PART XI: EMPLOYER-SPONSORED ACCIDENT & HEALTH INSURANCE BENEFITS

8725. May an employer deduct as a business expense the cost of premiums paid for accident and health insurance for employees?

An employer generally can treat accident and health insurance as a business expense, and can therefore deduct the cost of all premiums paid for employees' coverage. This includes premiums for medical expense insurance, dismemberment and sight loss coverage for the employee, the employee's spouse and dependents, disability income for the employee, and accidental death coverage.

The employer is entitled to deduct these premiums regardless of whether coverage is provided under a group policy or under individual policies. Despite this, the deduction will be disallowed if benefits are payable to the employer—the deduction for health insurance is allowable only if benefits are payable to employees or their beneficiaries.[1] However, if the employer's spouse is a bona fide employee and the employer is covered as a family member based on the spouse-employee's coverage, the premium is deductible.[2]

A corporation can deduct premiums it pays on group hospitalization coverage for commission salespersons, regardless of whether they are technically treated as employees or independent contractors.[3] The premiums paid, however, must qualify as additional reasonable compensation to the insured employees.[4]

A different rule applies for certain accrual basis employers that provide medical benefits to employees directly instead of through insurance or an intermediary fund. In this case, the employer may not deduct amounts estimated to be necessary to pay for medical care provided in the year, but for which no claims have 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]

8726. What credit is available for small employers for employee health insurance expenses?

Eligible small employers may take advantage of a tax credit for employee health insurance expenses for taxable years beginning after December 31, 2009, provided the employer offers health insurance to its employees and makes a non-elective contribution on behalf of each employee who participates in the plan.[6]

An eligible small employer is defined as an employer that has no more than twenty-five full time employees, the average annual wages of whom do not exceed $50,800 (as adjusted for inflation in 2014; in 2010 to 2013 the amount was $50,000).[7]

1. Treas. Reg. §1.162-10(a); Rev. Rul. 58-90, 1958-1 CB 88; Rev. Rul. 56-632, 1956-2 CB 101.
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).
6. IRC Sec. 45R, as added by PPACA 2010.
7. 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.

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In order to qualify, the 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.[1]

Subject to phase-out[2] 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 exempt organizations, of the lesser of the following:

(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.[3]

For years 2010 through 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 exempt entities);[4]

(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;[5] and

(3) the amount under (2) is determined by the average premium for the state small group market.[6]

The credit also is allowed against the alternative minimum tax.[7]

Planning Point: Proposed regulations explain how to calculate employer tax credits after 2013.[8] The regulations propose that the maximum credit for taxable years after 2014 (available for only 2 years) increase to 50 percent (35 percent for tax exempt organizations), with some adjustments. There is a proposed phase out for small employers with more than 10 employees or whose average annual wages exceed $25,000 (adjusted for inflation). In addition, the proposed regulations clarify that employer contributions to an HRA, FSA, and HSA are not considered premium payments[9] (See Q 8759).

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1. IRC Sec. 45R(d)(4), as added by PPACA 2010.
2. IRC Sec. 45R(c), as added by PPACA 2010.
3. IRC Sec. 45(b), as added by PPACA 2010.
4. IRC Sec. 45R(g)(2)(A), as added by PPACA 2010.
5. IRC Secs. 45R(g)(2)(B), 45R(g)(3), as added by PPACA 2010.
6. IRC Sec. 45R(g)(2)(C), as added by PPACA 2010.
7. IRC Sec. 38(c)(4)(B), as amended by PPACA 2010. The IRS has issued guidance; see IRS Notice 2010-44, 2010-22 IRB 717; IRS Notice 2010-82, 2010-51 IRB 1.
8. 2013 IRB LEXIS, 2013-38 IRB 211 (modifying IRS Notice 2010-44, 2010-22 IRB 717; IRS Notice 2010-82, 2010-51 IRB 1).
9. Prop. Treas. Reg. §1.45R-3.

8727. 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, the employee's spouse and dependents, and coverage providing for disability income for the employee. Unlike the exclusion for group-term life insurance, there is no specific limit on the amount of employer-provided accident or health coverage that may be excluded from an employee's gross income. Further, coverage is tax-exempt to an employee whether it is provided under a group or individual insurance policy.[1] Similarly, the employee is not taxed on the value of critical illness coverage.

