payments made to an institution for the provision of lifetime care are deductible under IRC Section 213(a) in the year paid to the extent that the payments are properly allocable to medical care, even if the care is to be provided in the future or possibly not provided at all.[5] The IRS has stated that its rulings should not be interpreted to permit a current deduction of payments for future medical care including medical insurance provided beyond the current tax year in situations where future lifetime care is not of the type associated with these rulings.[6]

324. Are benefits received under a personal health insurance policy taxable income?

No.

All kinds of benefits from personal health insurance generally are entirely exempt from income tax. This includes disability income; (Q 366), dismemberment and sight loss benefits; critical illness benefits;[7] and hospital, surgical, or other medical expense reimbursement. There is no limit on the amount of benefits, including the amount of disability income, that can be received tax-free under personally paid health insurance or under an arrangement having the effect of accident or health insurance.[8] At least one court has held, however, that the IRC Section 104(a)(3) exclusion is not available where a taxpayer's claims for insurance benefits were not made in good faith and were not based on a true illness or injury.[9]

1. Rev. Rul. 73-347, 1973-2 CB 25.
2. Rev. Rul. 68-433, 1968-2 CB 104.
3. IRC Sec. 213(d)(1)(D); Rev. Rul. 66-216, 1966-2 CB 100.
4. IRC Sec. 213(d)(7).
5. Rev. Rul. 76-481, 1976-2 CB 82; Rev. Rul. 75-303, 1975-2 CB 87; Rev. Rul. 75-302, 1975-2 CB 86.
6. Rev. Rul. 93-72, 1993-2 CB 77.
7. See, e.g., Let Rul. 200903001.
8. IRC Sec. 104(a)(3); Rev. Rul. 55-331, 1955-1 CB 271, *modified by* Rev. Rul. 68-212, 1968-1 CB 91; Rev. Rul. 70-394, 1970-2 CB 34.
9. *Dodge v. Comm.*, 93-1 USTC ¶50,021 (8th Cir. 1992).

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The accidental death benefit under a health insurance policy may be tax-exempt to a beneficiary as death proceeds of life insurance (Q 64).[1] Disability benefits received for loss of income or earning capacity under no fault insurance are excludable from gross income.[2] The exclusion also has been applied to an insured to whom policies were transferred by a professional service corporation in which the insured was the sole stockholder.[3]

Health insurance benefits are tax-exempt if received by the insured and if received by a person having an insurable interest in an insured.[4]

Medical expense reimbursement benefits must be taken into account in computing a taxpayer's medical expense deduction. Because only unreimbursed expenses are deductible, the total amount of medical expenses paid during a taxable year must be reduced by the total amount of reimbursements received in that taxable year.[5]

Likewise, if medical expenses are deducted in the year they are paid and then reimbursed in a later year, the taxpayer or the taxpayer's estate, where the deduction is taken on the decedent's final return but later reimbursed to the taxpayer's estate, must include the reimbursement, to the extent of the prior year's deduction, in gross income for the later year.[6]

Where the value of a decedent's right to reimbursement proceeds, which is income in respect of a decedent,[7] is included in the decedent's estate (Q 389), an income tax deduction is available for the portion of estate tax attributable to such value.

Disability income is not treated as reimbursement for medical expenses and, therefore, does not offset such expenses.[8]

> *Example*: Mr. Jones, whose adjusted gross income for 2013 was $25,000, paid $3,000 in medical expenses during that year. On his 2013 return, he took a medical expense deduction of $500 [$3,000 – $2,500 (10 percent of his adjusted gross income)]. In 2014, Mr. Jones receives the following benefits from his health insurance: disability income, $1,200; reimbursement for 2013 doctor and hospital bills, $400. He must report $400 as taxable income on his 2014 return. Had Mr. Jones received the reimbursement in 2013, his medical expense deduction for that year would have been limited to $100 ($3,000 – $400 [reimbursement] – $2,500 [10 percent of adjusted gross income]). Otherwise, he would have received the entire amount of insurance benefits, including the medical expense reimbursement, tax-free.

Planning Point: This example illustrates that the timing of medical expense payments and their submission for reimbursement may be critical to the individual's personal tax planning, particularly in regard to reaching the requisite 10 percent of adjusted gross income threshold.

1. IRC Sec. 101(a); Treas. Reg. §1.101-1(a).
2. Rev. Rul. 73-155, 1973-1 CB 50.
3. Let. Rul. 7751104.
4. See IRC Sec. 104; *Castner Garage, Ltd. v. Comm.*, 43 BTA 1 (1940), acq. 1941-1 CB 11.
5. Rev. Rul. 56-18, 1956-1 CB 135.
6. Treas. Regs. §§1.104-1, 1.213-1(g); Rev. Rul. 78-292, 1978-2 CB 233.
7. See Rev. Rul. 78-292, above.
8. *Deming v. Comm.*, 9 TC 383 (1947), *acq.* 1948-1 CB 1.

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325. If benefits received for specific medical expenses exceed those expenses, must the excess be treated as reimbursement for other medical expenses?

Yes.

In computing net unreimbursed expenses for the medical expense deduction, total medical expense benefits received during the taxable year, whether received by a taxpayer or a service provider, must be subtracted from total medical expenses paid.[1] If reimbursements for the year equal or exceed medical expenses for the year, a taxpayer is not entitled to a medical expense deduction. Any excess reimbursement need not be included in a taxpayer's gross income unless the reimbursements are partially attributable to the contributions of the taxpayer's employer.[2]

326. What are domestic partner benefits and how are they taxed?

Domestic partner benefits are benefits that an employer voluntarily offers to an employee's unmarried partner. An employee's domestic partner may be of the same sex or the opposite sex. An employer determines the scope of its plan's definition of domestic partner.

After July 13, 2013, same-sex couples who were married in a state in which sex marriage is recognized (the state of "celebration") are considered spouses, regardless of where they live.[3]

Employers may offer a range of domestic partnership benefits, such as family, bereavement, sick leave, and relocation benefits. In general, most people mean employer-provided health insurance coverage when they speak of domestic partnership benefits.

An employee is taxed on the value of employer-provided health benefits for his or her domestic partner unless the domestic partner qualifies as the employee's dependent under IRC Section 151. The tax is determined by assessing the fair market value of the coverage provided to the domestic partner. This amount then is reported on the employee's W-2 form and is subjected to Social Security (FICA) and federal income tax withholding taxes.

Any amount received by a domestic partner as payment or reimbursement of plan benefits will not be included in the income of the employee or the domestic partner to the extent that the coverage provided to the domestic partner was paid for by the employee's plan contributions or the fair market value of the coverage was included in the employee's income under IRC Section 104(a)(3).[4]

Coverage of domestic partners, whether or not they qualify as dependents, under an employer-provided health plan will not otherwise affect the ability of employees to exclude amounts paid, directly or indirectly, by a plan to reimburse employees for expenses incurred for medical care of the employees, their spouses, and dependents.

1. Rev. Rul. 56-18, 1956-1 CB 135.
2. Rev. Rul. 69-154, 1969-1 CB 46.
3. *United States v. Windsor*, 133 S. Ct. 2675 (2013).
4. Let. Ruls. 200846001, 9850011, 9717018, 9603011. See also Let. Ruls. 9109060, 9034048. See also Field Service Advice 199911012.

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Cafeteria Plans and Flexible Spending Accounts – Contributions used to provide coverage for a non-dependent domestic partner are treated as taxable income. Benefits under flexible spending accounts may not be provided to a domestic partner because these accounts can include only nontaxable income (Q 3501).

COBRA – A domestic partner may not make an independent election for COBRA coverage, but may be part of an employee's election (Q 335 - Q 352).

HIPAA – Domestic partners who are not dependents are not covered by HIPAA, although employers providing health insurance to domestic partners may voluntarily include them in HIPAA certification procedures (Q 353).

Stockholder-Employees, Self-Employed Individuals

327. How are accident or health benefits taxed if they are provided by a closely held C corporation only to its stockholder-employees?

To provide tax-free coverage and benefits, an employer's accident or health plan must be for employees.[1] The same is true with respect to amounts received under a state's sickness and disability fund under IRC Section 105(e)(2).

The IRS can challenge tax benefits claimed under a plan that covers only stockholder-employees on the ground that the plan is not for employees. The underlying problem is in establishing that the stockholder-employees are covered as employees rather than as stockholders. If this cannot be established, then premiums or benefits are likely to be treated as constructive dividends. The premiums will be nondeductible by the corporation and the premium costs will have to be reported by the shareholder as dividend income to the extent of the corporation's earnings and profits.[2]

Courts have taken the position that the tax benefits of employer-provided health insurance are available in a plan that covers only stockholder-employees if the plan covers a class of employees that can be segregated rationally from other employees, if any, on a criterion other than their being stockholders.[3]

The *Bogene, Smith, Seidel*, and *Epstein* cases were decided in favor of taxpayers; the plans in all of them covered only active and compensated officers of the corporation who also were stockholders.

In *Smith* and *Seidel*, the officer-shareholders also were the only employees, but in *Bogene* and *Epstein* there were other employees who were not shareholders and who were not covered.

1. IRC Sec. 105(e).
2. *Levine v. Commissioner* 50 TC 422 (1968); and *Larkin v. Commissioner* 394 F.2d 494 (1st Cir. 1968).
3. *Bogene, Inc. v. Comm.*, TC Memo 1968-147; *Smith v. Comm.*, TC Memo 1970-243; *Seidel v. Comm.*, TC Memo 1971-238; *Epstein v. Comm.*, TC Memo 1972-53; *American Foundry v. Comm.*, 536 F2d 289, 76-1 USTC ¶9401 (9th Cir. 1976), acq. 1974-2 CB 1; *Charlie Sturgill Motor Co. v. Comm.*, TC Memo 1973-281; *Oleander Co., Inc. v. U.S.*, 50 AFTR 2d 82-5170, 82-1 USTC ¶9395 (E.D.N.C. 1981); *Giberson v. Comm.*, TC Memo 1982-338; *Est. of Leidy*, above; *Wigutow v. Comm.*, TC Memo 1983-620.

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The plan in *American Foundry* covered only two of five active officers of a family corporation and was held not to be a plan for employees.

The plan in *Sturgill* covered four officer-stockholders of a family corporation but two of the four were not active or compensated as officer-employees and the plan was held not to be one for employees.

The plan in *Leidy* covered only the president, who was the sole stockholder, and the vice president, who was no longer active in the company.

In *American Foundry* and in *Sturgill*, courts allowed the corporations to deduct reimbursement payments to the active officers as reasonable compensation, even though the payments were not excludable by shareholder-employees under IRC Section 105.

For situations involving S corporations, see Q 329.

328. How is health insurance coverage for partners and sole proprietors taxed?

Partners and sole proprietors are self-employed individuals, not employees, and the rules for personal health insurance apply (Q 323, Q 324). Partners and sole proprietors can deduct 100 percent of amounts paid during a taxable year for insurance that provides medical care for the individual, his or her spouse, and dependents during the tax year. The insurance can also cover a child who was under age 27 at the end of the tax year, even if the child did not qualify as the taxpayer's dependent. A child includes a taxpayer's son, daughter, stepchild, adopted child, or foster child. A foster child is any child placed with the taxpayer by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

Certain premiums paid for long-term care insurance are also eligible for this deduction (Q 431).[1]

The deduction is not available to a partner or sole proprietor for any calendar month in which he or she is eligible to participate in any subsidized health plan maintained by any employer of the self-employed individual or his or her spouse. This rule is applied separately to plans that include coverage for qualified long-term care services or are qualified long-term care insurance contracts (Q 424) and plans that do not include that coverage and are not those kinds of contracts.[2]

The deduction is allowable in calculating adjusted gross income and is limited to the self-employed individual's earned income for the tax year that is derived from the trade or business with respect to which the plan providing medical care coverage is established. Earned income is, in general, net earnings from self-employment with respect to a trade or business in which the personal services of the taxpayer are a material income producing factor. Other rules govern contributions made to a qualified retirement plan (Q 3829).

1. IRC Secs. 162(l), 213(d)(1).
2. IRC Sec. 162(l).

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Any amounts paid for this kind of insurance may not be taken into account in computing (1) the amount of a medical expense deduction under IRC Section 213, and (2) net-earnings from self-employment for the purpose of determining the tax on self-employment income.[1]

If a partnership pays accident and health insurance premiums for services rendered by partners in their capacity as partners and without regard to partnership income, premium payments are considered to be guaranteed payments under IRC Section 707(c). Thus, the premiums are deductible by the partnership under IRC Section 162, subject to IRC Section 263, and includable in partners' income under IRC Section 61. A partner may not exclude premium payments from income under IRC Section 106 but may deduct payments to the extent allowable under IRC Section 162(l), as discussed above.[2] For partners, a policy can be either in the name of the partnership or in the name of the partner. The partner can either pay the premiums him or herself, or the partnership can pay them and report the premium amounts on Schedule K-1 (Form 1065) as guaranteed payments to be included in the partner's gross income. However, if the policy is in the partner's name and the partner pays the premiums him or herself, the partnership must reimburse the partner and report the premium amounts on Schedule K-1 (Form 1065) as guaranteed payments to be included in the partner's gross income. Otherwise, the insurance plan will not be considered to be established under the business.

Reasoning that consumer medical cards that provide discounts on certain medical services and items are not an insurance product, the IRS has concluded that the cost of these cards purchased for partners is not deductible by partners under either IRC Section 162(l) or IRC Section 213.[3] (See Q 315).

Regarding the income tax consequences of a self-funded medical reimbursement plan set up by a partnership, the IRS has concluded that payments from a plan made to partners and their dependents are excludable from partners' income and premiums paid by partners for coverage under a self-funded plan are deductible, subject to the limits of IRC Section 162(l).[4]

There is no limit on the amount of benefits a partner or sole proprietor can receive tax-free.[5]

For tax treatment of business overhead disability insurance, see Q 362.

The IRS has ruled that coverage purchased by a sole proprietor or partnership for non-owner-employees, including an owner's spouse, is subject to the same rules that apply in any other employer-employee situation.[6]

The IRS has issued settlement guidelines that address whether a self-employed individual ("employer-spouse") may hire his or her spouse as an employee ("employee-spouse") and provide family health benefits to the employee-spouse, who then elects family coverage including

1. IRC Sec. 162(l).
2. Rev. Rul. 91-26, 1991-1 CB 184.
3. Let. Rul. 9814023.
4. Let. Rul. 200007025.
5. Rev. Rul. 56-326, 1956-2 CB 100; Rev. Rul. 58-90, 1958-1 CB 88.
6. Rev. Rul. 71-588, 1971-2 CB 91; TAM 9409006.

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the employer-spouse. Essentially, the IRS position is that if an employee-spouse is a bona fide employee, the employer-spouse may deduct the cost of the coverage and the value of the coverage also is excludable from the employee-spouse's gross income.

IRS agents are to use the settlement guidelines to closely scrutinize whether an employee-spouse qualifies as a bona fide employee; merely calling a spouse an employee is insufficient. Part-time employment does not negate employee status, but nominal or insignificant services that have no economic substance or independent significance will be challenged.[1]

329. How is health insurance coverage for S corporation shareholders taxed?

A shareholder-employee who owns more than 2 percent of the outstanding stock or voting power of an S corporation will be treated as a partner, not an employee. Attribution rules apply in determining the shareholder-employee's ownership interest.[2] Thus, accident and health insurance premium payments for more-than-2 percent shareholders paid in consideration for services rendered are treated as guaranteed payments made to partners. Therefore, an S corporation can deduct premiums under IRC Section 162 and a shareholder-employee must include premium payments in income under IRC Section 61 and cannot exclude them under IRC Section 106. A shareholder-employee then may deduct the cost of the premiums to the extent permitted by IRC Section 162(l), as discussed earlier.[3]

With respect to coverage purchased by an S corporation for employees not owning any stock and for shareholder-employees owning 2 percent or less of the outstanding stock or voting power, the same rules apply as in any other employer-employee situation (Q 315).

Health Reimbursement Arrangements

330. What is a Health Reimbursement Arrangement ("HRA") and how is it taxed?

According to IRS guidance, an HRA is an arrangement that (1) is solely employer-funded and not paid for directly or indirectly by salary reduction contributions under a cafeteria plan, and (2) reimburses employees for substantiated medical care expenses incurred by the employee and the employee's spouse and dependents, as defined in IRC Section 152, up to a maximum dollar amount per coverage period.

Unused amounts in an individual's account may be carried forward to increase the maximum reimbursement amount in subsequent coverage periods.[4] HRAs are not available for self-employed individuals.

1. IRS Settlement Guidelines, 2001 TNT 222-25 (Nov. 16, 2001); see also *Poyda v. Comm.*, TC Summary Opinion 2001-91.
2. IRC Sec. 1372.
3. Rev. Rul. 91-26, 1991-1 CB 184.
4. Notice 2002-45, 2002-2 CB 93; Rev. Rul. 2002-41, 2002-2 CB 75. See also IRS Publication 969 (2009) "Health Savings Accounts and Other Tax-Favored Health Plans."

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Employer-provided coverage and medical care reimbursement amounts under an HRA are excludable from an employee's gross income under IRC Section 106 and IRC Section 105(b), assuming all requirements for HRAs are met.[1]

For taxable years beginning after December 31, 2010, reimbursements for medicine are limited to doctor-prescribed drugs and insulin. After 2010, over-the counter medicines are not qualified expenses unless prescribed by a doctor.

According to Notice 2002-45, an HRA may not offer cash-outs at any time, even on termination of service or retirement; it may continue to reimburse former employees for medical care expenses after such events, however, even if the employee does not elect COBRA continuation coverage. An HRA is a group health plan and, thus, is subject to COBRA continuation coverage requirements (Q 335 to Q 352).

On a one-time basis, an HRA may make a qualified HSA distribution, that is, a rollover to a health savings account, of an amount not exceeding the balance in the HRA on September 21, 2006 (Q 381).[2]

HRAs may not be used to reimburse expenses incurred before the HRA was in existence or expenses that are deductible under IRC Section 213 for a prior taxable year. An unreimbursed claim incurred in one coverage period may be reimbursed in a later coverage period, so long as the individual was covered under the HRA when the claim was incurred.[3]

The IRS has approved the use of employer-issued debit and credit cards to pay for medical expenses as incurred provided that the employer requires subsequent substantiation of the expenses or has in place sufficient procedures to substantiate the payments at the time of purchase.[4]

An employee may not be reimbursed for the same medical care expense by both an HRA and an IRC Section 125 health FSA. Technically, ordering rules from the IRS specify that the HRA benefits must be exhausted before FSA reimbursements may be made. An HRA can be drafted to specify that coverage under the HRA is available only after expenses exceeding the dollar amount of an IRC Section 125 FSA have been paid. Thus, an employee could exhaust coverage, which generally may not be carried over, before tapping into the employee's HRA coverage, which can be carried over.[5] (Note that the IRS now allows a health FSA to be amended in order to allow up to $500 of unused amounts remaining at the end of a plan year to be paid or reimbursed to participants during the following plan year, provided the FSA does not also allow for a grace period, see Q 3514.)[6]

1. Notice 2002-45, 2002-2 CB 93; Rev. Rul. 2002-41, 2002-2 CB 75.
2. IRC Sec. 106(e).
3. Notice 2002-45, 2002-2 CB 93.
4. Notice 2006-69, 2006-31 IRB 107; Rev. Proc. 2003-43, 2003-21 IRB 935. See also Notice 2007-2, 2007-2 IRB 254.
5. Notice 2002-45, 2002-2 CB 93.
6. Notice 2013-71, 2013-47 IRB 532.

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Employer contributions to an HRA may not be attributable in any way to salary reductions. Thus, an HRA may not be offered under a cafeteria plan, but may be offered in conjunction with a cafeteria plan. Where an HRA is offered in conjunction with another accident or health plan funded pursuant to salary reductions, then a facts and circumstances test is used to determine if salary reductions are attributable to the HRA. If a salary reduction amount for a coverage period to fund a non-HRA accident or health plan exceeds the actual cost of the non-specified accident or health plan coverage, the salary reduction will be attributed to the HRA. An example of the application of this rule can be found in Revenue Ruling 2002-41.[1]

Because an HRA may not be paid for through salary reduction, the following restrictions on health FSAs are not applicable to HRAs:

(1) the ban against a benefit that defers compensation by permitting employees to carry over unused elective contributions or plan benefits from one plan year to another plan year;

(2) the requirement that the maximum amount of reimbursement must be available at all times during the coverage period;

(3) the mandatory twelve month period of coverage; and

(4) the limitation that medical expenses reimbursed must be incurred during the period of coverage.[2]

Withholding

331. Are wage continuation payments under an accident and health plan subject to withholding?

Employers or former employers must withhold tax from payments made to an employee for a period of absence from work due to injury or sickness. If an employer has shifted the insurance risk to an insurer or trust, no income tax need be withheld from wage continuation payments that an insurance company or a separate trust makes on behalf of the employer.[3]

Amounts paid as sick pay during a temporary absence under a plan to which the employer is a party may be withheld by a third party payor at the employee's request.[4]

Amounts paid by a third party are wages subject to mandatory withholding if the insurance risk is not shifted by the arrangement because the third party is acting as the employer's agent if the employer reimburses the insurance company or trust on a cost plus fee basis.[5]

1. 2002-2 CB 75.
2. Notice 2002-45, 2002-2 CB 93.
3. Treas. Reg. §31.3401(a)-1(b)(8); Rev. Rul. 77-89, 1977-1 CB 300.
4. IRC Sec. 3402(o); Treas. Reg. §31.3402(o)-3.
5. Treas. Reg. §31.3401(a)-1(b)(8).

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Social Security

332. Is employer-provided sick pay subject to Social Security and federal unemployment tax?

Preretirement wage continuation payments by an employer or an insurance company to an employee because of his or her sickness or disability are subject to Social Security tax (FICA) and federal unemployment tax (FUTA) for the first six calendar months after the last month in which the employee worked for the employer.

After six months, they are exempt from Social Security and federal unemployment tax.[1]

Payments or parts of payments attributable to employee contributions made to a sick pay plan with after tax dollars are not subject to Social Security or FUTA taxes.

Information Return

333. Must an employer with an accident or health plan file an information return with respect to the plan?

A plan that covers fewer than 100 employees on the first day of the plan year and is unfunded, fully insured, or a combination of unfunded and fully insured, is exempt from the requirement to file an annual Form 5500 report. All other plans must file a Form 5500.[2] Note that if the plan is subject to ERISA, the Form 5500 is filed with the Department of Labor (DOL).

IRC Section 6039D requires an employer maintaining any accident or health plan to file an annual information return with the IRS for years beginning after December 31, 1988. Until the issuance of further guidance, the IRS has indefinitely suspended the reporting requirements of IRC Section 6039D.[3]

If in effect, IRC Section 6039D would require the reporting of the number of an employer's employees, employees eligible to participate in the plan, employees actually participating in the plan, highly compensated employees ("HCEs"), HCEs eligible to participate in the plan, and HCEs actually participating in the plan.

The return also would report the cost of the plan, the identity of the employer, and the type of business in which the employer is engaged.[4]

334. What notices must an employer that maintains an accident or health plan provide to Medicare-eligible individuals?

Employers and plan sponsors that offer prescription drug coverage to individuals eligible for Medicare Part D must advise those individuals whether the offered coverage is creditable. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA),

1. IRC Secs. 3121(a)(4), 3306(b)(4).
2. Instructions to Form 5500, Annual Return/Report of Employee Benefit Plan, p. 3.
3. Notice 90-24, 1990-1 CB 335; Notice 2002-24, 2002-1 C.B. 785.
4. IRC Sec. 6039D.

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eligible individuals who do not enroll in Part D when first available, but who enroll later, have to pay higher premiums permanently unless they have creditable prescription drug coverage.

To determine that coverage is creditable, a sponsor need only determine that total expected paid claims for Medicare beneficiaries under the sponsor's plan will be at least equal to the total expected paid claims for the same beneficiaries under the defined standard prescription drug coverage under Part D.[1] The determination of creditable coverage status for disclosure purposes requires attestation by a qualified actuary who is a member of the American Academy of Actuaries.[2]

Applicants may use qualified outside actuaries, including (but not limited to) actuaries employed by the plan administrator or an insurer providing benefits under the plan. If an applicant uses an outside actuary, the attestation can be submitted directly by the outside actuary or by the plan sponsor.[3]

The Center for Medicare & Medicaid Studies (CMS) has issued guidance to assist sponsors in making the determination that coverage is creditable. If the total expected claims requirement stated above is met, then the following types of coverage are considered creditable:[4]

(1) Coverage for prescription drugs under a PDP or MA-PD plan;

(2) Medicaid coverage under Title XIX of the MMA;

(3) Coverage under certain group health plans, such as the federal employee health benefits program and qualified retiree prescription drug plans;

(4) State Pharmaceutical Assistance Programs coverage;

(5) Prescription drug coverage for veterans, survivors, and dependents;

(6) Coverage for Medicare supplemental policies;

(7) Military coverage;

(8) Individual health insurance coverage that includes outpatient prescription drug coverage but is not an excepted benefit under the Public Health Service Act;

(9) Coverage provided by certain Indian or Tribal medical care programs;

(10) Coverage provided by a PACE organization;

(11) Coverage provided by a cost-based HMO or CMP;

(12) Coverage provided through a state high-risk pool; and

(13) Other coverage as deemed appropriate by federal regulators.

1. 42 CFR §423.884(d).
2. 42 CFR §423.884(d)(2).
3. 42 CFR §423.884(d)(2).
4. 42 CFR §423.56(b).

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Under CMS guidance, once a sponsor determines whether coverage is creditable, the sponsor must provide notice to all Part D-eligible individuals covered by or applying for the plan, including Part D-eligible dependents. In lieu of determining who is Part D eligible, an employer sponsor may provide notice to all active employees, along with an explanation of why the notice is being provided.

The required notice to beneficiaries must, at a minimum:

(1) Contain a statement that the employer has determined that the coverage is creditable or not creditable;

(2) Explain the limits on the periods in a year when individuals can enroll in Part D plans; and

(3) Explain that the individual may incur late enrollment penalties.[1]

The CMS guidance includes model initial notices that a sponsor may choose to use. Sponsors were required to provide initial notices to beneficiaries by November 15, 2005. CMS later issued updated guidance with model notices for use following the May 15, 2006 close of the initial enrollment period for Medicare Part D.

Following the initial enrollment period, sponsors must, at a minimum, provide the required notice to beneficiaries:

(1) Prior to an individual's initial enrollment period for the Medicare prescription drug benefit;

(2) Prior to the effective date of enrolling in the sponsor's plan and on any change that affects whether the coverage is creditable prescription drug coverage;

(3) Prior to the commencement of the annual coordinated election period that begins on October 15 of each year; and

(4) On beneficiary request.

The final regulation does not specify a specific time limit within which disclosure must be provided; it only requires that it be provided prior to any of the above events.[2]

Sponsors also must disclose to CMS annually whether coverage is creditable and any change that affects whether the coverage is creditable. CMS has outlined the requirements for this disclosure in separate guidance and provides disclosure forms on its website at http://www.cms.hhs.gov/CreditableCoverage.[3]

1. 42 CFR §423.56(d).
2. 42 CFR §423.56(f).
3. 42 CFR §423.56(e).

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COBRA Continuation Coverage Requirements

335. What are the coverage continuation or COBRA requirements that certain group health plans must meet?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers. See "Temporary COBRA Premium Assistance under ARRA 2009," Q 336.

An insured or self-funded group health plan maintained by an employer to provide health care, directly or otherwise, to the employer's employees, former employees, or their families generally must offer COBRA continuation coverage. Certain plans are exempt from the COBRA continuation coverage rules (Q 339). Insured plans are not only those providing coverage under group policies, but include any arrangement to provide health care to two or more employees under individual policies. A plan is an employer provided health plan if the plan's coverage would be unavailable at the same cost to individuals absent the individual's employment-related connection with the employer; it is immaterial whether the employer makes contributions to the plan on behalf of its employees.[1]

COBRA generally does not require plan sponsors to offer continuation coverage for disability income coverage.[2] For contracts issued after 1996, the COBRA requirements do not apply to plans under which substantially all of the coverage is for qualified long-term care services. A plan may use any reasonable method to determine whether substantially all of the coverage under the plan is for qualified long-term care services.