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

The IRS has ruled privately 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 personally-owned medical expense insurance and is reimbursed by the employer, IRC Section 106 similarly allows the reimbursement to be excluded from the employee's gross income.[5] On the other hand, an employee must include in income payments received from an employer that *may* be used to pay the accident and health insurance premiums if those amounts are not *required* to be used for that purpose.[6]

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.[7]

The IRS has ruled privately that a return of a premium rider on a health insurance policy was a benefit in addition to accident and health benefits, so that the premium paid by the employer had to be included in the employee's taxable income.[8]

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), fn.3, *aff'd* 394 F.2d 494 (1st Cir. 1968).; Let. Rul. 9840044.
6. Rev. Rul. 75-241, 975-1 CB 316, Let. Rul. 9022060. See also Let. Rul. 9104050.
7. Let. Rul. 9625012.
8. Let. Rul. 8804010.

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For purposes of determining the tax treatment of employer-provided accident and health insurance, full time life insurance salespersons are treated as employees if they are employees for Social Security purposes.[1] Coverage for other commission salespersons is taxable income to the salespersons, unless an employer-employee relationship exists.[2]

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.

For a discussion of the considerations applicable to S corporations, see Q 8835 to Q 8842.

8728. Is the value of employer-provided coverage under accident or health insurance taxable income to an employee if the employee has a choice as to whether to receive coverage or a higher salary?

Outside of the context of cafeteria plans, if an employer 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 the employee's choice. If the employee selects the health insurance option, the IRS will deem the employee 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.[3]

However, a federal district court faced with a similar fact situation 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.[4]

8729. Is the value of employer-provided coverage under accident or health insurance taxable income to an employee when the coverage is provided for the employee's spouse, children or dependents?

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.[5]

In 2010, the Affordable Care Act ("ACA"), expanded the exclusion from gross income for amounts expended on medical care 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. The IRS has released guidance indicating that the exclusion applies regardless of whether the adult child is eligible to be claimed as a dependent for tax purposes.[6]

1. IRC Sec. 7701(a)(20).
2. Rev. Rul. 56-400, 1956-2 CB 116; see also IRC Sec. 3508.
3. Let. Rul. 9406002. See also Let. Rul. 9513027.
4. *Express Oil Change, Inc. v. U.S.*, 25 F. Supp. 2d 1313 (N.D. Ala. 1996), *aff'd*, 162 F.3d 1290 (11th Cir. 1998).
5. Rev. Rul. 82-196, 1982-2 CB 53; GCM 38917 (11-17-82).
6. 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.

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8730. When will amounts received by an employee under employer-provided accident and health insurance be taxable income to the employee?

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 spouse and dependents are generally tax-exempt without limit.

Despite this, if the employee deducted the expense in a prior year and is later reimbursed, the reimbursement must be included in gross income. Moreover, if reimbursements exceed actual expenses, the excess must be included in gross income to the extent that it is attributable to employer contributions.[1]

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.[2]

Similarly, 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.[3]

Critical Illness Benefits

If the value of an employer-provided critical illness insurance policy was not includable in the employee's gross income, amounts later received by the employee under the policy are includable in that 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).[4]

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.[5]

Sight Loss and Dismemberment

An employee is only entitled to exclude payments not related to absence from work for the permanent loss, or loss of use, of a member or function of the body, or permanent disfigurement

1. IRC Sec. 105(b); Treas. Reg. §1.105-2; Rev. Rul. 69-154, 1969-1 CB 46.
2. Rev. Rul. 2002-3, 2002-1 CB 316.
3. Rev. Rul. 2002-80, 2002-2 CB 925.
4. See Treas. Regs. §§1.105-2, 1.213-1(e).
5. See Let. Ruls. 9103043, 9036049.

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of the employee or spouse or a dependent, if the amounts paid are computed with reference to the nature of the injury.[1]

An employee was entitled to exclude a lump-sum payment for incurable cancer under a group life-and-disability policy based upon this provision.[2]

However, if the benefits are determined based upon length of service rather than type and severity of injury, the exemption will not apply.[3] Similarly, if the benefits are determined as a percentage of the disabled employee's salary, rather than by the nature of the employee's injury, they are not excludable from income.[4] An employee who has permanently lost a bodily member or function, but who continues to work and draw 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.[5]

8731. Are benefits paid under an employer-sponsored plan by reason of the employee's death received tax-free?

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.[6] Death benefits payable under life insurance contracts issued after December 31, 1984, are excludable if the contract meets the statutory definition of a life insurance contract in IRC Section 7702. See Q 8702 to Q 8724 for a detailed discussion of the tax treatment of life insurance death proceeds.

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.[7]

8732. Are benefits provided under an employer's noninsured accident and health plan excludable from an employee's income?

Although there is no particular legal form of plan required, uninsured benefits must be received under some sort of accident and health plan established by the employer for its employees in order to be tax-exempt on the same basis as insured plans.[8] An Ohio federal District Court described the "plan" requirement as follows: "there is no legal magic to a form; the essence of the arrangement must determine its legal character."[9]

1. IRC Sec. 105(c).
2. Rev. Rul. 63-181, 1963-2 CB 74.
3. *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).
4. *Colton v. Comm.*, TC Memo 1995-275; *Webster v. Comm.*, 870 F. Supp, 202, 94-2 USTC ¶50,586 (M.D. Tenn. 1994).
5. *Laverty v. Comm.*, 61 TC 160 (1973) *aff'd*, 523 F.2d 479, 75-2 USTC ¶9712 (9th Cir. 1975).
6. Treas. Reg. §1.101-1(a).
7. Rev. Rul. 82-196, 1982-2 CB 53; GCM 38917 (11-17-82).
8. IRC Sec. 105(e).
9. *Epmeier v. U.S.*, 199 F.2d 508, 511 (7th Cir. 1959).

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A formal contract of insurance is not required 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 established for the benefit of its employees. For example, a provision for disability pay in an employment contract has been held to satisfy the condition.[1]

For tax purposes, it is not necessary for the plan to be in writing or even that an employee's rights to benefits under the plan be enforceable. For example, a plan has been found based on an employer's custom or policy of continuing wages during disability, which was generally known to employees.[2]

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.[3] Further, for a plan to exist 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 or sickness arises. *Ad hoc* payments that are made at the complete discretion of an employer do not qualify as a plan.[4]

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.[5] 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. For purposes of determining the excludability of employer-provided accident and health benefits, self-employed individuals and certain shareholders owning more than 2 percent of the stock of an S corporation are not treated as employees.[6]

Further, uninsured medical expense reimbursement plans for employees must meet nondiscrimination requirements for medical expense reimbursements to be tax-free to highly compensated employees. See Q 8733 for a discussion of the nondiscrimination requirements applicable to employer-provided health insurance plans.

8733. What nondiscrimination requirements apply to employer-provided health insurance plans?

Under current law, employer-provided health insurance plans are subject to nondiscrimination rules concerning discrimination based on health status under HIPAA '96. Though the HIPAA rules generally apply to both insured and uninsured plans, a plan that provides health benefits through an accident or health insurance policy need not meet the nondiscrimination requirements of IRC Section 105(h), which applies to amounts paid to highly compensated

1. *Andress v. U.S.*, 198 F. Supp. 371 (N.D. Ohio,1961).
2. *Niekamp v. U.S.*, 240 F. Supp. 195 (E.D. Mo. 1965); *Pickle v. Comm*, TC Memo 1971-304.
3. Treas. Reg. §1.105-5(a).
4. *Est. of Kaufman*, 35 TC 663 (1961), *aff'd*, 300 F.2d 128 (6th Cir. 1962); *Lang v. Comm*, 41 TC 352 (1963); *Levine v. Comm*, 50 TC 422 (1968); *Est. of Chism v. Comm*, TC Memo 1962-6, *aff'd*, 322 F.2d 956 (9th Cir. 1963); *Burr v. Comm*, TC Memo 1966-112; *Frazier v. Comm.*, TC Memo 1994-358; *Harris v. U.S.*, 77-1 USTC ¶9414 (E.D. Va. 1977).
5. Treas. Reg. §1.105-5(a); *Andress*, 198 F. Supp. 371.
6. IRC Sec. 105(g); Treas. Reg. §1.105-5(b).

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employees for coverage under *self-insured plans*, for covered employees to enjoy the tax benefits described in Q 8736.

For plan years beginning on or after September 23, 2010, which was six months after the date of enactment of the Affordable Care Act (ACA), insured plans that are not grandfathered were expected to become 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.[1] The IRS indicated that the guidance will not apply until plan years beginning a specified period after guidance is issued.