Additionally, amounts contributed by an employer to an HSA or an Archer MSA (Q 369, Q 387) are not considered part of a group health plan subject to COBRA continuation requirements.[3]

Employer-sponsored health care plans subject to COBRA requirements must provide that if, as a result of a qualifying event, any qualified beneficiary would lose coverage under the plan, the qualified beneficiary must be entitled to elect, within the election period, continuation coverage under the plan.[4]

Further, a group health plan generally will not meet the COBRA requirements unless the plan's coverage of the cost of pediatric vaccines is not reduced below the coverage provided by the plan as of May 1, 1993.[5]

Continuation Coverage Defined

COBRA continuation coverage must consist of coverage identical to that provided under the plan to similarly situated beneficiaries with respect to whom a qualifying event has not

1. IRC Sec. 4980B(g)(2); Treas. Reg. §54.4980B-2, A-1.
2. *Austell v. Raymond James & Assoc., Inc.*, 120 F.3d 32 (4th Cir. 1997).
3. IRC Sec. 4980B(g)(2); Treas. Reg. §54.4980B-2, A-1.
4. IRC Sec. 4980B(f)(1); Treas. Reg. §54.4980B-1, A-1.
5. IRC Sec. 4980B(f)(1).

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occurred. Any modification of coverage for similarly situated beneficiaries also must apply in the same manner for all COBRA qualified beneficiaries.[1]

A case brought under the COBRA provisions of ERISA held that an employer did not meet its obligation to offer continuation coverage where the only health plan available to a qualified beneficiary following the insolvency of a self-insured multiemployer trust under which the beneficiary originally had elected COBRA coverage was a geographically-restrictive HMO that did not provide service in the area of the beneficiary's residence.[2]

Qualified beneficiaries electing COBRA coverage generally are subject to the same deductibles as similarly situated non-COBRA beneficiaries. Amounts accumulated toward deductibles, plan benefits, and plan cost limits prior to a qualifying event are carried over into the COBRA continuation coverage period.[3]

A qualified beneficiary electing COBRA continuation coverage need not be given the opportunity to change coverage from the type he or she was receiving prior to the qualifying event, even where the coverage is of lesser or no value to the qualified beneficiary, except in two situations.

First, if a qualified beneficiary was participating in a region-specific plan that does not provide services in the region to which the beneficiary is relocating, the beneficiary must be able, within a reasonable period after requesting other coverage, to elect the alternative coverage that the employer or employee organization makes available to active employees. An employer or employee organization is not required to make any other coverage available to a relocating qualified beneficiary if the only coverage that the employer makes available to active employees is not available in the area where the qualified beneficiary is relocating.

Second, if an employer or employee organization makes an open enrollment period available to similarly situated active employees, the same open enrollment period rights must be offered to each qualified beneficiary receiving COBRA coverage.[4]

336. What special rules apply to provide COBRA premium assistance under legislation enacted in 2009 and 2010?

Ordinarily, if an unemployed worker elects to receive COBRA continuation coverage, the percentage of the applicable premium that may be charged can be as high as 102 percent (Q 347). In February 2009, Congress enacted temporary relief to help scores of unemployed workers maintain their health insurance coverage by making it more affordable.[5] Essentially a 65 percent subsidy or premium assistance was available for COBRA continuation coverage premiums for certain workers who have been involuntarily terminated as the result of a COBRA qualifying

1. IRC Sec. 4980B(f)(2).
2. *Coble v. Bonita House, Inc.*, 789 F. Supp. 320 (N. D. Cal. 1992).
3. Treas. Reg. §54.4980B-5, A-2, A-3.
4. Treas. Reg. §54.4980B-5, A-4.
5. Sec. 3001 of ARRA 2009 (P.L. 115-5).

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event occurring during the period from September 1, 2008, through May 31, 2010, as extended under the Continuing Extension Act of 2010.

An assistance eligible individual was eligible for the premium reduction for up to fifteen months as extended under the Department of Defense Appropriations Act of 2010 from the first month the premium reduction provisions applied to the individual. The premium reduction ended if the individual became eligible for coverage under any other group health plan or for Medicare benefits.[1]

Reduced Premium Amount

In the case of any premium for a period of coverage beginning on or after February 17, 2009, an assistance eligible individual was treated for purposes of any COBRA continuation provision as having paid the amount of such premium if the individual paid 35 percent of the amount of the premium, determined without regard to the premium assistance provision.[2] The employer was reimbursed for the other 65 percent of the premium that was not paid by the assistance eligible individual through a credit against its payroll taxes.[3]

The premium used to determine the 35 percent share that must have been paid by or on behalf of an assistance eligible individual was the cost that would be charged to him or her for COBRA continuation coverage if the individual were not an assistance eligible individual. Thus, if without regard to the subsidy an assistance eligible individual was required to pay 102 percent of the applicable premium for continuation coverage, that is, the maximum generally permitted under COBRA rules, the assistance eligible individual was then required to pay only 35 percent of the 102 percent of the applicable premium.

If the premium that would be charged to the assistance eligible individual was less than the maximum COBRA premium, for example, if the employer subsidized the coverage by paying all or part of the cost, then the amount actually charged to the assistance eligible individual was used to determine the assistance eligible individual's 35 percent share.[4]

In determining whether an assistance eligible individual had paid 35 percent of the premium, payments made on behalf of the individual by another person, other than an employer with respect to which an involuntary termination occurred, were taken into account; for example, by a parent, guardian, state agency, or charity.[5]

Premium Reduction Period

The premium reduction applied as of the first period of coverage beginning on or after February 17, 2009 for which the assistance eligible individual was eligible to pay only 35 percent of the premium, as determined without regard to the premium reduction, and still be treated

1. Sec. 3 of the Continuing Extension Act of 2010; Sec. 1010 of the Department of Defense Appropriations Act of 2009; Sec. 3001(a) of ARRA 2009; Notice 2009-27, 2009-16 IRB 838; IRS News Release IR-2010-52 (4-26-2010).
2. Sec. 3001(a)(1)(A) of ARRA 2009; Notice 2009-27, 2009-16 IRB 838.
3. See IRC Sec. 6432(c), as added by ARRA 2009; Notice 2009-27, 2009-16 IRB 838.
4. Notice 2009-27, 2009-16 IRB 838, Q&A 20.
5. Notice 2009-27, 2009-16 IRB 838, Q&A 20.

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as having made full payment. For this purpose, a period of coverage was a monthly or shorter period with respect to which premiums are charged by the plan with respect to such coverage.[1]

The premium reduction applied until the earliest of:

(1) the first date the assistance eligible individual became eligible for other group health plan coverage, with certain exceptions, or Medicare coverage;

(2) the date that was fifteen months (under the Department of Defense Authorizations Act of 2010; it was nine months under ARRA 2009) after the first day of the first month for which the ARRA premium reduction provisions applied to the individual; or

(3) the date the individual ceased to be eligible for COBRA continuation coverage.[2]

Coverage Eligible for Premium Reduction

The premium reduction was available for COBRA continuation coverage of any group health plan, except a flexible spending arrangement ("FSA") offered under a cafeteria plan, including vision-only and dental-only plans as well as mini-med plans. The premium reduction was not available for continuation coverage offered by employers for non-health benefits that were not subject to COBRA continuation coverage, for example, group life insurance.[3]

Retiree health coverage could have been treated as COBRA continuation coverage for which the premium reduction was available only if the retiree coverage did not differ from the coverage made available to similarly situated active employees. The amount charged for the coverage could be higher than that charged to active employees and the retiree coverage still may have been eligible for the ARRA premium reduction so long as the charge to retirees did not exceed the maximum amount allowed under federal COBRA.[4]

The premium reduction also was available for COBRA continuation coverage under a health reimbursement arrangement ("HRA"). Although an HRA may qualify as an FSA, the exclusion of FSAs from the premium reduction was limited to FSAs provided through a cafeteria plan, which would not include an HRA.[5]

Premium Reduction Extension under DDAA 2010

The Department of Defense Appropriations Act of 2010 ("DDAA 2010") amended ARRA 2009 by extending the period to qualify for the COBRA premium reduction until February 28, 2010, a period further extended to May 31, 2010, under the Continuing Extension Act of 2010, and extending the maximum period for receiving the subsidy an additional six months (from nine to fifteen months).[6]

1. Notice 2009-27, 2009-16 IRB 838, Q&A 30.
2. Notice 2009-27, 2009-16 IRB 838, Q&A 33; see Sec. 1010, DDAA 2010 and Sec. 3001(a)(2)(A) of ARRA 2009.
3. Notice 2009-27, 2009-16 IRB 838, Q&A 27.
4. Notice 2009-27, 2009-16 IRB 838, Q&A 28.
5. Notice 2009-27, 2009-16 IRB 838, Q&A 29.
6. Sec. 3001(a)(3)(A) of ARRA 2009, as amended by Sec. 1010(a) of DDAA 2010; Sec. 3001(a)(2)(A)(ii)(I) of ARRA 2009, as amended by Sec. 1010(b) of DDAA 2010.

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Assistance eligible individuals who have reached the end of the original premium reduction period were in a transition period which gave them additional time to pay extension-related reduced premiums.[1] An individual's transition period was the period that began immediately after the end of the maximum number of months, which generally is nine, of premium reduction available under ARRA prior to its amendment. An individual was in a transition period only if the premium reduction provisions would continue to apply due to the extension from nine to fifteen months and they otherwise remain eligible for the premium reduction.[2] These individuals must have been provided a notice of the extension within sixty days of the first day of their transition period.[3] The retroactive payment or payments for the period or periods of coverage must have been made by the later of February 17, 2010, or thirty days from when the notice was provided.[4]

DOL Procedure for Denial of Premium Reduction

The Department of Labor has issued a fact sheet entitled "COBRA Premium Reduction" that explains its expedited review of denials of premium reduction. The DOL states that individuals, who are denied treatment as assistance eligible individuals and, thus, are denied eligibility for the premium reduction, whether by their plan, employer, or insurer, may request an expedited review of the denial by the DOL. The DOL must make a determination within fifteen business days of receipt of a completed request for review. The official application form[5] can be filed online or submitted by fax or mail.

337. Who is eligible for the temporary COBRA premium assistance made available under legislation enacted in 2009 and 2010?

Under the temporary COBRA premium assistance rules enacted in 2009 and 2010, an assistance eligible individual meant any qualified beneficiary if:

(1) the qualified beneficiary was eligible for COBRA continuation coverage related to a qualifying event occurring during the period that began with September 1, 2008, and ended with May 31, 2010, under the Continuing Extension Act of 2010;

(2) the qualified beneficiary elected such coverage; and

(3) the qualifying event with respect to the COBRA continuation coverage consisted of an involuntary termination of the covered employee's employment and occurred during such period.[6]

If an assistance eligible individual who was receiving the premium reduction became eligible for coverage under any other group health plan or Medicare, the individual was required to

1. See Sec. 3001(a)(16)(C) of ARRA 2009, as added by Sec. 1010(c) of DDAA 2010.
2. See Sec. 3001(a)(16)(C)(i) of ARRA 2009, as added by Sec. 1010(c) of DDAA 2010.
3. See Sec. 3001(a)(16)(D) of ARRA 2009, as added by DDAA 2010.
4. See Sec. 3001(a)(16)(A)(ii) of ARRA 2009, as added by Sec. 1010(c) of DDAA 2010.
5. Available at: www.dol.gov/COBRA.
6. Sec. 3 of the Continuing Extension Act of 2010; Sec. 1010(a) of the Department of Defense Appropriations Act of 2010; Sec. 3001(a)(3)(C) of ARRA 2009; Notice 2009-27, 2009-16 IRB 838, Q&A 10; IRS News Release IR-2010-52 (4-26-2010).

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notify the group health plan in writing. The notice must have been provided to the group health plan in the time and manner specified by the Department of Labor ("DOL").[1] A person who was required to notify a group health plan but failed to do so was required to pay a penalty of 110 percent of the premium reduction improperly received after eligibility for the other coverage. No penalty was imposed with respect to any failure if it was shown that the failure was due to reasonable cause and not to willful neglect.[2]

Involuntary Termination

According to the IRS, an involuntary termination is:

(1) a severance from employment that is due to the independent exercise of the unilateral authority of the employer to terminate the employment;

(2) other than due to the employee's implicit or explicit request;

(3) where the employee was willing and able to continue performing services.[3]

Thus, an involuntary termination may include an employer's failure to renew a contract at the time the contract expires if the employee was willing and able to execute a new contract providing terms and conditions similar to those in the expiring contract and to continue providing the services. It also may include an employee-initiated termination from employment if the termination constitutes a termination for good reason due to employer action that causes a material negative change in the employment relationship for the employee.[4]

The IRS cautions that an involuntary termination is the involuntary termination of employment, not the involuntary termination of health coverage. Consequently, qualifying events other than an involuntary termination, for example, divorce or a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan, such as loss of dependent status due to aging out of eligibility, are not involuntary terminations qualifying an individual for the premium reduction.[5]

Involuntary termination generally includes the following:

(1) A lay-off period with a right of recall or a temporary furlough period (i.e., an involuntary reduction to zero hours resulting in a loss of health coverage);[6]

(2) An employer's action to end an individual's employment while the individual is absent from work due to illness or disability. Mere absence from work due to illness or disability before the action to end the individual's employment status is not an involuntary termination;[7]

1. Sec. 3001(a)(2)(C) of ARRA 2009; Notice 2009-27, 2009-16 IRB 838.
2. IRC Sec. 6720C, as added by ARRA 2009; Notice 2009-27, 2009-16 IRB 838.
3. Notice 2009-27, 2009-16 IRB 838, Q&A 1.
4. Notice 2009-27, 2009-16 IRB 838, Q&A 1.
5. Notice 2009-27, 2009-16 IRB 838, Q&A 1.
6. Notice 2009-27, 2009-16 IRB 838, Q&A 2.
7. Notice 2009-27, 2009-16 IRB 838, Q&A 4.

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(3) Retirement, if the facts and circumstances indicate that, absent retirement, the employer would have terminated the employee's services and the employee had knowledge that he or she would be terminated;[1]

(4) An involuntary termination for cause is considered to be an involuntary termination. For purposes of COBRA, if a termination of employment is due to gross misconduct of an employee, then the termination is not a qualifying event and the employee therefore is not eligible for COBRA continuation coverage;[2]

(5) A resignation as the result of a material change in the geographic location of employment for the employee;[3] and

(6) A buy-out, that is, a termination elected by the employee in return for a severance package, where the employer indicates that after the offer period for the severance package, a certain number of remaining employees in the employee's group will be terminated.[4]

Involuntary termination does not include the following:

(1) The death of an employee;[5]

(2) A mere reduction in hours (i.e., not a reduction to zero hours);[6] and

(3) A work stoppage as the result of a strike initiated by employees or their representatives, although a lockout initiated by an employer is an involuntary termination.[7]

The determination of whether a termination is involuntary or not is based on all the facts and circumstances. For example, if a termination is designated as voluntary or as a resignation, but the facts and circumstances indicate that absent the voluntary termination, the employer would have terminated the employee's services, and the employee had knowledge that the employee would be terminated, the termination then is considered to be involuntary.[8]

338. What are the tax implications of any premium reductions under the COBRA premium assistance rules?

The amount of any COBRA premium reduction taken under the special rules enacted in 2009 and 2010 (see Q 336 and Q 337) was excluded from an individual's gross income.[9] If the premium reduction was provided with respect to any COBRA continuation coverage that covered an individual, the individual's spouse, or the individual's dependent, and the individual's modified

1. Notice 2009-27, 2009-16 IRB 838, Q&A 5.
2. Notice 2009-27, 2009-16 IRB 838, Q&A 6.
3. Notice 2009-27, 2009-16 IRB 838, Q&A 7.
4. Notice 2009-27, 2009-16 IRB 838, Q&A 9.
5. Notice 2009-27, 2009-16 IRB 838, Q&A 1.
6. Notice 2009-27, 2009-16 IRB 838, Q&A 3.
7. Notice 2009-27, 2009-16 IRB 838, Q&A 8.
8. Notice 2009-27, 2009-16 IRB 838, Q&A 1.
9. IRC. Sec. 139C, as added by ARRA 2009. See also Notice 2009-27, 2009-16 IRB 838, 839.

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adjusted gross income, that is, the adjusted gross income plus amounts excluded under IRC Sections 911, 931, or 933, exceeds $145,000, or $290,000 for married couples filing jointly, then the amount of the premium reduction is recaptured as an increase in the individual's federal income tax liability.[1] The recapture is phased in for individuals with a modified adjusted gross income in excess of $125,000, or $250,000 for married couples filing jointly.[2] An individual may elect to permanently waive the right to the premium reduction, for example, to avoid receiving and then repaying the premium reduction.[3]

339. Are all employers subject to COBRA continuation coverage requirements?

No.

Church plans, as defined in IRC Section 414(e), governmental plans, as defined in IRC Section 414(d), and small-employer plans generally are not subject to COBRA continuation coverage requirements, although there are temporary rules applicable to small employers under the American Recovery and Reinvestment Act of 2009 ("ARRA").[4] ARRA provides a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 335) and also applies to small employers if health care continuation coverage is required by a state.[5]

A small-employer plan is defined as a group health plan maintained by an employer that normally employed fewer than twenty employees during the preceding calendar year on a typical business day.[6] Under final regulations, an employer is considered to have employed fewer than twenty employees during a calendar year if it had fewer than twenty employees on at least 50 percent of its typical business days during that year. Only common law employees are taken into account for purposes of the small-employer exception. Self-employed individuals, independent contractors, and directors are not counted. In the case of a multiemployer plan, a small-employer plan is a group health plan under which each of the employers contributing to the plan for a calendar year normally employed fewer than twenty employees during the preceding calendar year.[7]

340. What is a qualifying event for purposes of COBRA continuation coverage requirements?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 336).

A qualifying event is any of the following events that, but for the required COBRA continuation coverage, would result in the loss of coverage of a covered employee or a spouse or dependent child of a covered employee under the plan:

1. See Sec. 3001(b)(1), ARRA 2009. See also Notice 2009-27, 2009-16 IRB 838, 839.
2. See Sec. 3001(b)(2), ARRA 2009. See also Notice 2009-27, 2009-16 IRB 838, 839.
3. See Sec. 3001(b)(3), ARRA 2009. See also Notice 2009-27, 2009-16 IRB 838, 839.
4. IRC Sec. 4980B(d).
5. Sec. 3001(a)(10)(B) of ARRA 2009.
6. IRC Sec. 4980B(d).
7. Treas. Reg. §54.4980B-2, A-5.

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(1) Death of a covered employee;

(2) Voluntary or involuntary termination for reasons other than a covered employee's gross misconduct (Q 342) or reduction in hours of a covered employee's employment;

(3) Divorce or legal separation of a covered employee;

(4) A covered employee becoming entitled to Medicare benefits;

(5) A dependent child ceasing to be a dependent child for purposes of a plan; and

(6) A proceeding under the federal bankruptcy law with respect to an employer from whose employment the covered employee retired at any time.[1]

Taking a leave under the Family and Medical Leave Act of 1993 (FMLA) is not a qualifying event. A qualifying event does occur when an employee is covered under an employer's group health plan the day before beginning an FMLA leave, the employee does not come back to work at the end of the leave, and the employee would lose coverage under the plan (other than under the COBRA continuation coverage) before the end of what would be the maximum coverage period. The same is true for a spouse or dependent child of the employee. The date that such a qualifying event occurs is the last day of the employee's FMLA leave, and the period of maximum coverage is measured from this day.[2]

If an employer eliminates coverage for a class of employees to which an employee on FMLA leave would otherwise have belonged on or before the last day of the employee's FMLA leave, there is no qualifying event.

A qualifying event can occur even if an employee does not pay the employee's share of the premiums for coverage under a group health plan during an FMLA leave, or even if an employee declined coverage during FMLA leave.[3] Further, COBRA continuation coverage may not be conditioned on an employee reimbursing an employer for premiums paid by the employer for group health plan coverage during an FMLA leave taken by the employee.[4]

There is no qualifying event where, following a termination of employment, a loss of coverage does not occur until after the end of what would have been the maximum period of COBRA continuation coverage.[5]

341. Under what circumstances do employees serving in the military receive COBRA-like health insurance coverage continuation?

The call to active military duty of reserve personnel has been characterized as a qualifying event by the IRS. Although not specifically stated, the event presumably is a reduction in hours.[6]

1. IRC Sec. 4980B(f)(3); Treas. Reg. §54.4980B-4, A-1.
2. Treas. Reg. §54.4980B-10, A-1, A-2.
3. Notice 94-103, 1994-2 CB 569.
4. Treas. Reg. §54.4980B-10, A-1, A-3, A-5.
5. *Williams v. Teamsters Local Union No. 727*, Case No. 03 C 2122, 2003 US Dist. LEXIS 18906 (N.D. Ill., 10-22-03).
6. Notice 90-58, 1990-2 CB 345.

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Employees serving in the uniformed services are entitled to COBRA-like continuation health coverage under the Uniformed Services Employment and Reemployment Rights Act[1] regardless of whether the employer is otherwise exempt from COBRA's continuation coverage requirements. Consequently, employers with fewer than 20 employees must provide continuation benefits to service members even in the absence of an obligation to do so under COBRA. The Veteran's Benefit Improvement Act of 2004 increased the period for which the employee may elect from 18 to 24 months. This extension applies to all continuation elections made after December 10, 2004.

342. What is gross misconduct for the purposes of disqualifying an employee and the employee's beneficiaries from COBRA health insurance continuation requirements?

If a covered employee's employment is terminated for gross misconduct, no COBRA continuation coverage is available to the employee or to the employee's qualified beneficiaries.[2] If an employer fails to notify an employee at the time of the employee's termination that the termination is on account of gross misconduct, its ability to deny COBRA coverage may be undermined.[3]

The fact that an employer has grounds to terminate an employee for gross misconduct does not support a denial of COBRA coverage if the employee voluntarily resigns to avoid being fired. An allegation of gross misconduct after a voluntary termination cannot be used to evade liability where an employer has not properly processed a COBRA election and the carrier refuses to extend coverage.[4]

The Seventh Circuit Court of Appeals decided that it is not sufficient that an employer believed, in good faith, that an employee had engaged in gross misconduct. The district court had held that the proper test is not whether an employee actually engaged in gross misconduct but whether the employer believed in good faith that the employee had. The appeals court held that COBRA requires more than a good faith belief by an employer and that an employee should have been given the chance to demonstrate that the employer was mistaken and thus obtain COBRA rights.[5]

An insurance carrier is bound by an employer's determination and cannot decline COBRA coverage merely because the employer might have been entitled to terminate the employee on grounds of gross misconduct.[6]

Case Law Examples

The term "gross misconduct" is not specifically defined in COBRA or in regulations under COBRA. Therefore, whether a terminated employee has engaged in "gross misconduct" that will

1. USERRA, 38 USC Sec. 4317(a).
2. IRC Sec. 4980B(f)(3)(B); ERISA Sec. 603(2).
3. *Mlsna v. Unitel Com.*, Inc., 91 F.3d 876 (7th Cir. 1996).
4. *Conery v. Bath Assoc.*, 803 F. Supp. 1388 (N.D. Ind. 1992).
5. *Kariotis v. Navistar Int'l Transp. Corp.*, 131 F.3d 672 (7th Cir. 1997).
6. *Conery v. Bath Assoc.*, 803 F. Supp. 1388 (N.D. Ind. 1992).

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justify a plan not offering COBRA to that former employee and family members will depend on the specific facts and circumstances. Generally, it can be assumed that being fired for most ordinary reasons, such as excessive absences, or generally poor performance, does not amount to "gross misconduct."[1]

The IRS has announced that it will not issue rulings on whether an action constitutes gross misconduct for COBRA purposes.[2] For these reasons, the concept of gross misconduct has been developed through case law.

Some courts have provided a standard by which conduct can be judged, finding that conduct is gross misconduct if it is so outrageous that it shocks the conscious;[3] that gross misconduct may be intentional, wanton, willful, deliberate, reckless or in deliberate indifference to an employer's interest;[4] or that gross misconduct is conduct evincing such willful or wanton disregard of an employer's interests as is found in deliberate violation or disregard of standards of behavior which the employer has the right to expect of his or her employee.[5]

Some more specific examples follow.

Mere incompetence is not gross misconduct.[6]

One court has held that breach of a company confidence did not constitute "gross misconduct."[7]

An employee did not engage in gross misconduct by falsifying mileage reports, failing to attend mandatory meetings, and receiving an unsolicited offer of employment.[8]

Under a state law definition of gross misconduct, an employee who admitted stealing an employer's merchandise was considered to have been terminated for gross misconduct and, thus, was not entitled to COBRA continuation coverage.[9]

Cash handling irregularities, invoice irregularities, and the failure to improve the performance of one of an employer's stores was held to be gross misconduct.[10]

In a case where a court concluded that Congress left the definition of gross misconduct up to employers, two employees who had been terminated for refusing to comply with directions of a supervisor were considered to have been terminated for gross misconduct.[11]

1. U.S. Department of Labor Health Benefits Advisor Glossary, Office of Compliance Assistance Policy.
2. Rev. Proc. 2014-3, 2014-1 IRB 111, updating and revising Rev. Proc. 2011-3, 2011-1 IRB 111 and Rev. Proc. 2008-3, 2008-1 CB 561 (stating that gross misconduct definition will not be issued).
3. *Zickafoose v. UBServs., Inc.* 23 F.Supp.2d 652, 654 (S.D.W. Va. 1998).
4. *Collins v. Aggreko, Inc.* 884 F.Supp. 450, 454 (D. Utah 1995).
5. *Paris v. F. Korbel & Btos., Inc.*, 751 F.Supp. 834, 838 (N.D. Cal. 1990).
6. *Mlsna v. Unitel Com., Inc.*, 91 F.3d 876 (7th Cir. 1996).
7. *Paris v. F. Korbel & Bros., Inc.*, 751 F. Supp. 834 (N.D. Cal. 1990).
8. *Cabral v. The Olsten Corp.*, 843 F. Supp. 701 (M.D. Fla. 1994).
9. *Burke v. American Stores Employee Benefit Plan*, 818 F. Supp. 1131 (N.D. Ill. 1993).
10. *Avina v. Texas Pig Stands, Inc.*, 1991 U.S. Dist. LEXIS 13957 (W.D. Tex. 1991).
11. *Bryant v. Food Lion, Inc.*, 100 F. Supp.2d 346 (D. S.C. 2000).

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A bank employee who cashed a fellow employee's check knowing there were insufficient funds to satisfy it and held the check in her cash drawer until the check could be covered was held to have been terminated for gross misconduct.[1]

A bank employee's violation of a bank's corporate credit card policy and blatant misrepresentation concerning a small loan application to a federal agency constituted gross misconduct.[2]

In some cases, conduct was egregious. One court held that a security guard who "deserted his post … and was found asleep at his residence" and falsified records, creating a fictional guard to collect another paycheck, was terminated for gross misconduct.[3]

Throwing an apple at a co-worker and uttering racial slurs was found to be gross misconduct.[4]

Misconduct need not take place on the job to constitute gross misconduct. Off-duty behavior also may eliminate an employee's right to elect COBRA coverage. Gross misconduct was found where an employee assaulted a subordinate with whom the employee was having a romantic relationship while away from the workplace.[5]

Having an accident while driving a company vehicle under the influence of alcohol and on company business constituted gross misconduct, even though it was a misdemeanor offense under state law.[6]

343. For how long must COBRA continuation coverage generally be provided?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 337). This subsidy ended May 31, 2010.

COBRA continuation coverage must be provided from the date of a qualifying event until the earliest of any of the following events:

1. the passage of the maximum required period of coverage;
2. the date the employer ceases to provide any group health plan to any employee;
3. the date coverage ceases under the plan by reason of a failure to make timely payment of the applicable premium (Q 347);
4. the date the qualified beneficiary first becomes covered as an employee or otherwise after the date of the election under any other plan providing health care that does not contain any exclusion or limit with respect to any pre-existing condition of the beneficiary other than an exclusion or limitation that does not apply to, or

1. *Moffitt v. Blue Cross & Blue Shield Miss.*, 722 F. Supp. 1391 (N.D. Miss. 1989).
2. *Johnson v. Shawmut Nat'l Corp.*, 1994 U.S. Dist. LEXIS 19437 (D. Mass, 1994).
3. *Adkins v. United Int'l Investigative Servs, Inc.*, 1992 U.S. Dist. LEXIS 4719 (N.D. Calif. 1992).
4. *Nakisa v. Continental Airlines*, 26 EBC 1568 (S.D. Texas 2001).
5. *Zickafoose v. UB Servs., Inc.*, 23 F. Supp.2d 652 (S.D.W.V. 1998).
6. *Collins v. Aggreko, Inc.*, 884 F. Supp. 450 (D. Utah 1995).

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is satisfied by, the beneficiary by reason of the portability, access, and renewability requirements for group health plans found in the IRC as well as in similar sections of ERISA and the Public Health Service Act (Q 353 to Q 359);

5. the date the qualified beneficiary, other than a retired covered employee or a spouse, surviving spouse, or dependent child of the covered employee, first becomes entitled to Medicare benefits after the date of the election; or

6. in the case of a qualified beneficiary who is disabled at any time during the first sixty days of continuation coverage, the month that begins more than thirty days after the date when the Social Security Administration has made a final determination under Title II or XVI of the Social Security Act that the beneficiary is no longer disabled.[1]

Applying a strict reading of IRC Section 4980B(f)(2)(B), the U.S. Supreme Court found that an employee whose employment has been terminated is eligible to elect COBRA continuation coverage under the employee's former employer's group health plan despite the fact that the employee also had coverage under another plan offered by the employee's spouse's employer at the time the employee's employment was terminated. In effect, the Court concluded that an employee with coverage under another plan at the time of termination of employment does not fall within the requirement that the qualified beneficiary first becomes, after the date of the election, covered under any other medical care plan.[2]

A federal government plan is not considered another plan providing health care for this purpose, because the federal government is not an employer under IRC Section 5000(d). Thus, eligibility for a federal government group health plan will not terminate COBRA continuation coverage.[3]

Being entitled to Medicare benefits is defined not as mere eligibility for benefits, but as actual enrollment in either Part A or Part B of Medicare.[4] Entitlement to Medicare benefits will not terminate the obligation to provide continuation coverage to qualified beneficiaries entitled to continuation coverage by virtue of a proceeding in a case under the federal bankruptcy law. See Q 344 for a detailed discussion of the exceptions to the maximum required period of coverage.

344. What is the maximum required period of COBRA continuation coverage? Are there any exceptions to this required maximum period?

The general maximum required period of coverage is thirty-six months from the date of a qualifying event.[5] There are significant exceptions.

1. IRC Sec. 4980B(f)(2)(B).
2. *Geissal v. Moore Medical Corp.*, 524 U.S. 74 (1998); 118 S. Ct. 1869 (1998); Treas. Reg. §54.4980B-7, A-2. See also Ann. 98-22, 1998-12 IRB 33.
3. Notice 90-58, 1990-2 CB 345. See also *McGee v. Funderburg*, 17 F.3d 1122 (8th Cir. 1994).
4. Treas. Reg. §54.4980B-7, A-3.
5. IRC Sec. 4980B(f)(2)(B)(i)(IV).

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One exception is the termination or reduction of hours. When a qualifying event is a termination, other than by reason of a covered employee's gross misconduct (Q 342), or a reduction in hours of a covered employee's employment, the maximum required period of coverage generally is eighteen months from the date of the termination or reduction. If another qualifying event other than a proceeding in a case under the federal bankruptcy law occurs during the eighteen month period following the termination or reduction of hours, the maximum required period is extended to thirty-six months from the date of the termination or reduction.[1]

A second exception is disability. In the case of a qualified beneficiary who is determined, under Title II or Title XVI of the Social Security Act, to have been disabled any time during the first sixty days of continuation coverage, any reference to eighteen months dealing with termination of employment, a reduction in hours, or with multiple qualifying events is deemed to be a reference to twenty-nine months with respect to all qualified beneficiaries. This extension applies only if a qualified beneficiary has provided the plan administrator with appropriate notice of the determination of disability within sixty days of the determination and provides the plan administrator with notice within thirty days of the date of any final determination that the qualified beneficiary is no longer disabled.[2]

Regulations clarify that this extension of coverage to twenty-nine months due to disability is available if three conditions are satisfied: (1) a termination or reduction of hours of a covered employee's employment occurs, (2) an individual, whether or not the covered employee, who is a qualified beneficiary in connection with the qualifying event described in (1) is determined to have been disabled at any time during the first sixty days of COBRA coverage, and (3) any of the qualified beneficiaries affected by the qualifying event described in (1) provides notice to the plan administrator of the disability determination on a date that is both within sixty days after the date when the determination is issued and before the end of the original eighteen month period. The extension due to disability applies independently to each qualified beneficiary, whether or not he or she is disabled.[3]

A third exception relates to Medicare. In the case of a termination, other than by gross misconduct (Q 342), or a reduction in hours that occurs fewer than eighteen months after the date when a covered employee became entitled to Medicare benefits, the period of coverage for qualified beneficiaries other than the covered employee shall not terminate before the close of the thirty-six month period beginning when the covered employee became so entitled.[4]

A fourth exception is the employer's bankruptcy. The bankruptcy of an employer is the only qualifying event that can result in a maximum required period of coverage of more than thirty-six months.[5] Where the qualifying event is a proceeding in a case under the federal bankruptcy law and the covered employee is alive when the bankruptcy proceedings commence, the maximum required period extends until the death of the covered employee or, in the case of a

1. IRC Sec. 4980B(f)(2)(B)(i).
2. IRC Sec. 4980B(f)(2)(B)(i).
3. Treas. Reg. §54.4980B-7, A-5.
4. IRC Sec. 4980B(f)(2)(B)(i)(V).
5. Treas. Reg. §54.4980B-7, A-6.

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surviving spouse or dependent children of a covered employee, until thirty-six months after the death of the covered employee. When a covered employee dies before bankruptcy proceedings commence and the employee's surviving spouse is, as a surviving spouse, a beneficiary under the plan on the day before bankruptcy proceedings commence, the maximum required period extends until the surviving spouse's date of death.[1]

Finally, there is a conversion exception. A qualified beneficiary must be given the option to convert the insurance coverage during the 180 day period ending on the expiration of the COBRA continuation coverage period if a conversion option otherwise generally is available to similarly situated non-COBRA beneficiaries.[2]

345. Who is a qualified beneficiary for purposes of COBRA continuation coverage requirements?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 336). This subsidy ended May 31, 2010.

With respect to a covered employee under a group health plan, a qualified beneficiary is any other individual who, on the day prior to that covered employee's qualifying event, is a covered employee's spouse or dependent child. A child born to or placed for adoption with a covered employee during the period of continuation coverage is included in the definition of qualified beneficiary.[3] Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.[4] Each qualified beneficiary has individual rights so that continuation decisions may be made on a person by person basis.

Employers are not required to offer COBRA continuation coverage to domestic partners, though some employers have negotiated with their insurance companies to do so.

If a qualifying event is a proceeding in a case under federal bankruptcy law, a qualified beneficiary is any covered employee who retired on or before the date of substantial elimination of coverage and individuals who, on the day before bankruptcy proceedings commence, were covered under the plan as a covered employee's spouse, surviving spouse, or dependent child.[5]

Where a qualifying event is a change in employment status of a covered employee, qualified beneficiaries are the covered employee, spouse and dependent children covered under the plan on the day before the qualifying event.[6]

If a qualifying event is a covered employee's death, divorce, or legal separation, or the covered employee's entitlement to Medicare, the qualified beneficiaries are the covered employee's spouse and dependent children who were covered under the plan the day before the qualifying event.[7]

1. IRC Sec. 4980B(f)(2)(B)(i)(III).
2. IRC Sec. 4980B(f)(2)(E); Treas. Reg. §54.4980B-7, A-8.
3. IRC Sec. 4980B(g)(1)(A); Treas. Reg. §54.4980B-3, A-1.
4. FAQs for Employees About COBRA Continuation Health Coverage, U.S. Department of Labor Employee Benefits Security Administration.
5. IRC Sec. 4980B(g)(1)(D); Treas. Reg. §54.4980B-3, A-1.
6. IRC Sec. 4980B(f)(3).
7. IRC Sec. 4980B(f)(3).

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If a qualifying event is the loss of a covered child's dependent status, then that dependent child is the only qualified beneficiary.[1]

The term qualified beneficiary does not include an individual who is covered under a group health plan due to another individual's election of COBRA continuation coverage and not by a prior qualifying event. This means that an individual who marries a qualified beneficiary other than the covered employee on or after the date of the qualifying event does not become a qualified beneficiary in his or her own right by reason of the marriage.

Likewise, a child born to or placed for adoption with a qualified beneficiary does not become a qualified beneficiary. New family members do not become qualified beneficiaries themselves, even if they become covered under the group health plan.[2]

A person whose status as a covered employee is attributable to a time when the person was a nonresident alien who received no earned income from the person's employer that constituted income from sources within the United States is not a qualified beneficiary.[3]

An individual who does not elect COBRA continuation coverage ceases to be a qualified beneficiary at the end of the election period.[4]

There are situations in which a second qualifying event occurs. For example, an employee terminates employment and then subsequently divorces. In this situation, the maximum period of coverage for the employee remains eighteen months and the maximum period for the impacted dependents remains thirty-six months. Notice must be provided to the Plan administrator to obtain this extension.

346. Who is a covered employee for purposes of the COBRA continuation coverage requirements? Who is a similarly situated non-COBRA beneficiary?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 336). This subsidy ended May 31, 2010.

A covered employee is any individual who is or was provided coverage under a group health plan by virtue of the individual's performance of services for one or more persons maintaining the plan, including as an employee defined in IRC Section 401(c)(1), or because of membership in an employee organization that maintains the plan.[5]

In addition, the following persons are employees if their relationship to the employer maintaining the plan makes them eligible to be covered under the plan: self-employed individuals, independent contractors and their agents and independent contractors, and corporate directors.[6]

1. IRC Sec. 4980(f)(3)(E).
2. Treas. Reg. §54.4980B-3, A-1.
3. IRC Sec. 4980B(g)(1)(C).
4. Treas. Reg. §54.4980B-3, A-1.
5. IRC Sec. 4980B(f)(7); Treas. Reg. §54.4980B-3, A-2.
6. Treas. Reg. §54.4980B-3, A-2.

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A person eligible for coverage but not actually covered is not a covered employee.

Final COBRA regulations introduce the term similarly situated non-COBRA beneficiaries, defined as a group of covered employees, their spouses, or their dependent children receiving coverage under an employer's or employee organization's group health plan for a reason other than the rights provided under the COBRA requirements and who most similarly are situated to the qualified beneficiary just before the qualifying event, based on all the facts and circumstances.[1] COBRA beneficiaries are accorded the same rights and coverage as similarly situated non-COBRA beneficiaries.

347. Who must pay the cost of COBRA continuation coverage and how is the cost calculated? What is the health coverage tax credit?

Editor's Note: ARRA 2009 provides a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers. This subsidy ended May 31, 2010 (Q 336). This subsidy ended May 31, 2010.

A plan may require a qualified beneficiary to pay a premium for continuation coverage. The premium generally cannot exceed a percentage of the applicable premium.

The applicable premium is the plan's cost for similarly situated beneficiaries (Q 346) with respect to whom a qualifying event has not occurred. The applicable premium for each determination period must be fixed by the plan before the determination period begins. A determination period is defined as any twelve month period selected by the plan, provided that it is applied consistently from one year to the next. Because the determination period is a single period for any benefit package, each qualified beneficiary will not have a separate determination period.[2]

Except as provided under ARRA 2009 (Q 336), the percentage of the applicable premium that may be charged is generally 102 percent. In the case of a disabled qualified beneficiary, the premium may be as much as 150 percent of the applicable premium for any month after the eighteenth month of continuation coverage. A plan may require payment equal to 150 percent of the applicable premium if a disabled qualified beneficiary experiences a second qualifying event during the disability extension period, after the eighteenth month. The 150 percent amount may be charged until the end of the thirty-six month maximum period of coverage, that is, from the beginning of the nineteenth month through the end of the thirty-sixth month. A plan that does so will not fail to comply with the nondiscrimination requirements of IRC Section 9802(b) (Q 355).[3]

Coverage may not be conditioned on evidence of insurability and cannot be contingent on an employee's reimbursement of his or her employer for group health plan premiums paid during a leave taken under the Family and Medical Leave Act of 1993.[4]

1. Treas. Reg. §54.4980B-3, A-3.
2. Treas. Reg. §54.4980B-8, A-2(a).
3. IRC Sec. 4980B(f)(2)(C); Treas. Reg. §54.4980B-8, A-1.
4. IRC Sec. 4980B(f)(2)(D); Treas. Reg. §54.4980B-10, A-5; Notice 94-103, 1994-2 CB 569.

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During a determination period, a plan may increase the cost of the COBRA coverage only if the plan has previously charged less than the maximum amount permitted and even after the increase the maximum amount will not be exceeded or a qualified beneficiary changes his or her coverage. If a plan allows similarly situated active employees to change their coverage, each qualified beneficiary must be given the same opportunity.[1]

A qualified beneficiary must be permitted to make premium payments on at least a monthly basis. Any person or entity may make the required payment for COBRA continuation coverage on behalf of a qualified beneficiary.[2]

COBRA premiums must be paid in a timely fashion, which is defined as forty-five days after the date of election for the period between a qualifying event and an election, and thirty days after the first date of the period for all other periods.[3] An employer may retroactively terminate COBRA continuation coverage if the initial premium is not timely paid. In *Harris v. United Automobile Insurance Group, Inc*.[4], the Eleventh Circuit Court of Appeals ruled that the additional time provided in Treasury Regulation Section 54.4980B-8, A-5, applies only to those plans that are fully funded, that is, that involve an agreement with an insurance company to provide benefits. Because the health plan in *Harris* was funded and sponsored by the company, that is, it was self-funded, the IRS regulation did not apply; consequently, the time for submitting the taxpayer's premium payment was not extended beyond that provided by the plan. Accordingly, the company was within its right in terminating the taxpayer's coverage.

In effect, the *Harris* court ruled that the employer did not have an "arrangement" under which it was given a certain period of time to pay for the coverage of non-COBRA beneficiaries. The additional time frame provided in the regulation applies only to those plans that are fully-funded, meaning those that involve an agreement with an insurance company to provide benefits.

An employer is not required to set off the premium amount against the amount of a claim incurred during the sixty day election period but before the election was made.[5]

A plan must treat a timely payment that is not significantly less than the required amount as full payment, unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period for payment. A reasonable period of time for this purpose is thirty days after the date when notice is provided. An amount will be considered as not significantly less if the shortfall is no greater than the lesser of $50 or 10 percent of the required amount.[6]

Revenue Ruling 96-8 provides some guidance in the area of determining COBRA costs.[7]

1. Treas. Reg. §54.4980B-8, A-2(b).
2. Treas. Reg. §54.4980B-8, A-3, A-5.
3. Treas. Reg. §54.4980B-8, A-5.
4. *Harris v. United Automobile Insurance Group, Inc*., 579 F.3d 1227 (11th Cir. 2009).
5. *Goletto v. W. H. Braum Inc*., 25 EBC 1974 (10th Cir. 2001).
6. Treas. Reg. §54.4980B-8, A-5(b).
7. Rev. Rul. 96-8, 1996-1 CB 286.

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Health Coverage Tax Credit

Under the Trade Act of 2002, certain eligible individuals are entitled to receive a refundable, advanceable tax credit equal to 72.5 percent of the cost of certain types of health coverage, including COBRA continuation coverage. Individuals were not eligible for this credit if they were receiving the COBRA premium subsidy, but that has now expired. If an individual is still on COBRA, he or she may be eligible for the credit (Q 348).[1]

If eligible, an individual either can claim the credit annually on his or her tax return or if he or she pays monthly, the 20 percent can be added to 80 percent from the IRS and that payment is sent to the individual's health plan. These provisions applied for months beginning before January 1, 2014.[2]

348. What is the Health Coverage Tax Credit?

Under the Trade Act of 2002, certain eligible individuals are entitled to receive a refundable tax credit equal to 72.5 percent (after February 12, 2011 and before January 1, 2014) of the cost of certain types of health coverage, including COBRA continuation coverage. Eligible individuals are displaced workers qualifying for assistance under the Trade Adjustment Assistance program and individuals age fifty-five or older receiving a benefit from the Pension Benefit Guaranty Corporation.[3]

The Trade Act of 2002 also made the tax credit advanceable and, under the Health Coverage Tax Credit (HCTC) program established by the Treasury Department, eligible individuals receive a qualified health insurance costs credit eligibility certificate.[4] These individuals can pay 20 percent of a required premium to providers along with the certificate, and the government will pay the remaining 80 percent of the premium. The government may make advance payments of credit for health insurance costs of eligible individuals, but the total amount of these payments made cannot exceed 72.5 (was 65 percent) percent of the amount paid by a taxpayer for a taxable year.[5] Providers are required to file a prescribed information return identifying the individuals receiving subsidized coverage and the amount and timing of the payments. Providers must provide each covered individual with a statement of the information reported for that individual.[6] The HCTC program was effective August 1, 2003.

How to Claim the Additional 7.5 percent Retroactive Credit

If an eligible individual was enrolled in the monthly HCTC program during the 2011 tax year, they will be sent a Form 1099-H, Health Coverage Tax Credit (HCTC) Advance Payments. This form is provided because the HCTC Program made monthly payment(s) to the individual's health plan administrator in one or months in the 2011 tax year.

1. IRC Secs. 35, 7527.
2. IRC Sec. 35(b)(1).
3. IRC Sec. 35, as amended by ARRA 2009.
4. IRC Sec. 7527, as amended by ARRA 2009.
5. IRC Sec. 7527(b).
6. IRC Sec. 6050T.

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Boxes 3 through 14, on Form 1099-H, reflect the tax credit amount the individual received for each month in 2011 (an 80 percent tax credit for payments made by the HCTC Program in January and February 2011 and a 65 percent tax credit for payments made in March through December 2011).

To claim the additional 7.5 percent retroactive credit:

1. Refer to the box to the left of box 8 on Form 1099-H. This is the additional 7.5 percent retroactive credit that the HCTC Program has calculated. If the amount listed is $0.00, there is no retroactive credit amount.

2. Complete and file Form 8885, Health Coverage Tax Credit, with 2011 Form 1040, U.S. Individual Income Tax Return. Enter the retroactive tax credit amount on line 7 of Form 8885, Health Coverage Tax Credit. It is not necessary to complete lines 1 through 6 and it is not necessary to submit any supporting documentation.

Note: If a credit is claimed for any month for which a payment was made directly to a qualified health plan, lines 1 through 6 must be completed for those months. Then, the additional 7.5 percent retroactive credit amount is added to the sum of any amount on Part II, line 6, of Form 8885 and the total is entered on Part II, line 7. All required supporting documentation must be submitted and copies should be retained.

Planning Point: Form 8885 must be filed along with Form 1040.

349. When must an election to receive COBRA continuation coverage be made?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 336). This subsidy ended May 31, 2010.

The period during which a qualified beneficiary may elect continuation coverage runs from the date when the qualified beneficiary's coverage terminates under the plan by reason of a qualifying event until sixty days after the later of: 1) the date when the coverage terminates; or 2) the date when notice is provided by a plan administrator to any qualified beneficiary of the right to continued coverage.[1]

A COBRA continuation coverage election is considered made on the date it is sent to a plan administrator. If an election is made at any time during this period, the continuation coverage is provided from the date when coverage is lost.[2]

Where a former employee became incapacitated ten days after resigning without making a continuation coverage election, the sixty day election period was tolled. Thus, a continuation coverage election made by the former employee's temporary administrator approximately seventy days after the resignation was found to be timely.[3]

1. IRC Sec. 4980B(f)(5).
2. IRC Sec. 4980B(f)(5); Treas. Reg. §54.4980B-6, A-1, A-3.
3. *Branch v. G. Bernd Co.*, 955 F.2d 1574 (11th Cir. 1992).

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Each qualified beneficiary must be offered the opportunity to make an independent election to receive COBRA continuation coverage. If a qualified beneficiary who is either a covered employee or his or her spouse makes an election that does not specify for whom the election is being made, regulations provide that the election will be deemed to include an election for all other qualified beneficiaries.[1]

If a qualified beneficiary waives the right to COBRA coverage but subsequently revokes the waiver prior to the end of the election period, the employer must provide the qualified beneficiary with prospective coverage, but not for the period between the waiver and the revocation. A waiver or revocation of a waiver is considered to have been made on the date it is sent.[2]

An employer may not withhold any compensation or other benefits to which a qualified beneficiary is entitled to coerce the qualified beneficiary into a decision concerning COBRA continuation coverage.[3]

Second COBRA Election Period

The Trade Act of 2002 added a second sixty day COBRA election period for individuals eligible under the Trade Adjustment Assistance ("TAA") program if the individuals did not elect COBRA coverage during their initial election period. The second election period begins on the first day of the month in which an individual becomes TAA eligible, but no election can be made more than six months after an initial TAA-related loss of coverage. Any election during a second election period is retroactive to the first day of the second election period.[4]

The second opportunity to elect COBRA continuation coverage applies to individuals who are eligible for trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) and who did not elect COBRA during the general election period. This additional, second election period is measured sixty days from the first day of the month in which an individual is determined TAA-eligible. For example, if an individual's general election period runs out and he or she is determined TAA-eligible sixty-one days after separating from employment, at the beginning of the month, he or she would have approximately sixty more days to elect COBRA. However, if this same individual is not determined TAA-eligible until the end of the month, the sixty days are still measured from the first of the month, in effect giving the individual about thirty days. Additionally, the Trade Act of 2002 added another limit on the second election period. A COBRA election must be made not later than six months after the date of the TAA-related loss of coverage. COBRA coverage chosen during the second election period typically begins on the first day of that period. More information about the Trade Act is available at www.doleta.gov/tradeact.

TAA recipients are eligible for COBRA coverage extensions for as long as they have TAA eligibility or until January 1, 2014. PBGC payees are eligible for COBRA coverage extensions

1. IRC Sec. 4980B(f)(5)(B); Treas. Reg. §54.4980B-6, A-6.
2. Treas. Reg. §54.4980B-6, A-4.
3. Treas. Reg. §54.4980B-6, A-5.
4. IRC Sec. 4980B(f)(5)(C).

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until January 1, 2014. If the payee passes away, their spouse or dependents can receive an additional twenty-four months of COBRA or until January 1, 2014.[1]

350. What notice of COBRA continuation coverage is required?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 336). *This subsidy ended May 31, 2010.*

Employer's Initial Notice. A plan must provide written notice of COBRA continuation coverage rights to each covered employee and spouse at the commencement of their coverage under the plan[2] and the COBRA rights provided under the plan must be described in the plan's summary plan description (SPD).

ERISA requires group health plans to give covered employees an SPD within ninety days after the employee first becomes a participant in a plan (or within 120 days after the plan is first subject to the reporting and disclosure provisions of ERISA). In addition, if there are material changes to the plan, the plan must give employees a summary of material modifications (SMM) not later than 210 days after the end of the plan year in which the changes become effective. If the change is a material reduction in covered services or benefits, the SMM must be furnished not later than sixty days after the reduction is adopted. A participant or beneficiary covered under the plan may request a copy of the SPD and any SMMs (as well as any other plan documents), which must be provided within thirty days of a written request.

Within the first ninety days of coverage, group health plans must give each employee and each spouse who becomes covered under the plan a general notice describing COBRA rights.[3]

Notice to Plan Administrator. An employer must notify a plan administrator within thirty days of the date when any of the following qualifying events occur:

(1) the death of a covered employee;

(2) the termination or reduction in hours of employment of a covered employee;

(3) a covered employee's becoming entitled to Medicare benefits; or

(4) a proceeding in a case under federal bankruptcy law.[4]

Notice to Employer. A covered employee or spouse must notify the employer of a divorce or legal separation within sixty days.[5] At least one court has permitted a covered employee to terminate coverage for the employee's soon to be ex-spouse. That court denied the COBRA coverage the spouse sought upon learning that the spouse's coverage had been terminated because neither the spouse nor the covered employee had provided timely notice of the divorce

1. See "FAQs For Employees About COBRA Continuation Health Coverage, U.S. Department of Labor, Employee Benefits Security Administration".
2. Sec. 4980B(f)(6)(A).
3. See "An Employee's Guide to Health Benefits Under COBRA, U.S. Department of Labor Employee Benefits Security Administration".
4. IRC Sec. 4980B(f)(6)(B).
5. IRC Sec. 4980B(f)(6)(C).

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to the employer.[1] Where a covered employee told a plan administrator that he had divorced his spouse before directing that her coverage be terminated, the notice requirement was satisfied and the spouse had to be notified of her right to elect COBRA continuation coverage.[2]

An individual who ceases to be a dependent child is required to notify the employer of this occurrence within sixty days.[3]

Notice to Qualified Beneficiary. Within fourteen days of receiving notice from an employer, a plan administrator must notify any qualified beneficiary with respect to a qualifying event.[4] If coverage is continued at the employer's expense after the qualifying event, this notice may be delayed until coverage actually is lost.[5] This notice requirement will be deemed satisfied if notice is sent to the qualified beneficiary's last known address by first class mail, unless the plan administrator has reason to know that this method of delivery has failed.[6]

Notice of Disability. Additionally, each qualified beneficiary determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty days of continuation coverage must notify the plan administrator of that determination within sixty days after the date of that determination and must notify the plan administrator of any final determination that the qualified beneficiary is no longer disabled within thirty days of the date of that determination.[7]

Statute of Limitations. Because neither COBRA nor ERISA contain a statute of limitations for making a claim that the employer did not timely provide notice, courts may look to state statutes of limitations.[8]

Exhaustion of Administrative Remedies. Although covered employees and qualified beneficiaries generally must exhaust their administrative remedies under a plan before bringing suit, in the case of a failure to provide a COBRA election notice, exhaustion of remedies is not required, unless otherwise judicially imposed by a state court.[9]

ERISA and PHSA. COBRA continuation coverage is not only a tax requirement. There are similar requirements under ERISA and the Public Health Service Act (PHSA) with other sanctions. The Department of Labor issued proposed regulations in 2003 updating the various notices and disclosures required under COBRA.[10] The new regulations, which were effective in their final form for plan years beginning in 2004, provide rules that set minimum standards for the timing and content of the notices required under COBRA and establish standards for administering the notice process.[11]

1. *Johnson v. Northwest Airlines, Inc.*, 2001 U.S. Dist. LEXIS 2160 (N.D. CA. 2001).
2. *Phillips v. Saratoga Harness Racing Inc.*, 240 F.3d 174 (2d Cir. 2001). See also Rev. Rul 2002-88, 2002-5 2 IRB 995.
3. IRC Sec. 4980B(f)(6)(C).
4. IRC Sec. 4980B(f)(6)(D).
5. *Wilcock v. National Distributors, Inc.*, 2001 U.S. Dist. LEXIS 11413 (D. Maine 2001).
6. See *Wooderson v. American Airlines Inc.*, 2001 U.S. Dist. LEXIS 3721 (N.D. Texas 2001).
7. IRC Sec. 4980B(f)(6)(C).
8. *Mattson v. Farrell Distributing Corp.*, 163 F. Supp.2d 411 (D. Vt. 2001).
9. *Thompson v. Origin Tech. in Business, Inc.*, 2001 U.S. Dist. LEXIS 12609 (N.D. Texas 2001).
10. 29 CFR Part 2590, 68 Fed. Reg. 31832 (May 28, 2003).
11. 29 CFR Part 2590, 68 Fed. Reg. 31832 (May 28, 2003).