Affordable Care Act Rules

The ACA requires that a group health plan that is not a self-insured plan satisfy the requirements of IRC Section 105(h)(2). More specifically, the ACA provides 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).[2] A detailed discussion of the applicable definition of highly compensated individual under Section 105 is provided in Q 8737.

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

8734. What is a self-insured health plan?

A self-insured plan is one in which reimbursement of medical expenses is not provided under a policy of accident and health insurance.[3] 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.[4]

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. A plan will be found to be self-insured unless the policy involves shifting of risk to an unrelated third party.

A plan is not considered self-insured merely because prior claims experience is one factor in determining the premium.[5] Further, 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 equal to at least one-half of the total premiums received and the policy is similar to those sold to unrelated companies.[6]

1. 2011-1 CB 259.
2. Sec. 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.
3. See IRC Sec. 105(h)(6).
4. Treas. Reg. §1.105-11(b).
5. See, for example, Let. Rul. 8235047.
6. Treas. Reg. §1.105-11(b).

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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).[1]

8735. Are reimbursements attributable to employee contributions to a self-insured health plan taxable to the employee?

Generally, reimbursements attributable to employee contributions are received tax-free. However, an employee must include any reimbursed amount to the extent that the employee has taken a deduction for the expense.

Amounts attributable to employer contributions are determined based on the ratio that employer contributions bear to total contributions for the calendar years immediately preceding the year of receipt (up to three years may be taken into account). If the plan has been in effect for less than a year, then the determination may be based upon the portion of the year, or such determination may be made periodically (such as monthly or quarterly) and used throughout the succeeding period.[2]

For example, if an employee leaves employment on April 15, 2014, and 2014 is the first year the plan was in effect, the 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.

8736. What nondiscrimination requirements apply to self-insured health plans?

The nondiscrimination requirements set forth in IRC Section 105(h) apply to self-insured health benefits, although the IRS announced in Notice 2011-1 on December 22, 2010, that compliance with nondiscrimination rules for other 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 in a specified period after guidance is issued.

Benefits received pursuant to a self-insured plan are generally excludable from an employee's gross income. Despite this, 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 the highly compensated individuals will be taxable to those highly compensated individuals.

A medical expense reimbursement plan cannot be implemented retroactively because, if this were permitted, the nondiscrimination requirements of IRC Section 105 would be ineffective.[3]

1. IRC Sec. 3401(a)(20).
2. Treas. Reg. §1.105-11(i).
3. *Wollenburg v. U.S.*, 75 F. Supp. 2d 1032, 1035 n.2 (D. Neb. 1999) (noting that "An employer can choose to benefit or hurt certain employees with much greater precision, with the benefit of hindsight."); *American Family Mut. Ins. Co. v. U.S.*, 815 F. Supp. 1206 (W.D. Wisc. 1992). See also Rev. Rul. 2002-58, 2002-38 IRB 541.

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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.[1]

For purposes of these eligibility requirements, an employer is not required to consider those employees who:

(1) have not completed three years of service at the beginning of the plan year; however, 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.[2]

Part-time and Seasonal Workers

Part-time employees include those employees who are customarily employed for fewer than thirty-five hours per week. Seasonal employees are those who are customarily employed for fewer than nine months per year. In determining whether an employee is part-time or seasonal, the IRS will consider whether similarly situated employees of the employer or in the same industry or location are employed for substantially more hours or months, as applicable. A safe harbor rule provides that employees customarily employed for fewer than twenty-five hours per week or seven months per year may automatically be considered part-time or seasonal.[3]

Benefits

A plan discriminates as to benefits unless all benefits provided for participants who are highly compensated individuals are provided for all other participants.[4] If some participants

1. IRC Sec. 105(h)(3)(A).
2. IRC Sec. 105(h)(3)(B).
3. Treas. Reg. §1.105-11(c).
4. IRC Sec. 105(h)(4).

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become eligible for benefits immediately and others only after a waiting period, benefits are not considered to be available to all participants.[1] 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, 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, the plan will be found to discriminate with regard to benefits.

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.[2]

The nondiscrimination rules are not violated merely because benefits under the plan are offset by benefits paid under a self-insured or insured plan of the employer, 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.[3] 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 are treated as employed by a single employer.[4]

Highly Compensated Individual

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

(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, 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.[5] Fiscal year plans may determine compensation on the basis of the calendar year ending in the plan year.