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351. Which entity is responsible for providing COBRA continuation coverage following a business reorganization?

The parties to a business reorganization transaction generally are free to allocate responsibility for providing COBRA continuation coverage by contract even if the contract assigns the COBRA responsibility to a party other than the party to which it would be assigned under the final regulations. If the assigned party defaults on its responsibility to provide COBRA coverage and the other party would have had the responsibility under the final regulations, the responsibility will return to this other party.[1]

For both sales of stock and sales of substantial assets, final regulations provide that a seller retains the obligation to provide COBRA continuation coverage to existing qualified beneficiaries provided that the seller continues to maintain a group health plan. In the event of a stock sale where a seller ceases to provide any group health plan to any employee in connection with the sale and therefore is not responsible for providing COBRA continuation coverage, final regulations provide that the buyer is responsible for providing COBRA continuation coverage to existing qualified beneficiaries. A group health plan of the buying group has this obligation beginning on the later of: (1) the date the selling group ceases to provide any group health plan to any employee; or (2) the date of the stock sale. The obligation continues as long as the buying group continues to maintain a group health plan.[2]

In the event of an asset sale where the seller ceases to provide any group health plan and the buyer continues the business operations associated with the assets purchased without interruption, the buyer is considered to be a successor employer to the seller. As a successor employer, the buyer is obligated to offer COBRA continuation coverage. Final regulations provide examples as to which party has the obligation to offer COBRA continuation coverage with respect to both asset sales and stock sales.[3]

It is not considered a COBRA qualifying event if an employer stops making contributions to a multiemployer plan. Further, when an employer stops making contributions to a multiemployer group health plan, the plan continues to be obligated to make COBRA continuation coverage available to qualified beneficiaries associated with the employer. Once the employer provides group health insurance to a significant number of employees who were formerly covered under the multiemployer plan or starts contributing to another multiemployer plan, the employer's plan or the new multiemployer plan must assume the COBRA obligation.[4]

If, however, the employer that stops contributing to the multiemployer plan makes group health plan coverage available to (or starts contributing to another multiemployer plan that is a group health plan) a class of the employer's employees formerly covered under the multiemployer plan, the plan maintained by the employer (or the other multiemployer plan), from that date forward, has the obligation to make COBRA continuation coverage available to any

1. Treas. Reg. §54.4980B-9, A-7.
2. Treas. Reg. §54.4980B-9, A-8(b)(1).
3. Treas. Reg. §54.4980B-9, A-8.
4. Treas. Reg. §54.4980B-9, A-10.

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qualified beneficiary who was receiving coverage under the multiemployer plan on the day before the cessation of contributions. The qualifying event must have occurred in connection with a covered employee whose last employment prior to the qualifying event was with the employer.

352. What are the consequences of breaching COBRA continuation coverage requirements?

Editor's Note: ARRA 2009 provided a temporary premium subsidy for COBRA continuation coverage for certain unemployed workers (Q 336). *This subsidy ended May 31, 2010.*

Statutory Penalties

The penalty for failure to make continuation coverage available is an excise tax of $100 per day during the noncompliance period with respect to each qualified beneficiary, limited to $200 per day in the case of more than one qualified beneficiary in the same family. Attorney's fees also may be available. Where a covered employee's wife and children were not participants on the date of the qualifying event, the award was limited to penalties and attorney's fees based on the covered employee only.[1]

The noncompliance period begins on the date when the failure first begins and continues until the failure is corrected or the date that is six months after the last date on which the employer could have been required to provide continuation coverage to the beneficiary, whichever date is earlier.[2]

The minimum tax for a failure that is not discovered until after the employer receives a notice of tax audit is $2,500 (increasing to $15,000 for violations that are deemed more than de minimis). However, no tax is imposed on any failure for which it is established that the employer (or plan in the case of a multiemployer plan) did not know, or exercising reasonable diligence would not have known, that such failure existed.[3]

No tax is imposed for the period during which it is shown that none of the persons liable for the tax knew or, by exercising reasonable diligence, would have known, that the failure existed. There is no tax if the failure was due to reasonable cause, not willful neglect, and is corrected within the first thirty days of the noncompliance period.[4]

Normally, an employer is liable for the tax. In the case of a multiemployer plan, the tax is imposed directly on the plan. In addition, a person responsible for administering the plan or providing benefits under it pursuant to a written agreement is liable if that person causes the failure by failing to perform one or more of its responsibilities. A person also may be liable if the individual fails to comply, within forty-five days, with a written request of the employer, the plan administrator, or, in limited situations, a qualified beneficiary to provide benefits that the person provides to similarly situated active employees. This excise tax may be imposed on

1. *Wright v. Hanna Steel Corp.*, 270 F.3d 1336 (11th Cir. 2001).
2. IRC Sec. 4980B(b).
3. IRC Section 4980B(b)(3)(A).
4. IRC Sec. 4980B(c).

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a third party such as an insurer or third party administrator if the third party assumes certain responsibilities.[1]

In the case of single employer plans, the maximum excise tax for failures due to reasonable cause, not willful neglect, is 10 percent of the aggregate amount paid by the employer during the preceding tax year for medical care coverage or, if less, $500,000.[2] The maximum excise tax in the case of a person other than an employer is limited to $2 million with respect to all plans.[3]

In the case of a failure due to reasonable cause, the Secretary of the Treasury may waive part or all of the tax to the extent it is excessive relative to the failure involved. The determination of the excessiveness of the excise tax is to be made based on the seriousness of the failure, not on a particular taxpayer's ability to pay the tax.[4]

Failure to make continuation coverage available will be treated as corrected if it is retroactively undone to the extent possible and the qualified beneficiary is placed in as good a financial position as the individual would have been in had the failure not occurred and had the beneficiary elected the most favorable coverage in light of the expenses incurred since the failure first occurred.[5]

Other Remedies

In addition to the excise taxes discussed above, other civil remedies are available under ERISA.[6] Employees or other qualified beneficiaries can bring civil actions to obtain other equitable relief, including an injunction and restitution, and to recover additional penalties of up to $110 per day for failure to provide required notices or to furnish requested information.[7] Compensatory damages are not available.[8]

Portability, Access, and Renewability Rules

353. What portability, access, renewability mental health parity and other coverage requirements must be satisfied by group health plans?

Group health plans must comply with certain requirements concerning limitations on preexisting condition exclusions (Q 354), discrimination based on health status (Q 355), genetic information (Q 357) and guaranteed renewability in multiemployer plans (Q 357). Proposed regulations under the Patient Protection and Affordable Care Act (PPACA) may affect these requirements.

A group health plan is "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated

1. IRC Sec. 4980B(e); Treas. Reg. §54.4980B-2, A-10. See *Paris v. Korbel*, 751 F. Supp. 834 (N.D. Cal. 1990).
2. IRC Sec. 4980B(c)(4)(A).
3. IRC Sec. 4980B(c)(4)(C).
4. IRC Sec. 4980B(c)(5).
5. IRC Sec. 4980B(g)(4).
6. ERISA Sec. 502.
7. ERISA Secs. 502(a)(1), 502(a)(3); 62 Fed. Reg. 40696.
8. *Geissal v. Moore Med. Corp.*, 158 F. Supp.2d 976 (E.D. Mo. 2001).

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or formerly associated with the employer in a business relationship, or their families."[1] A similar definition[2] applies to a large group health plan, but for the requirement that the large plan cover employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

These requirements do not apply to governmental plans or group health plans with fewer than two participants as of the first day of the plan year.[3]

They also do not apply to plans providing only accident or disability income insurance coverage or issued as a supplement to liability insurance, workers' compensation, automobile medical payment insurance, or credit-only insurance.[4]

Also excluded is coverage for on-site medical clinics and other similar insurance coverage under which benefits for medical care are incidental to other insurance benefits.[5]

The requirements are not applicable to plans providing limited dental or vision benefits, benefits for long-term care, nursing home care, home health care, or community-based care, if such coverage is offered separately.[6]

Plans providing coverage only for a specific disease or illness and hospital indemnity insurance, if offered as an independent non-coordinated benefit, are not subject to these rules.[7]

These requirements do not apply to Medicare supplemental health insurance, if offered as a separate insurance policy or certificate.[8]

Penalties for noncompliance are imposed by IRC Section 4980D (Q 359).

Mental Health Parity

For plan years beginning on or after January 1, 1998, group health plans with more than fifty employees are required to provide parity between mental health benefits and medical and surgical benefits.[9]

For plan years beginning after October 3, 2008, group health plans with more than fifty employees must provide parity between mental health and substance use disorder benefits and medical and surgical benefits.[10]

1. IRC Sec. 5000(b)(1), as amended by Section 13561(e)(2)(A) of the Omnibus Budget Reconciliation Act of 1993.
2. IRC Sec. 5000(b)(2).
3. IRC Secs. 9831(a)-(b).
4. IRC Sec. 9832(c)(1).
5. IRC Sec. 9832(c)(1).
6. IRC Sec. 9832(c)(2).
7. IRC Sec. 9832(c)(3).
8. IRC Sec. 9832(c)(4).
9. See IRC Sec. 9812; ERISA Sec. 712, 29 USC 1185a.
10. IRC Secs. 9812(e)(4) and 9812(e)(5); ERISA Secs. 712(e)(4) and 712(e)(5), 29 USC 1185a.

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For plan years beginning after October 3, 2008, the scope of parity includes benefit limits, treatment limits, co-payments, deductibles, and out-of-network coverage.[1]

Plans must apply a single set of benefit limits and cost-sharing mechanisms to mental health and substance use disorder benefits and medical and surgical benefits.

354. What are the rules concerning preexisting condition exclusions under HIPAA?

HIPAA defines preexisting condition exclusion as "a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date."[2]

A group health plan may impose preexisting condition exclusion on a participant or a beneficiary only if:

(1) the exclusion relates to a physical or mental condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was either recommended or received within the six months prior to the enrollment date, the six month look-back rule;

(2) the exclusion extends for no more than twelve months after the enrollment date or eighteen months for a late enrollee, the look-forward rule; and

(3) the exclusion period is reduced by the length of the aggregate of the periods of creditable coverage applicable to a participant or beneficiary as of the enrollment date.[3]

The six-month period under item (1) above generally begins on the six-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 2014, the six-month period preceding the enrollment date is the period commencing on February 1, 2014 and continuing through July 31, 2014. As another example, for an enrollment date of August 30, 2014, the six-month period preceding the enrollment date is the period commencing on February 28, 2014 and continuing through August 29, 2014.[4]

Regulations provide examples of how this period is determined.[5]

The twelve-month period, or eighteen month period for late enrollees, under item (2) above is determined by looking to the anniversary of the enrollment date. Thus, if the enrollment date was August 1, 2014, the twelve-month period after the enrollment date began on August 1, 2014, and would run through July 31, 2015.[6]

1. IRC Sec. 9812(a); ERISA Sec. 712(a).
2. IRC Sec. 9801(b)(1)(A).
3. IRC Sec. 9801(a).
4. Treas. Reg. §54.9801-3(a)(2)(B).
5. See Treas. Reg. §54.9801-3(a)(2)(i)(B).
6. Treas. Reg. §54.9801-3(a)(2)(ii).

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Creditable coverage under item (3) above is coverage of an individual under many types of health plans, including a group health plan, health insurance coverage, Part A or Part B of Medicare, a state health benefits risk pool, and a public health plan.[1]

An individual will not receive credit for prior coverage if there was a break in coverage. For this purpose, a break in coverage is a period of at least 63 days occurring before the enrollment date during which the individual was not covered under any creditable coverage.[2] A waiting period for coverage under a group health plan is not counted for this purpose.[3] Regulations provide guidance on how to determine an individual's creditable coverage by using the standard method or, for certain categories of benefits, by using an alternative method.[4]

A group health plan generally must provide certificates of creditable coverage. An entity required to provide a certificate meets its obligation if another party provides a certificate that includes information about an individual's creditable coverage and waiting period but only to the extent that the certificate contains the required information. For example, a group health plan is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if any other entity actually provides a certificate that includes the required information with respect to the participant or beneficiary.[5]

A certificate of creditable coverage must be provided to participants or dependents that are or were covered under a group health plan on the occurrence of any one of several events. A certificate must be issued automatically to COBRA qualified beneficiaries (Q 345) on the occurrence of a qualified event (Q 340). A certificate also must be provided automatically to any qualified beneficiary who would lose coverage under a plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA coverage. A certificate must be issued automatically to other individuals when coverage ceases. An employer must automatically provide a certificate to individuals who are not qualified beneficiaries entitled to elect COBRA when they cease to be covered under the plan, and to COBRA qualified beneficiaries when COBRA continuation coverage ceases. The automatic certificate must be provided to individuals when their coverage under the plan ceases even if they already have received a certificate on the COBRA qualified event. Further, a certificate of creditable coverage also must be provided automatically if a request for one is made by or on behalf of an individual within twenty-four months of the time coverage ends.[6]

HIPAA prohibits a group health plan from imposing the preexisting condition exclusion on a newborn who is covered under creditable coverage on the last day of a thirty day period beginning with the date of birth.[7]

1. IRC Sec. 9801(c)(1).
2. IRC Sec. 9801(c)(2)(A).
3. IRC Sec. 9801(c)(2)(B).
4. Treas. Reg. §54.9801-4.
5. Treas. Reg. §54.9801-5(a)(1)(ii).
6. Treas. Reg. §54.9801-5(a)(2).
7. IRC Sec. 9801(d)(1).

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A group health plan cannot impose a preexisting condition exclusion on an adopted child under the age of eighteen who is covered under creditable coverage on the last day of a thirty day period beginning on the date of adoption.[1]

HIPAA prohibits a group health plan from imposing a preexisting condition exclusion relating to pregnancy.[2]

355. What are the rules concerning discrimination based on health status under HIPAA?

HIPAA prohibits a group health plan from establishing rules for eligibility or continued eligibility under the plan based on certain factors. These factors may be in relation to either the individual or his or her dependents.[3]

The prohibited factors include health status; medical conditions, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability; and disability.[4]

Evidence of insurability includes participation in motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and similar activities, and conditions arising from domestic violence.[5] A plan need not provide coverage for any particular benefit to any group of similarly-situated individuals.[6]

Under the general rule, a plan may not exclude a person from eligibility because the individual engages in certain hazardous recreational activities, but a plan may, in some cases, impose a source-of-injury exclusion and deny benefits for injuries arising out of a hazardous activity. The final regulations clarify that a plan may not use a source-of-injury exclusion to deny benefits if the injury was a result of a medical condition or domestic violence. For example, while a plan generally could exclude coverage for all injuries resulting from riding on a motorcycle, a plan could not deny benefits where a motorcycle rider lost control of the bike because of an epileptic seizure.

Likewise, a plan may not deny coverage for self-inflicted conditions, for example, injuries from an attempted suicide, if the conditions result from a medical condition such as depression.[7]

A group health plan may not require an individual to pay a premium greater than the premium for a similarly-situated participant or beneficiary based on any of the factors listed above as a condition of either enrollment or continued enrollment.[8] This rule does not restrict the

1. IRC Sec. 9801(d)(2).
2. IRC Sec. 9801(d)(3).
3. Proposed regulations under the PPACA may affect these rules.
4. IRC Sec. 9802(a)(1); Treas. Reg. §54.9802-1(a)(1).
5. Treas. Reg. §54.9802-1(a)(2).
6. Treas. Reg. §54.9802-1(b)(2).
7. Treas. Reg. §54.9802-1(b)(2)(iii).
8. IRC Sec. 9802(b)(1).

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amount that an issuer may charge an employer for coverage or prevent the plan from providing premium discounts or other financial incentives for employees who participate in a wellness plan.[1]

Wellness programs that offer unconditional rewards automatically comply with the nondiscrimination rules. Examples of such programs include reimbursement for membership in a fitness center or payment for participation in a smoking cessation program without regard to whether the employee quits smoking. Wellness programs that provide a reward based on satisfaction of a standard related to a health factor must meet five requirements:[2]

(1) The reward for the wellness program must not exceed 30 percent of the cost of employee-only coverage under the plan (this percentage may be increased to 50 percent if the additional percentage is in connection with a program designed to prevent or reduce tobacco use)[3];

(2) The program must be reasonably designed to promote health or prevent disease;

(3) The program must give eligible individuals the opportunity to qualify for the reward at least once per year;

(4) The reward must be available to all similarly-situated employees; and

(5) The plan must disclose in all plan materials the standard for obtaining the reward.

Planning Point: If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program does not violate the discrimination rules if participation in the program is made available to all similarly-situated individuals.

Church plans. A church plan (as defined in IRC Section 414(e)) does not fail to meet these requirements solely because the plan requires evidence of good health for coverage of (1) any employee, in the case of an employer with 10 or fewer employees, (2) any self-employed individual, or (3) any individual who enrolls in the plan after the first 90 days of initial eligibility. This exception is applicable for a given plan year only if the plan included these provisions on July 15, 1997, and at all times thereafter before the beginning of such year.[4]

356. What are the GINA nondiscrimination rules for group health plans?

Under GINA, a group health plan generally may not adjust premium or contribution amounts for a group covered under the plan on the basis of genetic information.[5] A group health plan generally is also prohibited from requesting or requiring an individual or family member of the individual to undergo a genetic test.[6]

1. Treas. Reg. §54.9802-1(c).
2. Treas. Reg. §54.9802-1(f)(2).
3. Treas. Reg. §54.9802-1(f)(5).
4. IRC Sec. 9802(f).
5. IRC Sec. 9802(b)(3), as added by GINA 2009; Treas. Reg. §54.9802-3T(b)(1). The interim final regulations are effective for plan years beginning on or after December 7, 2009 and expired on October 1, 2012. Treas. Reg. §§54.9802-3T(f)-(g).
6. IRC Sec. 9802(c)(1), as added by GINA 2009; Treas. Reg. §54.9802-3T(c)(1).

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Group health plans are prohibited from collecting, that is, requesting, requiring, or purchasing, genetic information for underwriting purposes.[1] A group health plan may not collect genetic information with respect to any individual prior to or in connection with the individual's enrollment under the plan or in connection with the enrollment.[2] Employers are prohibited from making predictive assessments concerning an individual's propensity to get an inheritable genetic disease or disorder based on the occurrence of an inheritable disease or disorder in a family member.[3]

Interim final regulations make clear that wellness programs that provide rewards for completing health risk assessments (HRAs) that request genetic information, including family medical history, violate the prohibition against requesting genetic information for underwriting purposes. This is the result even if rewards are not based on the outcome of the assessment, which otherwise would not violate the 2006 final HIPAA nondiscrimination rules regarding wellness programs. The regulations also do not provide an exception from underwriting for rewards provided by wellness programs, regardless of the amount of the award.[4]

Genetic information is defined as information about an individual's genetic tests, genetic tests of an individual's family members, and the manifestation or a disease or disorder in family members of an individual.[5] Genetic test means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes.[6] Genetic information does not include mere information about the sex or age of an individual.[7]

Family member means, with respect to any individual, a dependent as defined in IRC Section 9802(f)(2) of the individual or any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.[8]

Penalties for noncompliance are imposed by IRC Section 4980D (Q 359).

357. What is the HIPAA guaranteed renewability requirement?

A group health plan that is a multiemployer plan or a multiple employer welfare arrangement cannot deny an employer continued access to the same or different coverage under the plan except in the case of:

(1) nonpayment of contributions;

(2) fraud or other intentional misrepresentation by the employer;

(3) noncompliance with material plan provisions;

1. IRC Sec. 9802(d)(1), as added by GINA 2009; Treas. Reg. §54.9802-3T(d)(1).
2. IRC Sec. 9802(d)(2), as added by GINA 2009; Treas. Reg. §54.9802-3T(d)(2).
3. *Poore v. Peterbilt of Bristaol, LLC*, 852 F. Supp. 2d 727 (W.D. Va. 2012).
4. 74 Fed. Reg. 51664, 51668 (10-7-2009); see the examples in Treas. Reg. §1.54.9802-3T(d)(3).
5. IRC Sec. 9832(d)(7), as added by GINA 2009; Treas. Reg. §54.9802-3T(a)(3).
6. IRC Sec. 9832(d)(8), as added by GINA 2009; Treas. Reg. §54.9802-3T(a)(5).
7. *Culbreth v. Washington Metropolitan Area Transit Authority*, No. 2012 U.S. Dist. LEXIS 37335(D. MD. 2012).
8. IRC Sec. 9832(d)(6), as added by GINA 2009; Treas. Reg. §54.9802-3T(a)(2).

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(4) a plan that no longer offers coverage in a geographic area;

(5) a network plan where there is no longer an individual enrolled through the employer who lives or works in the service area of the network plan; or

(6) failure to meet the terms of a collective bargaining agreement.[1]

358. What rules apply to group health plan benefits provided to newborns and mothers?

A group health plan providing hospital stay benefits for either a mother or a newborn in connection with childbirth may not limit a stay to less than forty-eight hours for a normal delivery or ninety-six hours for delivery by caesarean section.[2] These limitations do not apply where the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

A group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not:

(1) deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section;

(2) provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this section;

(3) penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual participant or beneficiary in accordance with this section;

(4) provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section; or

(5) subject to subsection (c)(3) of this section, restrict benefits for any portion of a period within a hospital length of stay required under subsection (a) of this section in a manner which is less favorable than the benefits provided for any preceding portion of such stay.[3]

359. What penalties apply to a group health plan's failure to meet portability, access, and renewability requirements?

An excise tax is imposed on an employer sponsoring any group health plan that fails to meet portability, access, and renewability requirements.[4] The amount of the tax is $100 for

1. IRC Sec. 9803(a).
2. IRC Sec. 9811(a)(1)(2).
3. 29 USC §1185.
4. IRC Sec. 4980D(a).

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each individual to whom the failure relates for each day in the noncompliance period.[1] The noncompliance period begins on the date when a failure first occurs and ends on the date when it is corrected.[2] A failure is considered corrected if it is retroactively undone and the person to whom the failure relates has been placed in as good a financial position as he or she would have been in if the failure had not occurred.[3]

Although an employer sponsoring a plan generally is liable for the tax, in the case of a multiemployer plan, the plan is liable. Additionally, in the case of a failure that relates to guaranteed renewability (Q 357) with respect to a multiple employer welfare arrangement, the plan is liable.[4]

A special rule applies in the case of one or more failures relating to an individual that are not corrected before a notice of examination of income tax liability is sent to an employer and that either occurred or continued during the examination period. In this case, the amount of the tax shall not be less than the lesser of (1) $2,500, or (2) the amount of tax that normally would be imposed, without regard to IRC Sections 4980D(c)(1) and 4980D(c)(2).

Where violations are more than *de minimis*, $15,000 is substituted for $2,500.

The provisions regarding income tax liability examinations do not apply to church plans as defined in IRC Section 414(e).[5]

The $100 per day tax is not imposed if a person who otherwise would be liable for the tax can demonstrate that he or she did not know about the failure and would not have known about the failure through the exercise of reasonable diligence. Further, no tax is imposed if the failure was due to reasonable cause, not willful neglect, and is corrected within thirty days after the person who would be liable for the tax first knew or, by exercising reasonable diligence, would have known about the failure.

For church plans, a failure must be corrected before the close of the correction period as determined under IRC Section 414(e)(4)(C).[6]

There are other limits on the tax that may be applied in the case of unintentional failures. For failures with respect to single employer plans, the tax shall not exceed the lesser of 10 percent of the aggregate amount paid by an employer during the preceding taxable year for group health plans or $500,000.[7]

For failures with respect to a specified multiple employer health plan, the tax shall not exceed the lesser of 10 percent of the amount paid by the plan trust to provide medical care directly or through insurance, reimbursement, or otherwise, or $500,000.[8]

1. IRC Sec. 4980D(b).
2. IRC Sec. 4980D(b)(2).
3. IRC Sec. 4980D(f)(3).
4. IRC Sec. 4980D(e).
5. IRC Sec. 4980D(b)(3).
6. IRC Sec. 4980D(c).
7. IRC Sec. 4980D(c)(3)(A).
8. IRC Sec. 4980D(c)(3)(B).

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A specified multiple employer health plan is a group health plan that is any multiemployer plan or any multiple employer welfare arrangement as defined in Section 3(40) of ERISA.[1]

A portion or all of the tax imposed may be waived if it is excessive in relation to the failure involved and is due to reasonable cause.[2]

In the case of a small employer providing health coverage solely through a health insurance contract, no tax is imposed for any failure, other than a failure attributable to IRC Section 9811 (Q 358), arising solely because of the health insurance coverage offered by such insurer.[3]

For this purpose, a small employer is one that employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and at least two employees on the first day of the plan year.[4] If an employer was not in existence during the preceding year, this determination is based on the average number of employees that it is reasonably expected that the employer will employ on business days in the current calendar year.[5]

Final regulations released in October 2009 provide the manner and method of paying the excise tax under IRC Section 4980D. The regulations require that the excise tax must be reported on Form 8928[6]. In addition, the excise tax under IRC Section 4980D must be paid at the time prescribed for filing of the excise tax return without extensions.[7]

Health Benefits Under a Qualified Plan

360. May health benefits be provided for employees under qualified pension and profit sharing plans?

Yes. A qualified profit sharing plan may provide health insurance benefits for its employee-participants within limits (Q 3751). A qualified pension plan may provide disability pensions, but will not qualify if it provides regular health insurance benefits for active employees. A qualified pension plan may provide health insurance benefits for retired employees (Q 3751). For tax consequences to employees, see Q 368 and Q 3842.

Disability Income Coverage

361. What are the tax consequences when a corporation buys disability insurance on a key person under which benefits are paid to the corporation?

A corporation cannot deduct premiums it pays but can exclude insurance benefits from its gross income.[8] Disability income, regardless of amount, is wholly tax-exempt to the corporation under IRC Section 104(a)(3).[9] Because the disability income is tax-exempt, a deduction

1. IRC Sec. 4980D(f)(2).
2. IRC Sec. 4980D(c)(4).
3. IRC Sec. 4980D(d)(1).
4. IRC Sec. 4980D(d)(2)(A).
5. IRC Sec. 4980D(d)(2)(B).
6. Return of Certain Excise Taxes under Chapter 43 of the Internal Revenue Code.
7. TD 9457, 74 Fed. Reg. 45994, 45996 (9-8-2009); see Treas. Regs. §§54.6011-2, 54.6061-1, 54.6071-1, 54.6091-1, 54.6151-1.
8. Rev. Rul. 66-262, 1966-2 CB 105.
9. *Castner Garage, Ltd. v. Comm.*, 43 BTA 1 (1940), *acq.*

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for premiums is disallowable under IRC Section 265(a)(1) on the ground that the premiums are expenses paid to acquire tax-exempt income.[1] An accidental death benefit may be tax-exempt to a corporation under IRC Section 101(a) as death proceeds of life insurance (Q 62). Premiums paid for tax-exempt accidental death coverage are nondeductible under IRC Section 264(a)(1) (Q 245).

On January 16, 2009, the Office of Associate Chief Counsel (Income Tax & Accounting) issued Chief Counsel Advice[2] concluding that a taxpayer may not take a deduction under Section 162 for compensation paid to an employee pursuant to an employment contract, because the taxpayer was receiving disability insurance payments on account of the employee's injury and Section 162 disallows a deduction for an expense for which there is a right or expectation of reimbursement.

However, upon further consideration, the Office of Associate Chief Counsel (Income Tax & Accounting) concluded, based upon the facts in the prior CCA, that a taxpayer is not precluded from taking a Section 162 deduction for compensation paid to an employee pursuant to the employment contract merely because the taxpayer received insurance payments on account of an employee's disability. Nor does Section 265(a)(1) disallow such a deduction.[3]

362. Are premiums paid for overhead expense insurance deductible as a business expense?

The IRS has ruled that premiums paid on an overhead expense disability policy, a special type of contract that reimburses professionals or owner-operators for overhead expenses actually incurred during periods of disability, are deductible as a business expense and the proceeds are taxable.[4] The ruling relates to self-employed individuals.

Premiums paid on standard personal disability insurance are not deductible as a business expense but the proceeds are tax-exempt as compensation for personal injuries or sickness (Q 366).[5] This is true even though a taxpayer intends to use the benefits to pay his or her overhead expenses during periods of disability.[6] (see Q 361).

363. What are the tax consequences when disability insurance is purchased on the lives of business owners to fund a disability buy-out?

Whether a purchaser, policyowner, beneficiary, or premium payor is the business entity, as in an entity purchase agreement, or the business owner, as in a cross-purchase agreement, the premiums are nondeductible and the proceeds are exempt from regularly calculated income tax (Q 361).[7]

1. *Rugby Prod. Ltd. v. Comm.*, 100 TC 531 (1993).
2. CCA POSTF-135262-08.
3. IRS Office of Chief Counsel Memorandum No. 200947035, Nov. 20, 2009.
4. Rev. Rul. 55-264, 1955-1 CB 11.
5. Rev. Rul. 55-331, 1955-1 CB 271; Rev. Rul. 70-394, 1970-2 CB 34.
6. Rev. Rul. 58-480, 1958-2 CB 62; *Blaess v. Comm.*, 28 TC 710 (1957); *Andrews v. Comm.*, TC Memo 1970-32.
7. IRC Secs. 104(a)(3), 265(a)(1); Rev. Rul. 66-262, 1966-2 CB 105.

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Where a buy-out occurs between a corporation and a disabled shareholder, if the transaction qualifies as a complete redemption of all the shareholder's shares, the redemption will be treated as a capital transaction (Q 285). That is, the transaction will be considered the sale of a capital asset and the selling shareholder's gain or loss will be measured and taxed. A disability buy-out between shareholders also is a capital transaction and is taxed accordingly.[1]

Where a buy-out occurs between a partnership and a disabled partner, resulting in a termination of the disabled partner's interest, the transaction is taxed under the rules applying to a liquidation of a partner's interest (Q 296).

Where a buy-out occurs between partners, the transaction is taxed under the rules applying to a sale of a partner's interest (Q 296).

When a disabled business owner realizes gain on the sale of his or her business interest, the amount of gain is includable in his or her gross income in the taxable year in which the gain is actually or constructively received unless the gain is includable in a different year due to the taxpayer's method of accounting.[2] If a sale qualifies as an installment sale, a proportion of the gain is reportable for each taxable year installment payments are received.

364. Can an employer deduct premiums paid for employer-provided disability income coverage?

An employer generally can deduct all premiums paid for disability income coverage, as with all premiums paid for health insurance (Q 313), for one or more employees as a business expense.

Premiums are deductible by an employer whether coverage is provided under a group policy or under individual policies. The deduction is allowable only if benefits are payable to employees or their beneficiaries; it is not allowable if benefits are payable to an employer.[3]

The deduction of premiums paid for a disability income policy insuring an employee-shareholder was prohibited where the corporation was the premium payor, owner, and beneficiary of the policy. The Tax Court held that IRC Section 265(a) prevented the deduction because the premiums were funds expended to produce tax-exempt income. The Tax Court stated that disability income policy benefits, had any been paid, would have been tax-exempt under IRC Section 104(a)(3).[4]

365. How are benefits provided under an employer-provided disability income plan taxed?

Sick pay, wage continuation payments, and disability income payments, both preretirement and postretirement, generally are fully includable in gross income and taxable to an employee.[5]

1. IRC Secs. 61(a)(3), 1001, 1011, 1221, and 1222.
2. Treas. Reg. §1.451-1(a).
3. Treas. Reg. §1.162-10(a); Rev. Rul. 58-90, 1958-1 CB 88; Rev. Rul. 56-632, 1956-2 CB 101.
4. *Rugby Prod. Ltd. v. Comm.*, 100 TC 531 (1993). See Rev. Rul. 66-262, 1966-2 CB 105.
5. Let. Ruls. 9103043, 9036049.

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Specifically, long-term disability income payments received under a policy paid for by an employer are fully includable in income to a taxpayer.[1]

A disabled former employee could not exclude from income a lump sum payment received from the insurance company that provided the employee's employer-paid long-term disability coverage. The lump sum nature of the settlement did not change the nature of the payment into something other than a payment received under accident or health insurance.[2]

If benefits are received under a plan to which an employee has contributed, the portion of the disability income attributable to the employee's contributions is tax-free.[3] Under an individual policy, an employee's contributions for the current policy year are taken into consideration. With a group policy, an employee's contributions for the last three years, if known, are considered.[4]

In Revenue Ruling 2004-55, the IRS held that the three-year look back rule did not apply because the plan was amended so that, with respect to each employee, the amended plan was financed either solely by the employer or solely by the employee. The three-year look back rule does not apply if a plan is not considered a contributory plan.

An employer may allow employees to elect, on an annual basis, whether to have premiums for a group disability income policy included in employees' income for that year. An employee who elects to have premiums included in his or her income will not be taxed on benefits received during a period of disability beginning in that tax year.[5] An employee's election will be effective for each tax year without regard to employer and employee contributions for prior years.

Where an employee-owner reimbursed his corporation for payment of premiums on a disability income policy, the benefit payments that he received while disabled were excludable from income under IRC Section 104(a)(3).[6]

Where an employer initially paid disability income insurance premiums but, prior to a second period of benefit payments, an employee took responsibility for paying premiums personally, the benefits paid from the disability income policy during the second benefit-paying period were not includable in the employee's income.[7]

Premiums paid by a former employee under an earlier long-term disability plan were not considered paid toward a later plan from which the employee received benefit payments. Thus, disability benefits were includable in income.[8] If an employer merely withholds employee contributions and makes none itself, the payments are excludable.[9] A tax credit for disability retirement income is available to taxpayers receiving those payments after the minimum age

1. *Cash v. Comm.*, TC Memo 1994-166; *Rabideau v. Comm.*, TC Memo 1997-230. See also *Pearson v. Comm.*, TC Memo 2000-160; *Crandall v. Comm.*, TC Memo 1996-463.
2. *Kees v. Comm.*, TC Memo 1999-41.
3. Treas. Reg. §1.105-1(c).
4. Treas. Reg. §1.105-1(d).
5. Rev. Rul. 2004-55, 2004-26 IRB 1081.
6. *Bouquett v. Comm.*, 67 T.C.M. 2959 (1994).
7. Let. Rul. 9741035. See also Let. Rul. 200019005.
8. *Chernik v. Comm.*, TC Memo 1999-313.
9. Rev. Rul. 73-347, 1973-2 CB 25.

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at which they would have received a pension or annuity if not disabled. This credit is called the Disability and Earned Income Tax Credit (EITC).

366. Are premiums paid for personal disability income coverage tax deductible?

Premiums for non-medical care, such as personal disability income coverage, are not deductible.[1] Only premiums for medical care insurance are deductible as a medical expense (Q 323, Q 430).

A deduction is allowed for medical care that is not otherwise compensated for by insurance. The deduction is allowed to the extent that the medical care expenses exceed 10 percent of the taxpayer's adjusted gross income. For taxable years beginning prior to 2013, the deduction was allowed to the extent that the medical care expenses exceeded 7.5 percent of the taxpayer's adjusted gross income.[2] The threshold is 10 percent for the alternative minimum tax and there is a transition rule, so that the 10 percent threshold for regular tax does not apply until 2017 for people over 65.

367. How are benefits provided under a personal disability income coverage plan taxed?

Benefits from personal disability income coverage typically are entirely exempt from income tax. There is no limit on the amount of benefits, including the amount of disability income that can be received tax-free under personally paid disability income coverage.[3]

If benefits are received under a plan to which both an employer and employee have contributed, the portion of the disability income attributable to the employee's contributions is tax-free (Q 364).[4]

368. How are disability pension payments from a qualified pension or profit-sharing plan taxed?

Disability payments from a qualified plan receive different tax treatment, depending on whether the payments are made to common law employees or to self-employed individuals.

Payments to Common Law Employees

If a disability pension is derived from employer contributions and is made in lieu of wages to an employee who retired on account of permanent and total disability, the employee may be entitled to an Earned Income Tax Credit (EITC). (Q 364) The employee is not entitled to exclude from income any part of a disability benefit derived from employer contributions.

1. *See* IRC Sec. 213(d)(1).
2. IRC Sec. 213(a).
3. IRC Sec. 104(a)(3); Rev. Rul. 55-331, 1955-1 CB 271, modified by Rev. Rul. 68-212, 1968-1 CB 91; Rev. Rul. 70-394, 1970-2 CB 34.
4. Treas. Reg. §1.105-1(c).

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In a contributory plan, it will be presumed that a disability pension is derived from employer contributions unless the plan expressly provides otherwise.

Under IRC Section 72(d), amounts received from disability pensions can be excluded from income until an employee has excluded an amount that is equal to his or her consideration for the contract. Under the three-year rule, if the total amounts received by the employee during the first three years' payments are made on the contract either equal or exceed the consideration paid by the employee, then the payments will be excluded from the employee's income until the amount of consideration has been met. Any employee contributions that were allocated to provide disability payments cannot be included in the employee's cost basis in figuring the tax on his or her retirement pension payments.[1]

In the case of a plan that required employees to pay premiums for their disability coverage, subject to a right of reimbursement from their employer, the Tax Court determined that disability payments for a six month period where an employee was on leave without sick pay were includable in the employee's income. The Tax Court held that the employees were required to pay taxes on the recovered past-due benefits they received because there were no actual repayments made.[2]

The payment of post-retirement medical expense benefits is tax-free to an employee.[3]

A few courts have held that a profit sharing plan also can be an accident or health plan so that payment of the full amount in the employee's account on termination of employment because of permanent disability for loss of a bodily function is entirely excludable under IRC Section 105(c).[4] Absent clear evidence to the contrary, other courts have been reluctant to find deferred compensation profit sharing plans to be dual purpose plans intended to provide both retirement and health or accident benefits.[5] Distributions from these plans have been held to be taxable because they were not computed in reference to a taxpayer's disability, that is, in an accident or health plan, but to the taxpayer's length of service.[6]

An individual who terminated employment on account of disability after the normal retirement date but prior to a deferred retirement date could not claim the IRC Section 105(c) exclusion because the plan provided that payments after normal retirement age would be paid on account of age and years of service rather than on account of injury or sickness.[7]

The IRS has taken the position that distributions made from a qualified profit-sharing trust, when used to pay for an employee's medical-care expenses, cannot be excluded from income as

1. Treas. Reg. §1.72-15(c); *Butler v. Comm.*, TC Memo 1987-463.
2. *Andrews v. Comm.*, TC Memo 1992-668.
3. Treas. Reg. §1.72-15(h).
4. *Wood v. U.S.*, 590 F.2d 321 (9th Cir. 1979); *Masterson v. U.S.*, 478 F. Supp. 454, 79-2 USTC 9664 (N.D. Ill. 1979); *Berner v. U.S.*, 81-2 USTC 9733 (W.D. Pa. 1981).
5. *Caplin v. U.S.*, 718 F.2d 544 (2d Cir. 1983); *Berman v. Comm.*, 925 F.2d 936 (6th Cir. 1991); *Gordon v. Comm.*, 88 TC 630 (1987); *Paul v. U.S.*, 682 F.Supp. 329 (E.D. Mich. 1988).
6. *Est. of Hall v. Comm.*, 103 f. 3d 112, 97-1 USTC 50104 (3rd Cir. 1996); *Dorroh v. Comm.*, 74 F3d 1255, 96-1 USTC 50,119 (11th Cir. 1996); see also, Let. Rul. 8824013.
7. Let. Rul. 9504041.

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accident or health benefits under Section 105(b). Instead, the distributions must be included in employee income as previously earned deferred compensation under Section 402(a).[1]

Payments to Self-Employed Individuals

If a self-employed individual draws benefits from a plan because of permanent disability, the disability payments will be taxed under the same rules that apply to retirement benefits (Q 3864).

If a self-employed individual receives disability payments through health insurance, the employee may exclude from gross income any amounts attributable to nondeductible contributions as a self-employed person.[2]

Where contributions under a qualified plan are applied to provide incidental accident and health insurance for a self-employed individual, the insurance is treated as if the employee had purchased it directly from the insurance company.[3]

Health and Medical Savings Accounts

In General

369. What is a Health Savings Account (HSA) and how can an HSA be established?

An HSA is a trust created exclusively for the purpose of paying qualified medical expenses of an account beneficiary.[4]

An HSA must be created by a written governing instrument that states:

(1) no contribution will be accepted except in the case of a rollover contribution (Q 381) unless it is in cash or to the extent that the contribution, when added to previous contributions for the calendar year, exceeds the contribution limit for the calendar year;

(2) the trustee is a bank, an insurance company, or a person who satisfies IRS requirements;

(3) no part of trust assets will be invested in life insurance contracts;

(4) trust assets will not be commingled with other property, with certain limited exceptions; and

(5) the interest of an individual in the balance of his or her account is non-forfeitable.[5]

HSAs are available to any employer or individual for an account beneficiary who has high deductible health insurance coverage (Q 371). An eligible individual or an employer may

1. Rev. Rul. 69-141, 1969-1 CB 48.
2. IRC Secs. 105(g), 104(a)(3); Treas. Regs. §§1.105-1(a), 1.105-5(b).
3. See Treas. Reg. §1.72-15(g).
4. IRC Sec. 223(d)(1).
5. IRC Sec. 223(d)(1).

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establish an HSA with a qualified HSA custodian or trustee. No permission or authorization is needed from the IRS to set up an HSA. As mentioned above, any insurance company or bank can act as a trustee. Additionally, any person already approved by the IRS to act as an individual retirement arrangement (IRA) trustee or custodian automatically is approved to act in the same capacity for HSAs.[1]

Although an HSA is similar to an IRA in some respects, a taxpayer cannot use an IRA as an HSA, nor can a taxpayer combine an IRA with an HSA.[2]

Contributions to an HSA generally may be made either by an individual, by an individual's employer, or by both. If contributions are made by an individual taxpayer, they are deductible from income.[3] If contributions are made by an employer, they are excluded from employee income.[4]

An HSA itself is exempt from income tax as long as it remains an HSA.[5]

Contributions may be made through a cafeteria plan under IRC Section 125 (Q 3501).[6]

Distributions from HSAs are not includable in gross income if they are used exclusively to pay qualified medical expenses. Distributions used for other purposes are includable in gross income and may be subject to a penalty, with some exceptions (Q 381).[7]

An employer's contributions to an HSA are not considered part of a group health plan subject to COBRA continuation coverage requirements (Q 335).[8] Therefore, a plan is not required to make COBRA continuation coverage available with respect to an HSA.[9]

The IRS has stated that a levy to satisfy a tax liability under IRC Section 6331 extends to a taxpayer's interest in an HSA. A taxpayer is liable for the additional 10 percent tax (20 percent after December 31, 2010, under PPACA 2010[10]) on the amount of the levy unless, at the time of the levy, the taxpayer had attained the age of sixty-five or was disabled.[11]

370. Who is an eligible individual for purposes of a Health Savings Account (HSA)?

For purposes of an HSA, an eligible individual is an individual who, for any month, is covered under a high deductible health plan (HDHP) as of the first day of that month and is not also covered under a non-high deductible health plan providing coverage for any benefit covered under the high deductible health plan.[12]

1. Notice 2004-50, 2004-2 CB 196, A-72; Notice 2004-2, 2004-1 CB 269, A-9, A-10.
2. See Notice 2004-2, above.
3. IRC Sec. 223(a).
4. See IRC Sec. 106(d)(1).
5. IRC Sec. 223(e)(1).
6. IRC Sec. 125(d)(2)(D).
7. IRC Sec. 223(f).
8. See IRC Secs. 106(b)(5), 106(d)(2).
9. See Treas. Reg. §54.4980B-2, A-1 regarding Archer MSAs.
10. Patient Protection and Affordable Care Act.
11. CCA 200927019.
12. IRC Sec. 223(c)(1)(A).

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An individual enrolled in Medicare Part A or Part B may not contribute to an HSA.[1] Mere eligibility for Medicare does not preclude HSA contributions.[2]

An individual may not contribute to an HSA for a given month if he or she has received medical benefits through the Department of Veterans Affairs within the previous three months. Mere eligibility for VA medical benefits will not disqualify an otherwise eligible individual from making HSA contributions.[3]

A separate prescription drug plan that provides any benefits before a required high deductible is satisfied normally will prevent a beneficiary from qualifying as an eligible individual.[4] The IRS has ruled that if an individual's separate prescription drug plan does not provide benefits until an HDHP's minimum annual deductible amount has been met, then the individual will be an eligible individual under Section 223(c)(1)(A). For calendar years 2004 and 2005 only, the IRS provided transition relief such that an individual would not fail to be an eligible individual solely by virtue of coverage by a separate prescription drug plan.[5]

An individual will not fail to be an eligible individual solely because the individual is covered under an Employee Assistance Program, disease management program, or wellness program, if the program does not provide significant benefits in the nature of medical care or treatment.[6]

Certain kinds of insurance are not taken into account in determining whether an individual is eligible for an HSA. Specifically, insurance for a specific disease or illness, hospitalization insurance paying a fixed daily amount, and insurance providing coverage that relates to certain liabilities are disregarded.[7]

In addition, coverage provided by insurance or otherwise for accidents, disability, dental care, vision care, or long-term care will not adversely impact HSA eligibility.[8]

If an employer contributes to an eligible employee's HSA, in order to receive an employer comparable contribution the employee must:

(1) establish the HSA on or before the last day in February of the year following the year for which the contribution is being made and;

(2) notify the appropriate contact person of the HSA account information on or before the last day in February of the year described in (1) above and specify and provide HSA account information (*e.g.*, account number, name and address of trustee or custodian, etc.) as well as the method by which the account information will be provided (*e.g.*, in writing, by e-mail, on a certain form, etc.).

1. IRC Sec. 223(b)(7).
2. Notice 2004-50, 2004-2 CB 196, A-3.
3. Notice 2004-50, 2004-2 CB 196, A-5.
4. Rev. Rul. 2004-38, 2004-1 CB 717.
5. Rev. Proc. 2004-22, 2004-1 CB 727.
6. Notice 2004-50, 2004-2 CB 196, A-10.
7. IRC Sec. 223(c)(3).
8. IRC Sec. 223(c)(1)(B).

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An eligible employee that establishes an HSA and provides the information required as described in (1) and (2) above will receive an HSA contribution, plus reasonable interest, for the year for which contribution is being made by April 15 of the following year.[1]

371. What is a high deductible health plan for purposes of a Health Savings Account (HSA)?

For purposes of an HSA, the requirements for a high deductible health plan (HDHP) differ depending on the coverage.

In the case of self-only coverage, an HDHP is a health plan with an annual deductible of not less than $1,250 in 2013 and 2014 (increasing to $1,300 in 2015) and required annual out-of-pocket expenses of not more than $6,250 in 2013, $6,450 in 2014 and $6,650 in 2015.[2]

In the case of family coverage, a high deductible health plan is a health plan with an annual deductible of not less than $2,500 in 2013 and 2014 (increasing to $2,600 in 2015) and required annual out-of-pocket expenses of not more than $12,500 in 2013, $12,700 in 2014 and $12,900 in 2015.[3] For this purpose, family coverage is any coverage other than self-only coverage.[4]

Other Issues

Deductible limits for HDHPs are based on a twelve month period. If a plan deductible may be satisfied over a period longer than twelve months, the minimum annual deductible under IRC Section 223(c)(2)(A) must be increased on a pro-rata basis to take into account the longer period.[5]

An HDHP may impose a reasonable lifetime limit on benefits provided under the plan as long as the lifetime limit on benefits is not designed to circumvent the maximum annual out-of-pocket limitation.[6] A plan with no limitation on out-of-pocket expenses, either by design or by its express terms, does not qualify as a high deductible health plan.[7]

An HDHP may provide coverage for preventive care without application of the annual deductible.[8] The IRS has provided guidance and safe harbor guidelines on what constitutes preventive care. Under the safe harbor, preventive care includes, but is not limited to, periodic check-ups, routine prenatal and well-child care, immunizations, tobacco cessation programs, obesity weight-loss programs, and various health screening services. Preventive care may include drugs or medications taken to prevent the occurrence or reoccurrence of a disease that is not currently present.[9]

1. TD 9393, 2008-20 IRB.
2. IRC Sec. 223(c)(2)(A); Rev. Proc. 2012-26, 2012-20 IRB 933, Rev. Proc. 2013-25, 2013-21 IRB 1110; Rev. Proc. 2014-30, 2014 IRB LEXIS 313.
3. IRC Sec. 223(c)(2)(A); Rev. Proc. 2012-26, 2012-20 IRB 933, Rev. Proc. 2013-25, 2013-21 IRB 1110; Rev. Proc. 2014-30, 2014 IRB LEXIS 313.
4. IRC Sec. 223(c)(5).
5. Notice 2004-50, 2004-2 CB 196, A-24.
6. Notice 2004-50, 2004-2 CB 196, A-14.
7. Notice 2004-50, 2004-2 CB 196, A-17.
8. IRC Sec. 223(c)(2)(C).
9. Notice 2004-50, 2004-2 CB 196, A-27; Notice 2004-23, 2004-1 CB 725.

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For months before January 1, 2006, a health plan would not fail to qualify as a high deductible health plan solely because it complied with state health insurance laws that mandate coverage without regard to a deductible or before the high deductible is satisfied.[1] This transition relief only applied to disqualifying benefits mandated by state laws that were in effect on January 1, 2004. This relief extended to non-calendar year health plans with benefit periods of twelve months or less that began before January 1, 2006.[2]

Out-of-pocket expenses include deductibles, co-payments, and other amounts that a participant must pay for covered benefits. Premiums are not considered out-of-pocket expenses.[3]

Annual deductible amounts and out-of-pocket expense amounts stated above are adjusted for cost of living. Increases are made in multiples of $50.[4]

Contributions

372. What are the limits on amounts contributed to a Health Savings Account (HSA)?

An eligible individual may deduct the aggregate amount paid in cash into an HSA during the taxable year, up to $3,250 for self-only coverage and $6,450 for family coverage in 2013.[5] For 2014, HSA contribution limits increase to $3,300 for self-only coverage, and $6,550 for family coverage.[6]

For 2006 and prior years, the contribution and deduction were limited to the lesser of the deductible under the applicable HDHP or the indexed annual limits for self-only coverage or family coverage.[7]

The determination between self-only and family coverage is made as of the first day of the month. The limit is calculated on a monthly basis and the allowable deduction for a taxable year cannot exceed the sum of the monthly limitations, but see below for the rule applicable to newly eligible individuals, for the months during which an individual was an eligible individual (Q 370).[8]

For example, a person with self-only coverage under an HDHP would be limited to a monthly contribution limit of $275 for 2014 ($3,300 divided by 12). If a person was an eligible individual for only the first eight months of a year, the contribution limit for the year would be $2,200 (eight months multiplied by the monthly limit of $275). Although the annual contribution level is determined for each month, the annual contribution can be made in a single payment, if desired.[9]

1. Notice 2004-43, 2004-2 CB 10.
2. Notice 2005-83, 2005-2 CB 1075.
3. Notice 2004-2, 2004-1 CB 269, A-3; Notice 96-53, 1996-2 CB 219, A-4.
4. IRC Sec. 223(g).
5. IRC Secs. 223(a), 223(b)(2); Rev. Proc. 2010-22, 2010-1 CB 747; Rev. Proc. 2009-29, 2009-1 CB 1050.
6. Rev. Proc. 2013-25.
7. IRC Sec. 223(b)(2), prior to amendment by TRHCA 2006.
8. IRC Sec. 223(b)(1).
9. IRC Sec. 223(b); Notice 2004-2, 2004-1 CB 269, A-12.

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Individuals who attain age fifty-five before the close of a taxable year are eligible for an additional contribution amount over and above that calculated under IRC Section 223(b)(1) and IRC Section 223(b)(2). The additional contribution amount is $1,000 for 2009 and later years.[1] In 2014, this would allow individuals age fifty-five and older a total contribution of up to $4,300; the total contribution for a family would be $7,550.

An individual who becomes an eligible individual after the beginning of a taxable year and who is an eligible individual for the last month of the taxable year shall be treated as being an eligible individual for the entire taxable year. For example, a calendar-year taxpayer with self-only coverage under an HDHP who became an eligible individual for December 2014 would be able to contribute the full $3,300 to an HSA in that taxable year. If a taxpayer fails at any time during the following taxable year to be an eligible individual, the taxpayer must include in his or her gross income the aggregate amount of all HSA contributions made by the taxpayer that could not have been made under the general rule. The amount includable in gross income also is subject to a 10 percent penalty tax.[2]

For married individuals, if either spouse has family coverage, then both spouses are treated as having family coverage and the deduction limit is divided equally between them, unless they agree on a different division (note that this now applies to same sex couples equally, see Q 378). If both spouses have family coverage under different plans, both spouses are treated as having only the family coverage with the lowest deductible.[3]

An HSA may be offered in conjunction with a cafeteria plan (Q 3501). Both a high deductible health plan and an HSA are qualified benefits under a cafeteria plan.[4]

Employer contributions to an HSA are treated as employer-provided coverage for medical expenses to the extent that contributions do not exceed the applicable amount of allowable HSA contributions.[5]

An employee will not be required to include any amount in income simply because he or she may choose between employer contributions to an HSA and employer contributions to another health plan.[6]

An employer generally can deduct amounts paid to accident and health plans for employees as a business expense (Q 313).

An individual may not deduct any amount paid into his or her HSA; that amount is excludable from gross income under IRC Section 106(d).[7]

1. IRC Sec. 223(b)(3).
2. IRC Sec. 223(b)(8).
3. IRC Sec. 223(b)(5).
4. IRC Sec. 125(d)(2)(D).
5. IRC Sec. 106(d)(1).
6. IRC Secs. 106(b)(2), 106(d)(2).
7. See IRC Sec. 223(b)(4).

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No deduction is allowed for any amount contributed to an HSA with respect to any individual for whom another taxpayer may take a deduction under IRC Section 151 for the taxable year.[1]

373. Must an employer offering Health Savings Accounts (HSAs) to its employees contribute the same amount for each employee?

An employer offering HSAs to its employees must make comparable contributions to the HSAs for all comparable participating employees for each coverage period during the calendar year.[2] IRC Section 4980G incorporates the comparability rules of IRC Section 4980E by reference.[3]

Comparable contributions are contributions that either are the same amount or the same percentage of the annual deductible limit under a high deductible health plan (HDHP).[4]

Comparable participating employees are all employees who are in the same category of employee and have the same category of coverage.

Category of employee refers to full-time employees, part-time employees, and former employees.[5]

Category of coverage refers to self-only and family-type coverage. Family coverage may be subcategorized as self plus one, self plus two, and self plus three or more. Subcategories of family coverage may be tested separately, but under no circumstances may an employer contribute less to a category of family coverage with more covered persons.[6]

For years beginning after 2006, highly compensated employees are not treated as comparable participating employees to non-highly compensated employees.[7]

Employer contributions made to HSAs through a cafeteria plan, including matching contributions, are not subject to comparability rules but are subject to IRC Section 125 nondiscrimination rules (Q 3504).[8]

An employer may make contributions to the HSAs of all eligible employees at the beginning of a calendar year; it may contribute monthly on a pay-as-you-go basis; or it may contribute at the end of a calendar year, taking into account each month that an employee was a comparable participating employee. An employer must use the same contribution method for all comparable participating employees.[9]

If an employer does not prefund HSA contributions, regulations provide that it may accelerate all or part of its contributions for an entire year to HSAs of employees who incur, during the

1. IRC Sec. 223(b)(6).
2. IRC Secs. 4980E, 4980G.
3. Treas. Reg. §54.4980G-1, A-1.
4. IRC Sec. 4980E(d)(2); Treas. Reg. §54.4980G-4, A-1.
5. Treas. Reg. §54.4980G-3, A-5.
6. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-1, A-2, 54.4980G-4, A-1.
7. IRC Sec. 4980G(d), as added by TRHCA 2006.
8. Notice 2004-50, 2004-2 CB 196, A-47; IRC Sec. 125 (b), (c), and (g); Treas. Reg. §1.125-1, A-19.
9. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-4, A-4.