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

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A participant's status as officer or stockholder with respect to a particular benefit is determined at the time when the benefit is provided.[1] See Q 8737 for a discussion of the tax consequences to a self-insured plan that is found to be discriminatory under these rules.

8737. What are the tax consequences for amounts paid by an employer to highly compensated employees under a discriminatory self-insured medical expense reimbursement plan?

If a self-insured medical reimbursement plan is found to be discriminatory in favor of highly compensated employees, those highly compensated employees may be taxed on reimbursed amounts provided under the plan. The taxable amount of payments is the "excess reimbursement."[2] The two situations discussed below will 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 if the benefit otherwise discriminates in favor of highly compensated individuals. In this case, the total amount reimbursed under the plan to the employee with respect to that benefit is an excess reimbursement.

The second situation occurs when a plan discriminates as to participation, even though all benefits are available to all other participants and are not otherwise discriminatory. If this is the case, the excess reimbursement is determined by multiplying the total amount reimbursed to the highly compensated individual for the plan year by a fraction. The numerator of this fraction is the total amount reimbursed to all participants who are highly compensated individuals under the plan for the plan year and the denominator is the total amount reimbursed to all employees under the plan for such plan year. In determining the fraction, any reimbursement attributable to a benefit not available to all other participants is not taken into account.[3]

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

Unless a plan provides otherwise, reimbursements will be attributed to the plan year in which payment is made. Accordingly, they will be subject to tax 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.[4]

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

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8738. Are premiums paid by a taxpayer for personal health insurance deductible?

A taxpayer may deduct premiums paid for medical care insurance (including hospital, surgical, and medical expense reimbursement coverage) 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.

The 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. For taxpayers over the age of sixty-five, the threshold for deductibility will remain at the 7.5 percent level from years 2013 to 2016.

A taxpayer must itemize his or her deductions in order to take a deduction for medical care premiums or any other medical expenses.[1] The reduction of itemized deductions for certain high-income individuals is not applicable to medical expenses deductible under IRC Section 213.[2]

The only premiums deductible as a medical expense are for medical care insurance. Premiums for non-medical benefits, such as disability income, accidental death and dismemberment, and waiver of premium under a life insurance policy, are not deductible.

The definition of "medical care" generally includes amounts paid for any qualified long-term care insurance contract or for qualified long-term care services and, thus, these expenses may be deducted, subject to certain limitations.[3]

Mandatory contributions to a state disability benefits fund are not deductible under the provisions applicable to medical expense deductions, 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. In order to take advantage of this bifurcated approach, the medical portion must be stated separately in either the policy or in a statement furnished by the insurance company.[6]

Similarly, where a premium provides for medical care for individuals other than the taxpayer, spouse and dependents (such as with automobile insurance), a deduction will not be allowed unless the policy separately states the portion that is applicable to the taxpayer, spouse and dependents.[7]

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, 1981-2 CB 50 (citing N.Y. law); Rev. Rul. 81-193, 1981-2 CB 52 (citing N.J. law); Rev. Rul. 81-194, 1981-2 CB 54 (citing Cal. law).
6. IRC Sec. 213(d)(6).
7. Rev. Rul. 73-483, 1973-2 CB 75.

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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 by the taxpayer.[1] Premiums paid for a hospital insurance policy that provides a specific payment for each week the 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 are not deductible.[2]

Because the benefit under a critical illness insurance policy is payable regardless of any actual medical expenses incurred or reimbursement received, the premiums paid for this type of policy would appear not to be deductible.[3]

A deduction also will 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.[4]

A taxpayer may deduct premiums paid for a policy that reimburses the taxpayer for the cost of prescription drugs as medical care insurance premiums.[5]

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. However, the taxes paid by employees and self-employed individuals for basic hospital insurance under Medicare are not deductible.[6]

If a taxpayer prepays premiums before the taxpayer is sixty-five for insurance that will cover medical care for the taxpayer, spouse, and dependents *after* the taxpayer is sixty-five, these premiums 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.[7]

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.[8] The IRS has stated that its rulings should not be interpreted or expanded 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 the ruling at issue.