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calendar year, qualified medical expenses exceeding the employer's cumulative HSA contributions to date. If an employer permits accelerated contributions, the accelerated contributions must be available on a uniform basis to all eligible employees under reasonable requirements.[1]

To deal with employees who may not have established an HSA at the time an employer makes contributions, regulations require employers to provide to each eligible employee by January 15 a written notice that if the employee, by the last day of February, both establishes an HSA and notifies the employer that he or she has done so, the employee will receive a comparable contribution to the HSA for the prior calendar year. The written notice may be delivered electronically. For each eligible employee that notifies an employer that he or she has established an HSA, the employer must, by April 15, make comparable contributions, taking into account each month that an employee was a comparable participating employee, plus reasonable interest.[2]

There is a maximum contribution permitted for all employees who are eligible individuals during the last month of the taxable year. An employer may contribute up to the maximum annual contribution amount for the calendar year based on the employees' HDHP coverage to HSAs of all employees who are eligible individuals on the first day of the last month of the employees' taxable year, including employees who worked for the employer for less than the entire calendar year and employees who became eligible individuals after January 1 of the calendar year. For example, contributions may be made on behalf of an eligible individual who is hired after January 1 or an employee who becomes an eligible individual after January 1.[3]

Employers are not required to provide more than a pro rata contribution based on the number of months that an individual was an eligible individual and employed by the employer during the year. If an employer contributes more than a pro rata amount for a calendar year to an HSA of any eligible individual who is hired after January 1 of the calendar year, or any employee who becomes an eligible individual any time after January 1 of the calendar year, the employer must contribute that same amount on an equal and uniform basis to HSAs of all comparable participating employees who are hired or become eligible individuals after January 1 of the calendar year.[4]

Likewise, if an employer contributes the maximum annual contribution amount for the calendar year to an HSA of any eligible individual who is hired after January 1 of the calendar year or any employee who becomes an eligible individual any time after January 1 of the calendar year, the employer also must contribute the maximum annual contribution amount on an equal and uniform basis to HSAs of all comparable participating employees who are hired or become eligible individuals after January 1 of the calendar year.[5]

An employer who makes the maximum calendar year contribution or more than a pro rata contribution to HSAs of employees who become eligible individuals after the first day of the calendar year or to eligible individuals who are hired after the first day of the calendar year

1. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-4, A-15.
2. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-4, A-14.
3. Treas. Reg. §54.4980G-4.
4. Treas. Reg. §54.4980G-4.
5. Treas. Reg. §54.4980G-4.

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will not fail to satisfy comparability merely because some employees will have received more contributions on a monthly basis than employees who worked the entire calendar year.[1]

374. Are there any exceptions to the general rule that an employer offering Health Savings Accounts (HSAs) to its employees must make comparable contributions for all comparable participating employees?

The IRC provides an exception to comparability rules (Q 373) that allows, but that does not require, employers to make larger contributions to HSAs of non-highly compensated employees than to HSAs of highly compensated employees.[2] Regulations provide that employers may make larger HSA contributions for non-highly compensated employees who are comparable participating employees than for highly compensated employees who are comparable participating employees.[3] Employer contributions to HSAs for highly compensated employees who are comparable participating employees may not be larger than employer HSA contributions for non-highly compensated employees who are comparable participating employees.[4] Comparability rules continue to apply with respect to contributions to HSAs of all non-highly compensated employees and all highly compensated employees. Thus, employers must make comparable contributions for a calendar year to the HSA of each non-highly compensated comparable participating employee and each highly compensated comparable participating employee.[5]

375. Do the comparability rules that apply to employer-provided health savings accounts (HSAs) apply to qualified HSA distributions (rollovers)?

An employer who offers a rollover, namely, a qualified HSA distribution (Q 381), from a health reimbursement arrangement (Q 330) or a health flexible spending arrangement (Q 3515) for any employee must offer a rollover to any eligible individual covered under an HDHP of the employer. Otherwise, the comparability requirements of IRC Section 4980G do not apply to qualified HSA distributions.[6]

There are special comparability rules for qualified HSA distributions contributed to HSAs on or after December 20, 2006, and before January 1, 2012. Effective January 1, 2010, the comparability rules of IRC Section 4980G do not apply to amounts contributed to employee HSAs through qualified HSA distributions. To satisfy comparability rules, if an employer offers qualified HSA distributions to any employee who is an eligible individual covered under any HDHP, the employer must offer qualified HSA distributions to all employees who are eligible individuals covered under any HDHP. If an employer offers qualified HSA distributions only to employees who are eligible individuals covered under an employer's HDHP, the employer is not required to offer qualified HSA distributions to employees who are eligible individuals but are not covered under the employer's HDHP.[7]

1. Treas. Reg. §54.4980G-4.
2. IRC Sec. 4980G(d); Preamble, TD 9457, 74 Fed. Reg. 45994, 45995 (9-8-2009); see Treas. Reg. §54.4980G-6.
3. Treas. Reg. §54.4980G-6, Q&A-1.
4. Treas. Reg. §54.4980G-6, Q&A-2.
5. Treas. Reg. §54.4980G-6, Q&A-1.
6. IRC Sec. 106(e)(5).
7. Treas. Reg. §54.4980G-7, Q&A-1.

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376. What are the consequences if an employer does not meet the comparability requirements applicable to health savings accounts (HSAs)?

If an employer fails to meet comparability requirements applicable to HSAs (Q 373 to Q 375), a penalty tax is imposed, equal to 35 percent of the aggregate amount contributed by an employer to HSAs of employees for their taxable years ending with or within the calendar year.[1]

377. What is the tax consequence to individuals when excess contributions are made to a Health Savings Account (HSA)?

If an HSA receives excess contributions for a taxable year, distributions from the HSA are not includable in income to the extent that the distributions do not exceed the aggregate excess contributions to all HSAs of an individual for a taxable year if (1) the distribution is received by the individual on or before the last day for filing the individual's income tax return for the year, including extensions; and (2) the distribution is accompanied by the amount of net income attributable to the excess contribution. Any net income must be included in an individual's gross income for the taxable year in which it is received.[2]

Excess contributions to an HSA are subject to a 6 percent tax. The tax may not exceed 6 percent of the value of the account, determined at the close of the taxable year.[3]

Excess contributions are defined, for this purpose, as the sum of (1) the aggregate amount contributed for the taxable year to the accounts, excluding rollover contributions, which is neither excludable from gross income under IRC Section 106(b) nor allowable as a deduction under IRC Section 223, and (2) this amount for the preceding taxable year reduced by the sum of (x) the distributions from the accounts that were included in gross income under IRC Section 223(f)(2), and (y) the excess of the maximum amount allowable as a deduction under IRC Section 223(b)(1), for the taxable year, over the amount contributed for the taxable year.[4]

For these purposes, any excess contributions distributed from an HSA are treated as amounts not contributed.[5]

378. What is the result if a same sex couple contributed amounts to a Health Savings Account (HSA) that exceed the applicable contribution limit for married couples?

A same sex couple legally married under the law of any state is now subject to the same HSA contribution limits as an opposite gender couple (see Q 372). As a result, the IRS has issued guidance providing a remedy for situations in which both members of a same sex couple contributed funds to an HSA prior to the recognition of their marriage that, when combined,

1. IRC Secs. 4980E(a), 4980E(b), 4980G(b). For filing requirements for excise tax returns, see Treas. Regs. §§54.6011-2 (general requirement of return), 54.6061-1 (signing of return), 54.6071-1(c) (time for filing return), 54.6091-1 (place for filing return), and 54.6151-1 (time and place for paying tax shown on return).
2. IRC Sec. 223(f)(3)(A), Notice 2004-50, 2004-2 CB 196
3. IRC Sec. 4973(a).
4. IRC Sec. 4973(g).
5. IRC Sec. 4973(g).

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exceed the applicable limit for a married couple. The couple may choose to reduce one or both members' contribution to the HSAs in order to avoid exceeding the contribution limit. In the alternative, if their contributions have already exceeded the threshold, the excess may be distributed to the spouses prior to the due date for filing their tax return. Any remaining excess contributions will be subject to the penalty tax typically imposed under IRC Section 4973. These rules apply for the 2013 tax year and beyond.[1]

Distributions and Transfers

379. How are funds accumulated in a Health Savings Account (HSA) taxed prior to distribution?

An HSA generally is exempt from income tax unless it ceases to be an HSA.[2]

In addition, rules similar to those applicable to individual retirement arrangements (IRAs) regarding the loss of the income tax exemption for an account where an employee engages in a prohibited transaction[3] and those regarding the effect of pledging an account as security[4] apply to HSAs. Any amounts treated as distributed under these rules will be treated as not used to pay qualified medical expenses (Q 3608).[5]

380. How are amounts distributed from a Health Savings Account (HSA) taxed?

A distribution from an HSA used exclusively to pay qualified medical expenses of an account holder is not includable in gross income.[6] Any distribution from an HSA that is not used exclusively to pay qualified medical expenses of an account holder must be included in the account holder's gross income.[7]

Any distribution that is includable in income because it was not used to pay qualified medical expenses is also subject to a penalty tax.[8] The penalty tax is 10 percent of includable income for a distribution from an HSA.[9] For distributions made after December 31, 2010, the additional tax on nonqualified distributions from HSAs is increased to 20 percent of includable income.[10]

Includable distributions received after an HSA holder becomes disabled within the meaning of IRC Section 72(m)(7), dies, or reaches the age of Medicare eligibility are not subject to the penalty tax.[11]

1. Notice 2014-1, 2014-2 IRB 270.
2. IRC Sec. 223(e)(1).
3. See IRC Sec. 408(e)(2).
4. See IRC Sec. 408(e)(4).
5. IRC Sec. 223(e)(2).
6. IRC Sec. 223(f)(1).
7. IRC Sec. 223(f)(2).
8. IRC Sec. 223(f)(4)(A).
9. IRC Sec. 223(f)(4)(A).
10. IRC Sec. 223(f)(4)(A), as amended by PPACA 2010, as further amended by HCERA 2010.
11. IRC Secs. 223(f)(4)(B), 223(f)(4)(C).

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Qualified medical expenses are amounts paid by the account holder for medical care[1] for the individual, his or her spouse, and any dependent to the extent that expenses are not compensated by insurance or otherwise.[2] For tax years beginning after December 31, 2010, medicines constituting qualified medical expenses will be limited to doctor-prescribed drugs and insulin. Consequently, over-the counter medicines will no longer be qualified expenses unless prescribed by a doctor after 2010.[3]

With several exceptions, the payment of insurance premiums is not a qualified medical expense. The exceptions include any expense for coverage under a health plan during a period of COBRA continuation coverage, a qualified long-term care insurance contract (Q 424),[4] or a health plan paid for during a period in which the individual is receiving unemployment compensation.[5]

An account holder may pay qualified long-term care insurance premiums with distributions from an HSA even if contributions to the HSA were made by salary reduction through an IRC Section 125 cafeteria plan. Amounts of qualified long-term care insurance premiums that constitute qualified medical expenses are limited to the age-based limits found in IRC Section 213(d)(10) as adjusted annually (Q 430).[6]

An HSA account holder may make tax-free distributions to reimburse qualified medical expenses from prior tax years as long as the expenses were incurred after the HSA was established. There is no time limit on when a distribution must occur.[7]

HSA trustees, custodians, and employers need not determine whether a distribution is used for qualified medical expenses. This responsibility falls on individual account holders.[8]

381. When may an account owner transfer or rollover funds into an HSA?

Funds may be transferred or rolled over from one HSA to another HSA or from an Archer MSA (Q 387) to an HSA provided that an account holder effects the transfer within sixty days of receiving the distribution.[9]

An HSA rollover may take place only once a year. The year is not a calendar year, but a rolling twelve month period beginning on the day when an account holder receives a distribution to be rolled over.[10] Transfers of HSA amounts directly from one HSA trustee to another HSA trustee, known as a trustee-to-trustee transfer, are not subject to the limits under IRC Section 223(f)(5). There is no limit on the number of trustee-to-trustee transfers allowed during a year.[11]

1. As defined in IRC Section 213(d).
2. IRC Sec. 223(d)(2).
3. IRC Sec. 106(f), as added by PPACA 2010.
4. As defined under IRC Section 7702B(b).
5. IRC Sec. 223(d)(2).
6. Notice 2004-50, 2004-2 CB 196, A-40.
7. Notice 2004-50, 2004-2 CB 196, A-39.
8. Notice 2004-2, 2004-1 CB 269, A-29, A-30.
9. IRC Secs. 220(f)(5)(A), 223(f)(5)(A).
10. IRC Secs. 220(f)(5)(B), 223(f)(5)(B).
11. Notice 2004-50, 2004-2 CB 196, A-56.

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A participant in a health reimbursement arrangement ("HRA") (Q 330) or a health flexible spending arrangement ("Health FSA") (Q 3515) may make a qualified HSA distribution on a one time per arrangement basis. A qualified HSA distribution is a transfer directly from an employer to an HSA of an employee to the extent the distribution does not exceed the lesser of the balance in the arrangement on September 21, 2006, or the date of distribution. A qualified HSA distribution shall be treated as a rollover contribution under IRC Section 223(f)(5), that is, it does not count toward the annual HSA contribution limit.[1]

If an employee fails to be an eligible individual (Q 370) at any time during a taxable year following a qualified HSA distribution, the employee must include in his or her gross income the aggregate amount of all qualified HSA distributions. The amount includable in gross income is also subject to a 10 percent penalty tax.[2]

General purpose health FSA coverage during a grace period, after the end of a plan year, will be disregarded in determining an individual's eligibility to contribute to an HSA if the individual makes a qualified HSA distribution of the entire balance. Health FSA coverage during a plan year is not disregarded, even if a health FSA balance is reduced to zero. An individual who begins HDHP coverage (Q 371) after the first day of the month is not an eligible individual until the first day of the following month.

The timing of qualified HSA distributions therefore is critical for employees covered by general-purpose, that is, non-high-deductible, health FSAs or HRAs:[3]

(1) An employee only should make a qualified HSA distribution if he or she has been covered by an HDHP since the first day of the month;

(2) An employee must rollover general purpose health FSA balances during the grace period after the end of the plan year, not during the plan year, and, of course, he or she must not be covered by a general purpose health FSA during the new year; and

(3) An employee must rollover the entire balance in an HRA or a health FSA to an HSA. If a balance remains in an HRA at the end of a plan year or in a health FSA at the end of the grace period, the employee will not be an HSA-eligible individual.

Beginning in 2007, a taxpayer may, once in his or her lifetime, make a qualified HSA funding distribution. A qualified HSA funding distribution is a trustee-to-trustee transfer from an IRA to an HSA in an amount that does not exceed the annual HSA contribution limitation for the taxpayer (Q 372). If a taxpayer has self-only coverage under an HDHP at the time of the transfer, but at a later date during the same taxable year obtains family coverage under an HDHP, the

1. IRC Sec. 106(e); Notice 2008-51, 2008-1 CB 1163.
2. IRC Sec. 106(e); Notice 2008-51, 2008-1 CB 1163.
3. Notice 2007-22, 2007-1 CB 670.

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taxpayer may make an additional qualified HSA funding distribution in an amount not exceeding the additional annual contribution for which the taxpayer has become eligible.[1]

If a taxpayer fails to be an eligible individual at any time during a taxable year following a qualified HSA funding distribution, the taxpayer must include in his or her gross income the aggregate amount of all qualified HSA funding distributions. The amount includable in gross income also is subject to a 10 percent penalty tax.[2]

382. Can an individual's interest in a Health Savings Account (HSA) be transferred as part of a divorce or separation?

Yes.

An individual's interest in an HSA may be transferred without income taxation from one spouse to another or from a spouse to a former spouse if the transfer is made under a divorce or separation instrument described in IRC Section 71(b)(2)(A). Following this kind of transfer, an interest in an HSA is treated as an interest of a transferee spouse.[3]

Death-Benefit-Only Plans

383. What happens to a Health Savings Account (HSA) on the death of an account holder? May a surviving spouse continue an account?

The disposition of an HSA at the death of an account holder depends on who is the designated beneficiary. If an account holder's surviving spouse is a designated beneficiary, then, when an account holder dies, the surviving spouse is treated as the account holder.[4]

If an account holder's estate is a designated beneficiary, the fair market value of the assets in the HSA must be included in such beneficiary's gross income for the estate's last taxable year. A deduction for any federal estate taxes paid is allowed to any person other than a decedent or a decedent's spouse under IRC Section 691(c) with respect to amounts included in gross income by that person.[5]

If anyone other than a surviving spouse or an account holder's estate is a designated beneficiary, the account ceases to be an HSA as of the date of the account holder's death and the fair market value of the assets in the account must be included in the designated beneficiary's gross income for the year including the date of death. The amount that must be included in gross income by any person other than the estate is reduced by the amount of qualified medical expenses that were incurred by the decedent account holder before his or her death and paid by the designated beneficiary within one year after the date of death.[6]

1. IRC Sec. 408(d)(9).
2. IRC Sec. 408(d)(9)(D).
3. IRC Sec. 223(f)(7).
4. IRC Sec. 223(f)(8)(A).
5. IRC Sec. 223(f)(8)(B).
6. IRC Sec. 223(f)(8)(B).

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Social Security

384. Are amounts contributed to a Health Savings Account (HSA) subject to Social Security or federal unemployment taxes and federal income tax withholding?

The definition of wages for purposes of the federal unemployment tax (FUTA) does not include any payment made to or for the benefit of an employee if it is reasonable to believe that the employee will be able to exclude the payment from income under IRC Section 106(d), which deals with contributions to HSAs.[1]

Unfortunately, a similar change was not made to IRC Section 3121(a) with respect to FICA. The IRS has stated, however, that employer contributions to an HSA are not subject to withholding from wages for income tax or subject to the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), or the Railroad Retirement Tax Act.[2] A similar statement has been made by the Joint Committee on Taxation.[3]

Withholding and Reporting

385. Are employer contributions to a Health Savings Account (HSA) on behalf of an employee subject to withholding?

HSA contributions made to or for the benefit of an employee, which it is reasonable to believe will be excludable from the employee's income under IRC Section 106(d), dealing with contributions to HSAs, are not subject to income tax withholding.[4]

386. What tax reporting requirements apply to a Health Savings Account (HSA)?

Each year employers must report on the Form W-2 to each employee the amount contributed to an HSA for the employee or the employee's spouse. The report must be received by the employee by January 31 of the following year.[5]

Archer Medical Savings Account

387. What is an Archer Medical Savings Account ("MSA") and how is it taxed?

An Archer Medical Savings Account ("MSA") is a trust created exclusively for the purpose of paying qualified medical expenses of an account holder,[6] who is the individual for whom the Archer MSA was established.[7]

1. IRC Sec. 3306(b)(18).
2. Notice 2004-2, 2004-1 CB 269, A-19.
3. See General Explanation of Tax Legislation Enacted in the 104th Congress (JCT-12-96), n. 1642, p. 324.
4. IRC Sec. 3401(a)(22); Notice 2004-2, 2004-1 CB 269, A-19.
5. IRC Sec. 6051(a); Notice 2004-2, 2004-1 CB 269, A-34.
6. IRC Sec. 220(d)(1).
7. IRC Sec. 220(d)(3).

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Archer MSAs were available through the cutoff date discussed below to small business employees and self-employed individuals with high deductible health insurance coverage.

Any insurance company or bank can act as a trustee of an Archer MSA. Additionally, any person already approved by the IRS to act as an individual retirement arrangement ("IRA") trustee or custodian automatically is approved to act in the same capacity for Archer MSAs.[1]

Contributions

Contributions to an Archer MSA may be made either by an individual or by his or her small employer, but not by both.[2] If made by an individual taxpayer, Archer MSA contributions are deductible from income.[3] If made by a small employer, Archer MSA contributions are excluded from employee income.[4] An Archer MSA itself is exempt from income tax.[5]

Distributions

Distributions from Archer MSAs are not includable in gross income if they are used exclusively to pay qualified medical expenses.[6] For this purpose, for tax years beginning after December 31, 2010, medications included in qualified medical expenses will be limited to doctor-prescribed drugs and insulin. Consequently, over-the counter medicines will no longer be qualified expenses unless prescribed by a doctor after 2010.[7]

Distributions used for other purposes are includable in gross income and may be subject to a 15 percent penalty tax, with some exceptions. For distributions made after December 31, 2010, the additional tax on nonqualified distributions from Archer MSAs is increased to 20 percent of any includable amounts.[8]

High Deductible Health Plan

For Archer MSAs in 2014, in the case of self-only coverage, a high deductible health plan is defined as a health plan with an annual deductible of not less than $2,200 ($2,150 in 2013) and not more than $3,250 ($3,200 in 2013), and required annual out-of-pocket expenses of not more than $4,350 ($4,300 in 2013).[9]

In the case of family coverage in 2014 a high deductible health plan is a health plan with an annual deductible of not less than $4,350 ($4,300 in 2013) and not more than $6,550 ($6,450 in

1. Notice 96-53, 1996-2 CB 219, A-9, A-10.
2. Notice 96-53, 1996-2 CB 219, A-12.
3. IRC Sec. 220(a).
4. See IRC Sec. 106(b)(1).
5. IRC Sec. 220(e)(1).
6. IRC Sec. 220(f)(1).
7. IRC Sec. 220(d)(2)(A), as amended by PPACA 2010.
8. IRC Secs. 220(f)(2), 220(f)(4), as amended by PPACA 2010.
9. IRC Sec. 220(c)(2)(A); Rev. Proc. 2012-41, 2012-2 CB 539; Rev. Proc. 2013-35.

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2013), and required annual out-of-pocket expenses of not more than $8,000 ($7,850 in 2013).[1] For this purpose, family coverage is defined as any coverage other than self-only coverage.[2]

Deduction

An eligible individual may deduct the aggregate amount paid in cash into an Archer MSA during a taxable year, subject to a limitation of 65 percent of the annual deductible for individuals with self-only coverage and 75 percent of the annual deductible for individuals with family coverage.[3]

In addition, IRC Section 220(j)(4)(D) specifies that, to the extent practical, all Archer MSAs established by an individual are aggregated and two married individuals opening separate Archer MSAs are to be treated as having a single Archer MSA for purposes of determining the number of Archer MSAs.[4]

For married individuals, if either spouse has family coverage, then both spouses are treated as having only family coverage and the deduction limit is divided equally between them, unless they agree on a different division.[5] If two spouses both have family coverage under different plans, both spouses are treated as having only the family coverage with the lower deductible.[6]

An Archer MSA deduction cannot exceed an employee's compensation attributable to employment with the small employer offering the high deductible health plan. Similarly, an Archer MSA deduction cannot exceed a self-employed individual's earned income derived from the trade or business with respect to which the high deductible plan is established.[7]

Excess Contributions

Excess contributions to an HSA or an Archer MSA are subject to a 6 percent tax. The tax may not exceed 6 percent of the value of the account, determined at the close of the taxable year.[8]

Pilot Cutoff

Archer MSAs were initially available on a pilot basis. The cut-off year for new accounts under the Archer MSA pilot program originally was 2003 but was extended through the end of 2007, which was the last year for creating an Archer MSA.[9] No new Archer MSAs may be set up except in some specified circumstances. For instance, eligible individuals still may make contributions to existing accounts. In recent years very few people have chosen to open Archer MSAs (forty-five were opened in 2005 and only eleven in 2006).

1. IRC Sec. 220(c)(2)(A); Rev. Proc. 2012-41, 2012-2 CB 539; Rev. Proc. 2013-35.
2. IRC Sec. 220(c)(5).
3. IRC Secs. 220(a), 220(b)(2).
4. See IRS Announcement 2002-90, 2002-2 CB 684.
5. IRC Sec. 220(b)(3).
6. IRC Sec. 220(b)(3).
7. IRC Sec. 220(b)(4).
8. IRC Sec. 4973(a).
9. IRC Sec. 220(i)(2)(A). See also Ann. 2002-90, 2002-2 CB 684.

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No individual is treated as an eligible individual for any taxable year beginning after the cut-off year unless (1) the individual was an active Archer MSA participant for any taxable year ending on or before the close of the cut-off year, or (2) the individual first became an active Archer MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an Archer MSA-participating employer.[1]

Health Insurance and the Estate Tax

388. Is an accidental death benefit payable under a health insurance policy includable in an insured's gross estate?

Accidental death benefits are life insurance proceeds subject to the same rules as proceeds under regular life insurance policies (Q 76).[2]

When an insured purchased a one year accidental death policy and arranged for the policy to be owned by the insured's children from the beginning, the proceeds were includable in the insured's estate as a transfer in contemplation of death when the insured died within the policy term.[3]

389. Are medical expense reimbursement insurance proceeds received by an insured decedent's estate includable in the decedent's gross estate?

Yes.

The IRS has ruled that these proceeds are includable under IRC Section 2033.[4]

Health Insurance and the Gift Tax

390. Is the gift tax exclusion for qualified transfers available for amounts paid for health insurance?

Yes.

The gift tax exclusion is available for qualified transfers for educational and medical purposes.[5] Qualified transfers include amounts paid for medical insurance but not for medical care that is reimbursed by insurance. Qualified transfers do not include amounts transferred to a person receiving medical care, rather than directly to a person rendering medical care.[6]

Planning Point: Qualified transfers can include amounts paid for medical insurance and amounts paid for medical care not covered by medical insurance whether because of exclusions, deductibles, co-pays, or lack of coverage.

1. IRC Sec. 220(i)(1).
2. *Comm. v. Est. of Noel*, 380 U.S. 678 (1965); *Est. of Ackerman v. Comm.*, 15 BTA 635 (1929); see Rev. Rul. 66-262, 1966-2 CB 105.
3. Rev. Rul. 71-497, 1971-2 CB 329; *Bel v. U.S.*, 452 F.2d 683 (5th Cir. 1971), cert. den. 406 U.S. 919.
4. Rev. Rul. 78-292, 1978-2 CB 233.
5. IRC Sec. 2503(e).
6. Treas. Regs. §§25.2503-6(b)(3), 25.2503-6(c).

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The Health Care Reform Law

391. What does health care reform do?

On March 23, 2010, President Obama signed comprehensive health care reform into law. The Patient Protection and Affordable Care Act amends in significant ways the IRC, ERISA, and the Public Health Service Act. The new law, known as the PPACA, ACA, and Affordable Care Act, focuses on expanding health care coverage, controlling health care costs, and improving the health care delivery system. It attempts to accomplish these goals in a variety of ways, as will be further described in the following questions and answers.

The new health care reform law is, in many places, a broad outline, the details of which will be completed by regulators. Regulations are being written and will continue to be written by the Department of Labor, the Treasury Department, and the Department of Health & Human Services.

392. When does health care reform go into effect?

The PPACA goes into effect between 2010 and 2018. The bulk of the provisions are effective beginning in 2011 through 2014. The effective date for the state health insurance exchanges is January 1, 2014. One provision, the tax on so-called "Cadillac" health care plans, goes into effect in 2018.

393. What kinds of health plans are governed by the PPACA, and what plans are not covered?

Health care reform covers insured and self-funded comprehensive medical health plans. In effect, the PPACA governs major medical insurance and self-insured major medical plans.

Health care reform does not regulate excepted benefits, which include standalone vision, standalone dental, cancer, long-term care insurance, Medigap insurance, certain flexible spending accounts ("FSAs"), and accident and disability insurance that make payments directly to individuals. However, it does impose an annual limit of $2500 per year on health FSAs.

The PPACA also does not affect retiree-only plans. Although it removed the exemption for retiree-only plans and excepted benefit plans from the PHS Act, it left those exemptions in the IRC and ERISA. The preamble and footnote 2 of interim final grandfathered plan regulations explain that the exemption for retiree-only plans and excepted benefit plans still applies for those plans subject to the IRC and ERISA.

With respect to retiree-only and excepted benefit plans, federal regulators have decided that even though those provisions were removed by the PPACA, they will read the PHS Act as if an exemption for retiree-only and excepted benefit plans was still in effect. Federal regulators have encouraged state insurance regulators to do the same, although in any given state it is possible, although unlikely, that regulators will decide to enforce the PPACA mandates on all fully insured plans.

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394. When does the new employer tax credit for purchases of health insurance become effective?

The new tax credit is effective for 2010 and thereafter. Beginning in 2014, it is only available for two consecutive years. Thus, the maximum number of years that an employer can take advantage of this tax credit is six, namely 2010 through 2013, plus any two consecutive years beginning in 2014.

395. How much is the new employer tax credit for purchases of health insurance?

The new tax credit applies to for-profit and non-profit employers meeting certain requirements. From 2010 through 2013, the amount of the credit for for-profit employers is 35 percent (25 percent for non-profit employers) of qualifying health insurance costs. The credit is increased for any two consecutive years beginning in 2014 to 50 percent of a for-profit employer's qualifying expenses and 35 percent for non-profit employers.

Planning Point: The credit is not terribly useful, as the practitioner's cost to calculate it is often near the value of the credit.

396. What employers are eligible for the new tax credit for health insurance, and how does it work?

The new health insurance tax credit is designed to help approximately four million small for-profit businesses and tax-exempt organizations that primarily employ low and moderate-income workers. The credit is available to employers that have twenty-four or fewer eligible full time equivalent ("FTE") employees, excluding owners and their family members, paying wages averaging under $50,000 per employee per year.

IRC Section 45R provides a tax credit beginning in 2010 for a business with twenty-four or fewer eligible FTEs. Eligible employees do not include seasonal workers who work for an employer 120 days a year or fewer, owners, and owners' family members, where average compensation for the eligible employees is less than $50,000 and where the business pays 50 percent or more of employee-only (single person) health insurance costs. Thus, owners and family members' compensation is not counted in determining average compensation, and the health insurance cost for these people is not eligible for the health insurance tax credit.

The credit is largest if there are ten or fewer employees and average wages do not exceed $25,000, in both cases excluding owners and their family members. The amount of the credit phases out for business with more than ten eligible employees or average compensation of more than $25,000 and under $50,000. The amount of an employer's premium payments that counts for purposes of the credit is capped by the average premium for the small group market in the employer's geographic location, as determined by the Department of Health and Human Services.

Example: In 2014, a qualified employer has nine FTEs (excluding owners, owners' family members, and seasonal employees) with average annual wages of $24,000 per FTE. The employer pays $75,000 in health care premiums for these employees, which does not exceed the average premium for the small group market in

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the employer's state, and otherwise meets the requirements for the credit. The credit for 2014 equals $37,250 (50 percent x $75,000). Note that the credit in 2013 would have been $26,250 (35 percent x $75,000).

Additional examples can be found online at http://www.irs.gov/pub/irs-utl/small_business_health_care_tax_credit_scenarios.pdf.

397. How do the rules for obtaining the tax credit for health insurance change over the years?

To obtain the credit, an employer must pay at least 50 percent of the cost of health care coverage for each counted worker with insurance.

In 2010, an employer may qualify if it pays at least 50 percent of the cost of employee-only coverage, regardless of actual coverage elected by an employee. For example, if employee-only coverage costs $500 per month, family coverage costs $1,500 per month, and the employer pays at least $250 per month (50 percent of employee-only coverage) per covered employee, then even if an employee selected family coverage the employer would meet this contribution requirement to qualify for the tax credit in 2010.

Beginning in 2011, however, the percentage paid by an employer for each enrolled employee must be a uniform percentage for that coverage level. If an employee receives coverage that is more expensive than single coverage, such as family or self-plus-one coverage, an employer must pay at least 50 percent of the premium for each employee's coverage in 2011 and thereafter.

Thus, grandfathered health insurance plans that provide, for instance, for 100 percent of family coverage for executives and employee-only coverage for staff will qualify for the tax credit in 2010 but not in 2011 or beyond.

398. What are the health insurance nondiscrimination rules? When are they effective? Are there any exceptions?

Self-insured plans are subject to nondiscrimination rules for income tax purposes. The PPACA imposed the same nondiscrimination rules that apply to self-insured plans to insured plans for plan years beginning on or after September 23, 2010. These health insurance nondiscrimination rules have been delayed, however, and do not apply at all to grandfathered health insurance plans as long as they remain grandfathered and have covered at least one participant continuously since March 23, 2010. These rules are intended to prevent discrimination in favor of higher paid employees in nongrandfathered health insurance plans.

IRS Notice 2011-1 delayed the application of the nondiscrimination rules for insured health plans that are not grandfathered from the first plan year beginning on or after September 23, 2010, until a date that will be specified after regulations on these rules are issued. As of this writing, no regulations have been proposed and informal discussions with Treasury personnel indicate that they may not be issued in the near future.

PPACA Sections 1001 and 1562(e)-(f) add ERISA Section 715 and IRC Section 9815, respectively. Both ERISA Section 715 and IRC Section 9815 incorporate by reference

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Section 2716 of the Public Health Service Act ("PHSA"), a section that applies to employer health insurance plans. PHSA Section 2716 incorporates by reference the concepts of IRC Section 105(h), which applies to self-funded health plans, and applies those nondiscrimination rules to insured group health plans. Regulations will determine the exact definition of nondiscrimination.

399. When is a health insurance plan discriminatory?

To satisfy nondiscrimination eligibility classifications when required to do so under regulations yet to be issued by the IRS, it will be likely, based on the rules for self-insured plans that a plan must:

(1) benefit 70 percent or more of all employees;

(2) benefit 80 percent or more of all eligible employees if 70 percent or more of all employees are eligible for benefits under the plan; or

(3) benefit employees who qualify under an employer's classification scheme that the IRS determines to be nondiscriminatory.

Excludable Employees

For purposes of the foregoing percentage tests, employees are not counted if they meet any one or more of the following tests:

(1) have been employed by an employer for fewer than three years;

(2) are under twenty-five years old;

(3) are employed part-time;

(4) are included in a bargaining unit covered by a collective bargaining agreement where accident and health benefits were the subject of good faith bargaining; or

(5) are nonresident aliens with no U.S. source earned income.

Part-time employees are (1) those whose customary weekly employment is fewer than thirty-five hours if other employees in similar work with the same employer or, if no employees of the employer are in similar work, in similar work in the same industry and location, have substantially more hours and (2) seasonal employees whose customary annual employment is fewer than nine months, if other employees in similar work with the same employer or, if no employees of the employer are in similar work, in similar work in the same industry and location, work substantially more months.

Any employee whose customary weekly employment is fewer than twenty-five hours or any employee whose customary annual employment is fewer than seven months also may be considered a part-time or seasonal employee.

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Highly Compensated Individuals

Under IRC Section 105(h), a plan cannot discriminate in favor of highly compensated individuals as to their eligibility to participate and benefits provided under a plan cannot discriminate in favor of participants who are highly compensated individuals.

For purposes of these nondiscrimination rules, highly compensated individuals are:

(1) individuals who are among the five most highly paid officers of a corporation;

(2) any shareholder who owns, including through attribution of ownership by others, more than 10 percent in value of an employer corporation's stock; or

(3) individuals who are among the most highly paid 25 percent of all employees.

Planning Point: Items (1) and (2) above apply to corporations. Presumably the new regulations will deal with LLCs, partnerships, and other forms of businesses.

400. What are the consequences for violating the new health insurance nondiscrimination rules?

The health insurance nondiscrimination rules, the effective date of which has been delayed until regulations have been released and a new effective date has been announced by the IRS, have different sanctions than self-insured plans that fall under IRC Section 105(h).

For discriminatory self-insured plans, highly compensated employees have taxable income based on the benefits paid by their employer. By contrast, with respect to the new health insurance nondiscrimination requirements, the sanction under IRC Section 4980D is a $100 per day excise tax on affected employees.

Although the IRS has not yet issued regulations on the penalty, its request for comments indicates that the term affected employees means those who are not highly compensated. Thus, if an employer has an insured health plan that is not grandfathered and that violates these new nondiscrimination rules for a plan year after these rules go into effect, and if that employer has twenty non-highly compensated employees, the penalty will be $2,000 per day as a result of having a discriminatory non-grandfathered health insurance plan.

IRC Section 4980(D)(d)(1) contains an exception to the excise tax for small employers, but the language is somewhat ambiguous. It states, "In the case of a group health plan of a small employer which provides health insurance coverage solely through a contract with a health insurance issuer, no tax shall be imposed by this section on the employer on any failure (other than a failure attributable to section 9811) which is solely because of the health insurance coverage offered by such issuer." It is not clear whether this exception applies to the new nondiscrimination rules or simply to a health insurance policy that does not meet federal requirements. For the purpose of this exception, a small employer is defined as two to fifty employees.

There also is a 10 percent cap on the excise tax, that is, 10 percent of aggregate premiums paid by an employer, for inadvertent violations of the nondiscrimination rules.

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401. Are grandfathered health insurance plans exempt from nondiscrimination and all health care reform requirements?

Yes and no.

Although grandfathered health insurance plans are exempt from many requirements, they are not exempt from all health care reform requirements. Instead, they are subject to the following:

(1) Prohibition of lifetime benefit limits;

(2) No rescission except for fraud or intentional misrepresentation;

(3) Children, who are not eligible for employer-sponsored coverage, covered up to age twenty-six on a family policy, if the dependent does not have coverage available from his or her employer;

(4) Pre-existing condition exclusions for covered individuals younger than nineteen are prohibited; and

(5) Restricted annual limits for essential benefits.

Grandfathered health plans are exempt from the following additional requirements that apply to new and non-grandfathered health plans:

(1) No cost-sharing for preventive services;

(2) Nondiscrimination based on compensation;

(3) Children covered up to age twenty-six on family policy regardless of whether a policy is available at work. Grandfathered status for the adult dependent coverage ends on January 1, 2014;

(4) Internal appeal and external review processes;

(5) Emergency services at in-network cost-sharing level with no prior authorization; and

(6) Parents must be allowed to select a pediatrician as a primary care physician for their children and women must be allowed to select an OB-GYN for their primary care physician.

402. How does health care reform apply to self-insured plans?

Self-funded plans generally are treated the same as insured plans under the PPACA. Analysis of the application of PPACA to self-insured plans begins with Section 1562, which adds Section 715 to ERISA and Section 9815 to the IRC. These provisions state that all of the provisions of Part A of Title XXVII of the Public Health Service Act ("PHSA"), as amended by the PPACA, apply to both ERISA group health plans and health insurance issuers that insure group health plans. ERISA group health plans include both self-insured and insured plans.

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The section further provides that if anything in ERISA's group plan requirements conflicts with Part A of the PHSA, the PHSA shall govern. The fact that this section refers both to group health plans and to insured group health plans makes it clear that the provision is meant to apply to self-insured plans. This is reinforced by subsection (b) of this section adding new Section 715 to ERISA and IRC Section 9815 to the IRC, both of which state that Section 2716 and Section 2718 of the PHSA do not apply to self-insured plans, suggesting that the remaining provisions do.

This analysis is strengthened by the definition of group health plan under PPACA Section 1301(b)(3), which incorporates the definition of Section 2791 of the PHSA, defining group health plan to mean an employee welfare benefit plan as defined in ERISA Section 3(1). Section 1551 of the PPACA also provides that the definitions of PHSA Section 2791 apply to the PPACA.

Several sections of the PPACA refer specifically to self-insured plans.

Section 2701(a)(5), applying the health status underwriting provisions to large group plans in an exchange, does not apply to self-insured plans. Section 2715 requires a plan sponsor or designated administrator to make disclosures required by that section for self-insured plans.

Section 2716, discrimination in favor of highly-compensated employees, expressly states that it does not apply to self-insured plans, which already are covered by a similar requirement under IRC Section 105(h).

Self-insured plans expressly are subject to the external review requirements, that is, the appeal requirements, of Section 2719 to be established by HHS.

The reinsurance provisions of Section 1341 expressly apply to self-insured plans; the risk-pooling provisions of Section 1343 expressly do not.

Self-insured plans expressly are subject to a per-member fee to fund patient centered outcomes research under recently added IRC Section 4376.

The Department of Health and Human Services ("HHS") has addressed amendments by the PPACA to the law permitting self-funded nonfederal governmental plans to opt out of compliance with certain federal benefit mandates. Except for a narrow band of requirements, these group health plans will no longer be permitted to opt out of HIPAA rules regarding the preexisting condition exclusion and special enrollment. Plan sponsors may continue to opt out of requirements under the Newborns' and Mothers' Health Protection Act, Mental Health Parity and Addiction Equity Act, Women's Health and Cancer Rights Act, and Michelle's Law.

These changes are effective beginning on or after September 23, 2010, for non-collectively bargained self-funded nonfederal governmental plans. Self-insured nonfederal governmental plans maintained pursuant to a collective bargaining agreement ratified before March 23, 2010, and that have been exempted from any of the relevant HIPAA requirements, for example, limits on preexisting condition exclusions, special enrollment periods, and health status nondiscrimination requirements, will not have to come into compliance with those requirements until the first day of the first plan year following the expiration of the last plan year governed by a collective bargaining agreement.

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Although all plans except grandfathered plans are subject to the new appeals rules, effective for plan years beginning after September 23, 2011, with limited exceptions, self-insured plans are most affected because compliance for insured plans is handled by the insurance company, not the plan sponsor.

403. How does health care reform apply to collectively bargained plans?

There is no delayed effective date for collectively bargained plans, whether fully insured or self-insured. Thus, plans maintained pursuant to one or more collective bargaining agreements in effect on March 23, 2010, must comply with the new rules at the same time as other grandfathered plans, although with a few differences.

The interim final grandfather regulations provide that fully insured, but not self-insured, collectively bargained plans retain their grandfathered status until the expiration of the agreement in effect on March 23, 2010. Self-insured collectively bargained plans are subject to the rules in the same way as other covered health plans.

Thus, a change in carriers under a fully insured collectively bargained plan does not result in the loss of grandfathered status if the change is made before the expiration of the agreement in effect on March 23, 2010. Additionally, changes to benefits that apply while that collective bargaining agreement is in effect, including increasing co-payments, do not result in loss of grandfathered status.

Whether grandfathered status applies after expiration of a collective bargaining agreement is determined by comparing benefits in effect at that time to benefits in effect on March 23, 2010. If the changes are not within permitted parameters, then a plan will cease to be grandfathered when the relevant agreement expires.

The interim final rule for grandfathered plans makes two clarifications with respect to collectively bargained plans.

First, it confirms that both insured and self-funded collectively bargained plans that are grandfathered health plans are subject to the same coverage reform mandates under the PPACA at the same time that its mandates are effective with respect to other grandfathered health plans. Therefore, collectively bargained plans must comply with the extension of dependent coverage mandate, the elimination of lifetime and annual dollar limits, and the prohibition on pre-existing condition exclusions at the same time that these mandates become effective for all other grandfathered health plans.

Second, a collectively bargained insured plan may maintain its grandfathered status beyond the termination of the last of the applicable collective bargaining agreements provided that any changes to the terms of coverage under the plan are not changes that would cause the plan to lose grandfathered status under the interim final rule. Thus, collectively bargained insured plans are treated the same as all other grandfathered health plans on the termination of the last of the applicable collective bargaining agreements in effect on March 23, 2010, so their grandfathered status may last indefinitely as well.

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Regulations also provide that a collectively bargained plan may be amended early for some or all of the law's rules. This voluntary amendment is not a termination of the collective bargaining agreement that otherwise might subject the plan to an earlier compliance deadline.

404. What is a grandfathered health plan?

A grandfathered health plan is any group health plan or individual health insurance policy that was in effect on the date of the PPACA's enactment, March 23, 2010, and that has covered at least one person continuously. Even if an individual re-enrolls in a grandfathered health plan or new employees or their families are added to a plan after March 23, 2010, a plan's grandfathered status continues. Interim final regulations provide that if any benefit is eliminated or employees' cost is increased more than a minor amount, then grandfathered status is lost. In addition, the regulations require that to maintain a grandfathered status, the plan must give an annual notice to participants, advising them that the plan is grandfathered and the consequences.

Original regulations provided that if an insured non-collectively bargained plan changes insurance carriers, even if benefits are the same or greater, grandfathered status is lost. The HHS, IRS, and DOL later amended the regulations to provide that new group health insurance would not cause loss of grandfathered status if it was effective on or after November 15, 2010, if coverage is at least as good and costs are not increased more than allowed to retain grandfather status. The amendment to the regulations applies only to group health plans, not to individual health insurance.

This change, allowing a switch in insurance companies without losing grandfathered status, does not apply to changes in policies between June 14 and November 15, 2010. Changes in insurance carriers during that time still cause loss of grandfathered status. For this purpose, the date new coverage becomes effective is controlling, not the date the new insurance contract or policy is entered into. For changes to group health insurance coverage on or after March 23, 2010, but before June 14, 2010, the date the regulations were made publicly available, the agencies' enforcement safe harbor remains in effect for good faith efforts to comply with a reasonable interpretation of the law.

For self-insured plans, a change in third party administrator, in and of itself, does not cause a group health plan to cease to be a grandfathered plan. Additionally, grandfathered status can be retained when a plan changes its structure from self-insured to insured or insured to self-insured.

Planning Point: An IRS representative has informally indicated that eliminating coverage for a group or segment of a workforce would not cause a plan to relinquish its grandfathered status. Eliminating coverage for a class of employees is not one of the changes prohibited by regulations.

Although most of the mandates in the PPACA apply to both group health plans and group health insurance issuers, new Public Health Service Act ("PHSA") Section 2716 applies only to insured group health plans. Accordingly, even if Section 2716 were interpreted to apply to future modifications to existing health benefit designs that are discriminatory in favor of highly compensated employees, there may be structures available to an employer whereby it can cause an insurer to issue a special individual policy, or to provide special individual coverage, to highly

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compensated individuals without the policy or arrangement being treated as part of a new non-grandfathered group health plan.

Where special individual benefits are provided to a group of highly compensated employees, however, they may be considered to be part of a group health plan.

As discussed above, multi-employer and single-employer collectively bargained health plans in effect on March 23, 2010 are not subject to the reform law until the date on which the last of the collective bargaining agreements relating to the coverage terminates. At that time, a collectively bargained plan then is subject to health care reform rules and, assuming that it remains grandfathered, based on the rules then in effect, it would have to comply with the requirements for grandfathered plans.

405. What are the new protections offered to minor children and young adults by health care reform?

Teens and young adults, even if they are no longer dependents for income tax purposes and even if they are married, can stay on or be added to their parents' health insurance plan until age twenty-six, or through age twenty-six if a plan or policy allows. Young adults also are not required to live with their parents or, as noted above, to be financially dependent on them. This right to coverage applies to all types of plans that offer dependent coverage.

In grandfathered employer group plans, that is, policies that existed on March 23, 2010, and that have not changed substantially, children are not eligible to go on parents' plans if the children have access to coverage through their own workplace.

In non-grandfathered plans, they are eligible to be covered on their parents' policy even if they have coverage through work.

New rules prevent insurers from denying coverage to children under age nineteen with pre-existing medical conditions including asthma or cancer for plan years beginning on or after September 23, 2010. Insurers may limit certain open enrollment periods when children are signed up; this does not apply to grandfathered individual plans.

Similar protections for adults with pre-existing medical conditions will not begin until 2014. In the interim, adults with medical conditions who have been uninsured for at least six months can purchase coverage through federal high-risk pools created by the health care reform law.

406. How does health care reform affect employer-provided plans, including health flexible spending arrangements, health reimbursement arrangements, health savings accounts, and Archer medical savings accounts, that pay for non-prescription medicines?

Section 9003 of the PPACA adds IRC Section 106(f), which revises the definition of medical expenses for employer-provided accident and health plans, including health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs). Section 9003 also revises the definition of qualified medical expenses for health savings accounts and Archer

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medical savings accounts. Nonprescription drugs are not eligible for reimbursement by these plans unless a physician issues a prescription. Presumably, such a prescription would be done in the same way as regular prescriptions. For example, if a physician were to prescribe aspirin, this expense could be reimbursed but the purchase of aspirin without a prescription could not be reimbursed.

Other changes in health FSAs and HRAs are discussed in the following Q&As.

407. What are the new rules regarding reimbursement of non-prescription medicines?

For plan years beginning in 2011 and thereafter, no plan can provide for, or reimburse on a tax favored basis, non-prescription over-the-counter drugs. This prohibition applies to medical expense reimbursement plans, cafeteria plans, flexible spending accounts, health savings accounts, health reimbursement accounts, and Archer medical savings accounts.

408. What changes does the PPACA mandate that affect health FSAs?

Under IRC Section 106(f), expenses incurred for medicines or drugs may be paid or reimbursed by an employer-provided plan, including a health FSA or HRA, only if the medicine or drug:

(1) requires a prescription;

(2) is available without a prescription, that is, is an over-the-counter medicine or drug, and the individual obtains a prescription; or

(3) is insulin.

This applies to expenses incurred for taxable years beginning January 1, 2011, and after.

Additionally, for plan years beginning in 2013 and thereafter, contributions to flexible savings accounts will be limited to $2,500 per year, as indexed by the Consumer Price Index in subsequent years. Flexible spending accounts are those accounts, typically in cafeteria plans, that may be used to reimburse medical or dependent care expenses.

Further, the IRS has modified the cafeteria plan use it or lose it rule for health FSAs. Health FSAs may now be amended so that $500 of unused amounts remaining at the end of the plan year may be carried forward to the next plan year.[1] However, plans that incorporate the carry forward provision may not also offer the two-month grace (run-out) period that would otherwise allow FSA participants an additional two-month period after the end of the plan year to exhaust account funds.

GCM 201413005 states that carrying over FSA funds from year one to year two will prevent an individual from participating in a health savings account (HSA) in year two. HSA-eligible individuals must have qualifying high-deductible health plan (HDHP) coverage and no non-HDHP

1. IRS Notice 2013-71.

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coverage other than permitted insurance, permitted coverage, coverage providing only certain types of preventive care, or coverage with a deductible that equals or exceeds the statutory minimum annual HDHP deductible (collectively, HSA-compatible coverage). Unused amounts from a general-purpose health FSA that could be carried over to an HSA-compatible health FSA may be used during the general-purpose health FSA's run-out period to reimburse expenses covered by the general-purpose health FSA that were incurred during the previous plan year.

A health FSA that reimburses all qualified section 213(d) medical expenses without other restrictions is a health plan. Consequently, an individual who is covered by a general purposes health FSA that pays or reimburses qualified medical expenses is not an eligible individual for purposes of contributing to an HSA. This disqualification includes the entire plan year, even if the health FSA has paid or reimbursed all amounts prior to the end of the plan year. To prevent this, an individual may decline or waive a health FSA carryover in order to become eligible for the HSA, at least if the FSA plan permits.

A cafeteria plan may provide that if an individual participates in a general purpose health FSA that provides for a carryover of unused amounts, the individual may elect prior to the beginning of the following year to decline or waive the carryover for the following year. In that case, the individual who declines under the terms of the cafeteria plan may contribute to an HSA during the following year if the individual is otherwise eligible for a Health Savings Account.

However, if a cafeteria plan offers an HSA-compatible (limited purpose) health FSA, i.e., one that covers, dental, vision, preventive care, and/or pharmaceutical expenses not covered under a health insurance plan, this does not prohibit funding an HSA. Thus, individuals wishing to participate in an HSA should either not carryover any FSA funds into the next plan year or make sure carryover funds are deposited in an HSA-compatible FSA, i.e., one that convers solely incidental benefits or reimburses other medical expenses after the deductible is met. There is no requirement that the unused amounts in the general purpose health FSA only be carried over to a general purpose health FSA. However, the carryover amounts may not be carried over to a non-health FSA or another type of cafeteria plan benefit.

Thus, if a carryover feature is included in the general-purpose health FSA plan, an employer has three options available to preserve employees' HSA eligibility for the following plan year:

- Option 1: Allow participants with a general-purpose health FSA to elect and enroll in a limited-purpose FSA — an FSA plan that is compatible with an HSA — for the following plan year. Those participants can carry over unused funds (up to the maximum limit) to a limited-purpose FSA; however, the carryover cannot be applied to another non-health FSA or another cafeteria plan benefit.

- Option 2: Automatically enroll participants in a limited-purpose FSA if those participants enroll in a qualifying high deductible health plan (HDHP) and have a carryover balance in a general-purpose health FSA.

- Option 3: Allow individuals to waive or decline a health FSA carryover prior to the beginning of the next plan year to become eligible

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Planning Point: An employer may have both a general purpose health FSA and an HSA-compatible FSA. Where an employee participates in both and does not utilize all elected benefits in a year, GCM 201413005 provides an example for maximizing the benefits for the succeeding year while maintaining eligibility to participate in an HSA, as follows:

Example: Employer offers a calendar year general purpose health FSA and a calendar year HSA-compatible health FSA. Both FSAs provide for a carryover of up to $500 of unused amounts and do not have a grace period. Employee has an unused amount of $600 in the general purpose health FSA on December 31 of Year 1. Prior to December 31 of Year 1, Employee elects $2,500 in the HSA-compatible health FSA for Year 2 and elects to have any carryover go to the HSA-compatible health FSA. Employee also elects coverage by an HDHP for Year 2. In January of Year 2, Employee incurs and submits a claim for $2700 in dental care covered by the HSA-compatible health FSA. The plan timely reimburses $2,500, the amount elected. In February of Year 2, Employee submits and is reimbursed from the general purpose health FSA for $300 in medical expenses incurred prior to December 31 of Year 1. At the end of the run-out period, $300 in the general purpose health FSA is unused and carried over to the HSA-compatible health FSA. Employee is then reimbursed $200 for the excess of the January claim over the amount elected for the HSA-compatible health FSA. Employee has $100 remaining in the HSA-compatible health FSA to be used for expense incurred in the year or carried over to the next year. Employee is allowed to contribute to an HSA as of January 1 of Year 2.

In addition, an employer cannot sponsor a stand-alone health FSA. An employer may only offer a health FSA if it also offers a major medical plan to the health FSA participants, who are not required to accept the offer of coverage in the employer's major medical plan.

409. Under the PPACA, can a health reimbursement arrangement (HRA) be integrated with health insurance coverage without violating the prohibition on plans that place annual dollar limits on available benefits?

The IRS has issued guidance providing that a health reimbursement arrangement (HRA) cannot be integrated with individual coverage (whether purchased in the individual insurance markets or an exchange) in order to comply with the ACA prohibition against annual dollar limits on benefits available under a plan, eliminating the possibility that employers could use HRAs to subsidize employees' purchase of health insurance.

Further, the guidance provides the circumstances under which an HRA will be considered integrated with a health plan so that it does not violate the annual dollar limit prohibition. An HRA may be considered integrated with another health plan (and, thus, not in violation of the prohibition against annual dollar limits) if it meets one of two tests.

First, an HRA can be integrated if (1) the employer offers a second group health plan that does not consist solely of certain excepted benefits, (2) the employee receiving the HRA is actually enrolled that group health plan or a spouse's plan, (3) the HRA is only available to employees enrolled in the non-HRA group coverage, (4) the HRA is only permitted to reimburse one or more of: co-payments, co-insurance, deductibles, and premiums under the non-HRA coverage, or medical expenses for non-essential benefits and (5) the employee is permitted to opt-out of the HRA.

Under the second method, if the HRA does not limit reimbursements as required under the first method, (1) the employer must offer a group health plan in addition to the HRA that provides certain minimum value under IRC Section 36B, (2) the employee must actually be

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enrolled in that plan or a spouse's plan, (3) the HRA must only be available to employees enrolled in non-HRA plan and (4) the employee must be permitted to opt-out.

An exception to these rules applies for employer sponsored HRAs offered to one participant or solely to retirees. These HRAs may be offered on a stand-alone basis without its participant(s) being covered by the employer's major medical health plan.

410. How does the PPACA affect HSAs and Archer MSAs?

The health care reform law amends IRC Section 223(d)(2)(A) with respect to health savings accounts ("HSAs") and IRC Section 220(d)(2)(A) with respect to Archer medical savings accounts ("MSAs") to provide that for amounts paid after December 31, 2010, a distribution from an HSA or Archer MSA for a medicine or drug is a tax-free qualified medical expense only if the medicine or drug (1) requires a prescription, (2) is an over-the-counter medicine or drug and the individual obtains a prescription, or (3) is insulin.

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

IRS guidance reflecting these statutory changes makes it clear that the rules in IRC Sections 106(f), 223(d)(2)(A), and 220(d)(2)(A) do not apply to 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. These items may qualify as medical care if they otherwise meet the definition of medical care in IRC Section 213(d)(1), 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.

411. How does the PPACA affect the use of debit cards to pay for medical care expenses?

Another issue to consider is the use of health flexible spending account ("FSA") or health reimbursement account ("HRA") debit cards. The current rules are set forth in Prop. Treas. Reg. §1.125-6 and in Rev. Rul. 2003-43, 2003-1 C.B. 935; Notice 2006-69, 2006-2 C.B. 107; Notice 2007-2, 2007-1 C.B. 254; and Notice 2008-104, 2008-2 C.B. 1298.

Debit card systems have not been capable of substantiating compliance with new IRC Section 106(f) with respect to over-the-counter medicines or drugs because the systems were incapable of recognizing and substantiating that the medicines or drugs were prescribed. Therefore, except as noted below, for expenses incurred on and after January 1, 2011, these health FSA and HRA debit cards could not be used to purchase over-the-counter medicines or drugs.

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The IRS indicated, however, that to facilitate the significant changes to existing systems necessary to reflect the statutory change, it would not challenge the use of health FSA and HRA debit cards for expenses incurred through January 15, 2011, if the use of the debit cards complied with then current rules.

The IRS made it clear, however, that on and after January 16, 2011, over-the-counter medicine or drug purchases at all providers and merchants, whether or not they have an inventory information approval system ("IIAS"), must be substantiated before reimbursement may be made. Substantiation is accomplished by submitting the prescription, a copy of the prescription, or other documentation that a prescription has been issued for an over-the-counter medicine or drug and other information from an independent third party that satisfies the requirements under Proposed Treasury Regulation Section 1.125-6(b)(3)(i).

Thus, for example, the substantiation requirements for over-the-counter medicines or drugs are satisfied by (1) a receipt without a prescription number accompanied by a copy of the prescription or (2) a customer receipt issued by a pharmacy that identifies the name of the purchaser or the name of the person for whom the prescription applies, the date and amount of the purchase, and a prescription number. Debit cards may continue to be used for medical expenses other than over-the-counter medicines or drugs.

Health FSA and HRA debit cards may be used at a pharmacy that does not have an IIAS if 90 percent of the store's gross receipts during the prior taxable year consisted of items that qualified as expenses for medical care under IRC Section 213(d).

Until further guidance is issued, debit cards may be used at a pharmacy that satisfies the 90 percent test to purchase over-the-counter medicines or drugs that have been prescribed provided that substantiation is properly submitted in accordance with the terms of the plan, including the prescription or a copy of the prescription or other documentation that a prescription has been issued, and other information from an independent third party that satisfies the requirements under Proposed Treasury Regulation Section 1.125-6(b)(3)(i). Solely for the purpose of determining whether a pharmacy meets this 90 percent test, sales of over-the-counter medicines and drugs at the pharmacy may continue to be taken into account after December 31, 2010.

412. What is the required W-2 reporting for health insurance expenses?

For tax years beginning after December 31, 2010, health care reform originally required that employers disclose the value of benefits provided for each employee's health insurance coverage on employee W-2 forms. This reporting was to give the federal government statistical information and did not change the income tax treatment for employers or employees.

The required reporting rules have been delayed twice. Health care reform required W-2s for the 2011 year to provide the cost of health coverage. That requirement was delayed and made applicable for W-2s issued for the 2012 year. Additionally, IRS Notice 2011-28 provides an exemption for this delayed reporting requirement. Until further notice from the IRS, an employer is not subject to the reporting requirement for any calendar year if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year.

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Planning Point: If employees talk to one another, the new W-2 reporting may mean that employees can discover that their employer pays nothing for some employees and thousands for others, especially in grandfathered plans that are not subject to nondiscrimination rules so long as they retain their grandfathered status. It has been quite common for small employers to provide family coverage for owners and key employees, to provide single employee coverage often with less than 100 percent of cost for other employees, and to exclude employees who have health insurance through another source, such as a spouse's employment.

413. What is the new simple cafeteria plan that is available beginning in 2011?

The health care reform law includes a provision creating simple cafeteria plans for small businesses, namely those with average employment of 100 or fewer employees, effective for years beginning in 2011. The concept is similar to 401(k) retirement plan safe harbors, SIMPLE 401(k)s, and SIMPLE-IRAs.

Employer and employee contributions are deductible, not subject to Social Security tax, and not taxable income to participants. Thus, available benefits can be purchased with pre-tax dollars. Available benefits include health and dental insurance, reimbursement for health and dental expenses not covered by insurance, dependent care, group term life insurance, health savings accounts, and disability insurance.

Simple cafeteria plans automatically meet nondiscrimination requirements of IRC Section 125(b), the 25 percent concentration test, and nondiscrimination requirements of IRC Sections 79(d), 105(h), and 129(d) applicable to group term life insurance, self-insured health benefits (medical reimbursement), and dependent care assistance benefits (child care), respectively.

Through an apparent oversight, IRC Section 125(j) does not provide an express exception for the health insurance nondiscrimination rules of new IRC Section 9815. It is likely that if the same insurance options are available to all participants, regardless of their use, the health insurance nondiscrimination rules will be met. The health insurance nondiscrimination regulations will provide the definitive answer.

Where a business wants to avoid the 25 percent concentration test and contribute for owner-employees, only a regular C corporation can do so because only they are employees for income tax purposes. Sole proprietors, 2 percent or more S corporation shareholders, and partners, including members of LLCs taxed as partnerships, are not employees for income tax purposes; rather, they are self-employed individuals.

414. What are the requirements for the new simple cafeteria plan?

100 or Fewer Employees

An employer is eligible to implement a simple cafeteria plan if, during either of the preceding two years, it employed 100 or fewer employees on average, based on business days.

For a new business, eligibility is based on the number of employees the business reasonably is expected to employ.

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Businesses maintaining a simple cafeteria plan that grow beyond 100 employees can continue to maintain the simple arrangement until they have exceeded an average of 200 or more employees during a preceding year.

Employees include leased employees.

Controlled and Affiliated Service Groups

For purposes of determining an eligible employer, employer aggregation rules govern under (1) IRC Section 52, which applies the rules of IRC Section 1563, except "more than 50 percent" is substituted for "at least 80 percent" in IRC Section 1563(a)(1), and subsections 1563(a)(4) and 1563(e)(3)(C) are disregarded, and (2) IRC Section 414, relating to controlled and affiliated service groups. Additionally, an employer includes a predecessor employer, which is undefined.

Qualified Employees

All non-excludable employees who had at least 1,000 hours of service during a preceding plan year must be eligible to participate in a simple cafeteria plan. The term qualified employee means any employee who is not a highly compensated employee under IRC Section 414(q) or a key employee under IRC Section 416(i) and who is eligible to participate in a plan.

This definition of qualified employee is relevant only to the two alternative minimum contribution requirements, discussed below, and to highly compensated employees ("HCEs") and key employees. HCEs and key employees may participate as everyone else so long as they are employees and do not receive disproportionate employer nonelective or matching contributions. Comparable contributions must be made for all eligible employees.

Excludable Employees

Excludable employees are those who:

(1) have not attained age twenty-one or a younger age provided in the plan before the end of the plan year;

(2) have less than one year of service as of any day during a plan year;

(3) are covered under a collective bargaining agreement; or

(4) are nonresident aliens.

An employer may have a shorter age and service requirement but only if such shorter service or younger age applies to all employees.

Employees who previously worked 1,000 hours in a plan year but do not currently can be excluded because employees who do not have a year of service in the current plan year can be excluded. Because the rule is that they can be excluded if they do not have a year of service on any day in the year, they will have 1,000 hours if they go from full-time to part-time at the beginning of the current year. This is an important point where an employee's salary is less than

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the health benefits. The employee should be entitled to the entire maximum benefit if elected, even if greater than his or her compensation, to safeguard simple status.

Benefit Nondiscrimination

Each eligible employee must be able to elect any benefit under a plan under the same terms and conditions as all other participants.

Minimum Contribution Requirement

The minimum must be available for application toward the cost of any qualified benefit, other than a taxable benefit, offered under a plan.

Employer contributions to a simple cafeteria plan must be sufficient to provide benefits to non-highly compensated employees ("NHCEs") of at least either:

(1) A uniform percentage of at least two percent of compensation, as defined under IRC Section 414(s) for retirement plan purposes, whether or not the employee makes salary reduction contributions to a plan; or

(2) The lesser of a 200 percent matching contribution or six percent of an employee's compensation. Additional contributions can be made, but the rate of any matching contribution for HCEs or key employees cannot be greater than the rate of match for NHCEs under IRC Section 125(j)(B).

The same method must be used for calculating the minimum contribution for all NHCEs. The rate of contributions for key employees and HCEs cannot exceed that for NHCEs. Compensation for purposes of this minimum contribution requirement is compensation with the meaning of IRC Section 414(s).

415. What are the deadlines for amending cafeteria plans?

Cafeteria plans that allow reimbursement for over the counter drugs must be amended for the new over-the-counter drug requirements. An amendment to conform a cafeteria plan to the new requirements that was adopted no later than June 30, 2011, may be made effective retroactively for expenses incurred after December 31, 2010, or after January 15, 2011, for health FSA and HRA debit card purchases.

Additionally, fiscal year cafeteria plans may be amended to provide that elections to purchase health insurance can be changed mid-year to purchase insurance on exchange or in plan for the fiscal year cafeteria plan year beginning in 2013.

Such an election to purchase or to cease purchasing health insurance can be made mid-year despite the fact that this is not a change in status, which is a normal prerequisite to change a cafeteria plan election. Employees may want to terminate their election to purchase health insurance through the employer's cafeteria plan and go to the exchange if they eligible for health insurance exchange tax credits. Other employees may want to elect to purchase health insurance from the employer plan effective Jan. 1, 2014 to avoid the individual mandate penalty.

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If the cafeteria plan year is a fiscal year, employees wanting exchange insurance on Jan. 1, 2014 would have to terminate or change their elections mid-year. However, under current cafeteria plan regulations, these two elections are not a change in status allowing an election change mid-year. The proposed regulations allow an applicable large employer with a fiscal year cafeteria plan, at its election, to amend the plan any time during the year on a retroactive basis (by Dec. 31, 2014, retroactive to beginning of 2013 plan year) to permit either or both of the following changes in salary reduction elections:[1]

(1) An employee who elected to salary reduce through the fiscal year cafeteria plan for accident and health plan coverage beginning in 2013 is allowed to prospectively revoke or change his or her election with respect to the accident and health plan once, during that plan year, without regard to whether the employee experienced a change in status event described in Reg. §1.125-4; and

(2) An employee who failed to make a salary reduction election through his or her employer's fiscal year cafeteria plan beginning in 2013 for accident and health plan coverage before the deadline in proposed §1.125-2 for making elections is allowed to make a prospective salary reduction election for accident and health coverage on or after the first day of the 2013 plan year of the cafeteria plan without regard to whether the employee experienced a change in status event described in Reg. §1.125-4.

Planning Point: Some provisions of the transition relief refer to "applicable large employer members" (i.e., employers that are subject to healthcare reform's employer mandate), raising questions as to whether the relief is available for all non-calendar-year cafeteria plans or only those that are sponsored by applicable large employer members.

416. Did Congress repeal the new and expanded 1099 requirements that were to be effective in 2012?

Yes.

Under current tax law, a business making payments to a service provider other than a corporation aggregating $600 or more for services in the course of a trade or business in a year is required to send an information return (Form 1099) to the IRS (and to the service provider-payee) setting forth the amount, as well as name and address of the recipient of the payment (generally on Form 1099).

The new law changed this requirement so that businesses had to issue 1099 forms to all persons and businesses, including corporations, for which aggregate annual payments are $600 or more, among other things.

On April 5, 2011 the Senate approved H.R. 4, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, which retroactively repeals expanded Form 1099 information reporting rules. President Obama signed the bill into law on April 14, 2011.

1. Preamble to Proposed Rules on Shared Responsibility for Employers Regarding Health Coverage, 78 Fed. Reg. 217, 237 (Jan. 2, 2013).

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417. Do taxpayers need to take any steps in 2012 to comply with new 1099 requirements?

No.

Health care reform expanded the 1099 requirements in two ways:

(1) 1099s were required to be issued to corporations, and

(2) 1099s were required to be issued for purchases of goods and products, not just services, that exceeded $600 per year.

On April 5, 2011, the Senate approved H.R. 4, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, which retroactively repealed health care reform's expanded Form 1099 information reporting rules. The bill was signed into law by President Obama on April 14, 2011.

418. What new federal long-term care benefit was to become available in 2012 for which employees could elect to pay?

In October of 2011, the Department of Health and Human Services ("HHS") announced that it had suspended its work on implementing the Community Living Assistance Services and Support ("CLASS") Act, which was to provide long-term care benefits in voluntary employer sponsored plans. HHS announced that it was unable to find a way to make the program work. The American Taxpayer Relief Act of 2012 formally repealed the CLASS program.

Under the proposed plan, employees of companies that elected to participate would be automatically enrolled, but could elect to opt out. Employees who did not opt out would pay for this coverage through payroll deductions. Other workers and self-employed individuals could have enrolled on their own. Retirees were not eligible.

After an individual paid premiums for five years and had worked for three of those five years, the employee would have been eligible for a cash benefit of about $50 per day if unable to perform two or three activities of daily living, such as walking, bathing, or dressing, or if becoming cognitively impaired.

HHS had not yet set the premiums, but the American Academy of Actuaries estimated that the premiums could average as much as $125 to $160 per month, or as little as $5 per month for those below the poverty line. The high-end estimate is about the same price that a relatively healthy fifty year old would pay for a private long-term care policy providing about three times that daily benefit for three years. A study by the actuarial consulting firm, Milliman, found that only 8 percent of long-term care claimants who had policies with a three year benefit period exhausted their benefits.

Under the CLASS Act, a person could not be rejected for coverage because of health, so it was meant to help people with medical conditions that do not qualify for private long-term care insurance or are highly rated. Additionally, it would have covered many services that are not eligible for benefits under most long-term care plans, including homemaker services,

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home modifications, and transportation, that are typically used to help a person stay out of a nursing home.

419. What are the new requirements regarding the purchase of health insurance or the payment of a penalty?

Health care reform requires most Americans to have health insurance beginning in 2014, or there is a monetary penalty called the individual mandate.

Unless exempt, Americans must have major medical health coverage provided by their employer or that they purchase themselves, or they must pay a fine that is the greater of a flat amount, or a percentage of income (above the tax filing threshold). The amounts are $95 or 1 percent of income in 2014; $325 or 2 percent of income in 2015; and $695 or 2.5 percent of income in 2016. Families will pay half the penalty amount for children under eighteen, up to a cap of $2,085 per family. After 2016, penalties are indexed to the Consumer Price Index. In no event can the penalty exceed the average national annual cost of a bronze plan purchased on an exchange

Exemptions from the individual penalty will be granted for financial hardship, religious objections, American Indians, those without coverage for fewer than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of an individual's income, and those with incomes below the tax filing threshold.

420. What is the employer mandate imposed by the PPACA?

Employers with at least fifty full-time equivalent employees ("FTEs") must offer insurance meeting specified requirements or pay a $2,000 per full-time worker penalty after its first thirty employees if any of its full-time employees receive a federal premium subsidy through a state health insurance exchange (which would occur because the employee was not being offered sufficient coverage through the employer).

A different penalty applies for employers of at least fifty full-time equivalent employees that offer some insurance coverage but not enough to meet federal requirements. In this case, the penalty is $3,000 per full-time employee who gets government assistance and buys coverage in an exchange, subject to a maximum penalty of $2,000 times the number of full-time employees in excess of the first thirty.

The shared responsibility penalty on employers for failing to provide minimum essential health insurance excludes excepted benefits under Public Health Service Act 2971(c), including long-term care as well as standalone vision and standalone dental plans.

On June 28, 2012, the Supreme Court, in National Federation of Independent Business v. Sebelius, upheld the constitutionality of the Patient Protection and Affordable Care Act, with only minor changes to certain Medicaid provisions.

Previous guidance delayed application of the employer penalty from 2014 to 2015. These final regulations provide new transitional relief for two types of employers. The applicable large

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employer status (what triggers the potential application of the mandate) for a calendar year is still based on the number of employees in the preceding calendar year.[1] Transition rules, discussed below, include those for non-calendar year health plans, the ability to count employees for less than 12 months in 2014 to determine applicable large employer status, initial offers of health coverage in 2015, dependent coverage, employers with at least 50 but less than 100 full-time and full-time equivalent (FTE) employees, and reduction of the 95 percent offer of health coverage requirement to 70 percent for 2015.

The proposed employer mandate regulations allowed employers with fiscal year cafeteria plans to amend their cafeteria plans to permit employees to elect or revoke health coverage elections mid-year even absent a corresponding change in status or cost or coverage change during a non-calendar plan year that began in 2013.[2] The final regulations did not extend this relief.

For purposes of determining FTEs for determining if an employer is an applicable large employer subject to the employer mandate, full-time is 120 hours per month. If an employer was not in existence during the prior calendar year, an employer is a large employer for the current calendar year if it is reasonably expected to employ at least 50 FTEs. If an employer's FTEs exceed 50 for 120 days or less and the excess employees are seasonal workers, then the employer is not a large employer.

For purposes of the employer mandate penalty assessments (as opposed to determining whether the employer is an applicable large employer), the law defines full-time as 30 hours of service per week, and the regulations provide that 130 (not 120) hours per month is the monthly equivalent, both determined in the current month/year. To address the calculation difficulty concern, the regulations provide alternatives to a month-by-month determination. For on-going employees, an employer has the option of using a "look-back measurement" method for determining current full-time status. The employer selects a measurement period of three to twelve months and calculates whether the employee on average had 30 hours of service per week (or 130 hours per month) during that period. If so, the employer must treat the employee as full-time during a subsequent "stability period," which must be at least six months but no shorter than the length of the measurement period. Thus, if the employer used a twelve-month look-back measurement period beginning on January 1, 2014, employees who are determined to be full-time must be treated as full-time for all of calendar year 2015. An employer may also utilize an optional administrative period of up to 90 days between the measurement period and the stability period in order to determine which on-going employees are eligible for health insurance coverage during the subsequent stability period. However, the administrative period cannot create a gap in coverage. An employee who was enrolled in coverage must remain enrolled during the administrative period.

1. 26 CFR §54.4980H-2(b).
2. See IRS Notice 2013-71, which clarified this transition relief.

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If employer has on average fewer than 50 Full-Time (and full-time equivalent) Employees in 2014:

- No change. Employer is not subject to the mandate. Employers close the fifty employee threshold may count employees during any consecutive six-month period (as chosen by the employer) during 2014.

If employer has on average between 50 and 99 Full-Time (including full-time equivalents) Employees in 2014:

- Employer has a one-year delay in the employer mandate, until January 1, 2016 (and for non-calendar-year plans, any calendar months during the plan year beginning in 2015 that fall in 2016) if:
  - Employer certifies it did not lay off employees during the period beginning on February 9, 2014 and ending on Dec. 31, 2014 to fall below the 100 employee threshold and that employer did not reduce any coverage you were already offering, and
  - During the period beginning on February 9, 2014 and ending on Dec. 31, 2014, employer does not eliminate or materially reduce the health coverage, if any, offered as of February 9, 2014. An employer will not be treated as eliminating or materially reducing health coverage if, for each employee who is eligible for coverage on February 9, 2014:
    (a) The employer offers to make a contribution toward the cost of employee-only coverage that is either (i) at least 95 percent of the dollar amount of the contribution the employer was making toward the coverage in effect as of February 9, 2014, or (ii) at least the same percentage of the cost of coverage that the employer offered to contribute toward coverage in effect as of February 9, 2014;
    (b) Benefits offered as of February 9, 2014 at the employee-only coverage level does not change, or, if it does, the coverage after the change provides minimum value; and
    (c) Eligibility under the employer's group health plans is not amended to narrow or reduce the class or classes of employees (or the employees' dependents) to whom coverage under those plans was offered as of February 9, 2014.
  - Such employer must report coverage of employer's employees for 2015.

If employer has on average 100 or more Full-Time (including full-time equivalents) Employees in 2014:

- If an employer fails to offer coverage to a full-time employee for any day of a calendar month, that employee is treated as not having been offered coverage during the entire month. For January 2015, if an employer offers coverage to a full-time employee no later than the first day of the first payroll period that begins in January 2015, the employee will be treated as having been offered coverage for January 2015.

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- Employers With Fiscal Year Health Plans. The employer mandate remains effective on January 1, 2015. However, employers with non-calendar (fiscal) year plans can be subject to the mandate based on the start of their 2015 plan year rather than on January 1, 2015, and other transition relief when certain conditions are met, as follows:

  (a) Pre-2015 Fiscal Year Plan Eligibility Transition Relief. Pre-2015 eligibility transition relief applies to employees, whenever hired, who are:

  - Eligible for coverage on the first day of the 2015 plan year under the eligibility terms of the plan as of February 9, 2014 (whether or not they elected coverage); and
  - Offered affordable coverage that provides minimum value effective no later than the first day of the 2015 plan year.

  Where these two conditions are satisfied, the employer will not be subject to a potential employer shared responsibility payment until the first day of the 2015 plan year. This relief applies only to employees to whom coverage was previously offered by the employer. Thus, penalties may still be imposed for the months in 2015 that are part of the plan year commencing in 2014 for employees to whom coverage was not previously offered.

  (b) Significant Percentage Fiscal Year Plan Transition Relief (All Employees). No employer mandate penalty applies for any month before the first day of the plan year beginning in 2015 for employees who are offered affordable coverage that provides minimum value by the first day of the 2015 plan year if as of any date in the 12 months ending on February 9, 2014, an employer:

  - Covers at least one-quarter of its employees (full-time and part-time) under its non-calendar year plan; or
  - Offered coverage under the plan to one-third or more of its employees during the open enrollment period that ended most recently before February 9, 2014.

  To qualify for this relief, the employee must not have been eligible for coverage as of February 9, 2014 under any group health plan maintained by his or her employer that has a calendar year plan year.

Planning Point: Unlike the pre-2015 eligibility transition relief discussed above, an employer that qualifies for this relief and who offers affordable, minimum value coverage commencing with the 2015 plan year has no Code section 4980H exposure for periods before the 2015 plan year. Relief under this and the next transition rule applies for the period before the first day of the first non-calendar year plan year beginning in 2015 but only for employers that maintained non-calendar year plans as of December 27, 2012, and only if the plan year was not modified after December 27, 2012, to begin at a later calendar date.

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- 70 Percent Offer In 2015. For 2015 (and for any calendar months during a non-calendar year plan year beginning in 2015 that fall in 2016), the 95 percent offer of coverage threshold is lowered to 70 percent. Thus, in 2015, an employer will be in compliance if employer offers coverage to at least 70 percent of full-time employees and dependents in 2015 ((unless the employer qualifies for the 2015 dependent coverage transition relief, discussed below), although an employer will owe penalty if at least one of the full-time employees receives a premium tax credit for coverage in the public marketplace, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered was either unaffordable or did not provide minimum value.

- Dependent Coverage. In order to avoid exposure for the employer mandate penalty, an employer must offer coverage not only to full-time employees but also their dependents (but not spouses). The final regulations provide transition relief to plan years that begin in 2015 if the employer takes steps during the 2015 plan year toward satisfying this requirement.in 2016. The transition relief applies to employers for the 2015 plan year for plans under which (i) dependent coverage is not offered, (ii) dependent coverage that does not constitute minimum essential coverage is offered, or (iii) dependent coverage is offered for some, but not all, dependents. This relief is not available, however, if the employer had offered dependent coverage during either the plan year that begins in 2013 or the 2014 plan year and subsequently eliminated that offer of coverage.

- In 2016 and after, employer must offer coverage to at least 95 percent of full-time employees and dependents.

- These applicable large employers must report coverage of employees beginning with 2015.

- An applicable large employer will not be subject to shared responsibility penalties with respect to employees for whom the employer is required by the collective bargaining agreement or appropriate related participation agreement to make contributions to the multiemployer plan.

421. What is the premium tax credit that is available to low and moderate income taxpayers beginning in 2014?

Starting in 2014, health care reform legislation requires state-based health insurance exchanges through which individuals and smaller businesses can purchase health insurance coverage, with premium and cost-sharing credits available to individuals and families with incomes between 133-400 percent of the federal poverty level. The 2014 poverty level (which are updated annually by the Department of Health and Human Services) for a family of three generally is $19,790, except in Alaska and Hawaii, where it is $24,740 and $22,760, respectively, for a family of three.

In addition to meeting the income requirements a qualifying taxpayer must purchase health insurance on one of the exchanges, must be otherwise unable to obtain affordable coverage through an employer or government program and cannot be eligible to be claimed as a dependent by any other taxpayer. The tax credit can either be paid by the government to the insurance company

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in advance, or can be refunded to a taxpayer who has already paid for health coverage after the taxpayer files a 2014 tax return

Additionally, in 2014, Medicaid will be expanded and available to all families with incomes at or below 133 percent of the federal poverty level. However, this Medicaid expansion requires each state to authorize the expansion, and almost half the states have not done so.

On June 28, 2012, the Supreme Court, in *National Federation of Independent Business v. Sebelius*, upheld the constitutionality of the Patient Protection and Affordable Care Act, with only minor changes to certain Medicaid provisions.

422. What is the penalty for employers with employees who obtain health coverage through a health care exchange and are eligible for the premium tax credit?

Employers with fifty or more full-time equivalent (FTE) employees and more than thirty full-time employees (where full time employees are those regularly scheduled to work more than thirty hours per week and more than 120 days per year), may be required to pay penalties (in the form of a nondeductible excise tax) for employees who do not receive coverage through the employer and instead purchase health insurance through a state health insurance exchange and receive tax credits (see Q 421). For further description of potential health care coverage penalties, see Q 419.

Employers with fewer than fifty FTE employees are exempt from the penalty. Workers who are independent contractors do not count as employees unless it is found that they actually are employees despite being called independent contractors.

423. How will health reform affect small business?

Businesses with fewer than twenty-five full-time employees ("FTEs") with average compensation of under $50,000 will be eligible for a tax credit for health insurance purchased for employees. Owners, their family members, and seasonal employees are not counted and premiums paid are not eligible for the credit. This tax credit, however, is temporary. If claimed in 2010, the credit can be claimed only for a maximum of six years.

All businesses, large and small, will need to retain their current insurance plan and not reduce benefits or materially increase employee costs if they want to retain grandfathered status and be exempt from the new nondiscrimination rules for health insurance.

Employers without a grandfathered health insurance plan that provides benefits favoring highly compensated employees will be subject to a penalty of $100 per day per employee who is not highly compensated once the IRS announces that the new health insurance nondiscrimination rules are in effect.

Companies with no more than forty-nine full-time and FTE workers will be less affected by the new rules because they will not be subject to any penalties for not providing adequate affordable coverage. Businesses with fifty or more FTEs must offer coverage or pay a penalty

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beginning in 2014. This penalty provides employers with fifty or more FTE employees an incentive to provide coverage and not dump employees onto exchanges to buy their own insurance. The penalties are far less than the cost of health insurance, however, which is subsidized by the exchanges for those earning less than 400 percent of the federal poverty level.

Planning Point: In 2014, when state health insurance exchanges are available and subsidize those with incomes below 400 percent of the federal poverty level, many businesses may consider eliminating their health insurance for employees and perhaps increasing their compensation, which in many cases will be less expensive than continuing to provide health insurance.

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