1. Rev. Rul. 58-602, 1958-2 CB 109, modified by Rev. Rul. 68-212, 1968-1 CB 91.
2. Rev. Rul. 68-451, 1968-2 CB 111.
3. See Treas. Reg. §1.213-1(e)(4).
4. Rev. Rul. 73-347, 1973-2 CB 25.
5. Rev. Rul. 68-433, 1968-2 CB 104.
6. IRC Sec. 213(d)(1)(D); Rev. Rul. 66-216, 1966-2 CB 100.
7. IRC Sec. 213(d)(7).
8. Rev. Rul. 76-481, 1976-2 CB 82; Rev. Rul. 75-303, 1975-2 CB 87; Rev. Rul. 75-302, 1975-2 CB 86.

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8739. 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 exemption applies to disability income, dismemberment and sight loss benefits, critical illness benefits,[1] and hospital, surgical, and other medical expense reimbursement. The taxpayer is not limited as to the amount of benefits, including the amount of disability income that he or she can receive tax-free under personally paid health insurance or under an arrangement having the effect of accident or health insurance.[2] However, courts have held that the IRC Section 104(a)(3) exclusion will be denied where a taxpayer's claims for insurance benefits were not made in good faith and were not based on a true illness or injury.[3]

If a health insurance policy provides for accidental death benefits, the proceeds of these death benefits may be tax-exempt to the policy beneficiary as death proceeds of life insurance.[4] A taxpayer may exclude from gross income disability benefits received for loss of income or earning capacity under no fault insurance.[5] The exclusion also has been applied where the policies were provided to the insured taxpayer by a professional service corporation in which the insured was the sole stockholder.[6]

Health insurance benefits are also tax-exempt if received by a person who has an insurable interest in the individual insured by the policy, rather than by that individual himself.[7]

Medical expense reimbursement benefits will impact the amount that a taxpayer is allowed to deduct for medical expenses. 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.[8]

Similarly, if the taxpayer deducts medical expenses in the year they are paid and then receives reimbursement 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.[9]

Where the value of a decedent's right to reimbursement proceeds, which is income in respect of a decedent,[10] is included in the decedent's estate, an income tax deduction is available for the portion of estate tax attributable to such value.

1. See, e.g., Let Rul. 200903001.
2. 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.
3. *Dodge v. Comm.*, 981 F.2d 350 (8th Cir. 1992).
4. IRC Sec. 101(a); Treas. Reg. §1.101-1(a).
5. Rev. Rul. 73-155, 1973-1 CB 50.
6. Let. Rul. 7751104.
7. See IRC Sec. 104; *Castner Garage, Ltd. v. Comm.*, 43 BTA 1 (1940), *acq*. 1941-1 CB 11.
8. Rev. Rul. 56-18, 1956-1 CB 135.
9. Treas. Regs. §§1.104-1, 1.213-1(g); Rev. Rul. 78-292, 1978-2 CB 233.
10. See Rev. Rul. 78-292, above.

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Disability income is not treated as reimbursement for medical expenses and, therefore, does not offset such expenses.[1]

> *Example*: Ryan, whose adjusted gross income for 2014 was $25,000, paid $4,000 in medical expenses during that year. On his 2014 return, he deducted medical expenses totaling $1,500 [$4,000 - $2,500 (10 percent of his adjusted gross income)]. In 2015, Ryan receives the following benefits from his health insurance: disability income of $1,200 and reimbursement for 2014 doctor and hospital bills of $400. He must report $400 as taxable income on his 2015 return. Had Ryan received the reimbursement in 2014, his medical expense deduction for that year would have been limited to $1,100 (4,000 - $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.

8740. How are accident or health benefits taxed for stockholder employees of a closely-held C corporation?

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

If a plan covers only stockholder-employees, the IRS can challenge tax benefits claimed under the plan on the ground that the plan is not for employees. The challenge for the closely-held C corporation is in establishing that the stockholder-employees are covered as employees, rather than in their capacity as stockholders. If this cannot be established, then premiums or benefits are likely to be treated as dividends. The result is that the premiums will be nondeductible by the corporation and the premiums or benefits will be includable in the gross incomes of covered stockholder-employees.[3]

Courts have found, however, that the tax benefits of employer-provided health insurance are available in a plan that covers only stockholder-employees. This is the case only if the plan covers a class of employees that can be segregated rationally from other employees, if any non-stockholder employees exist, on a criterion other than their being stockholders.[4]

The *Bogene, Smith, Seidel*, and *Epstein* cases, which were decided in favor of the taxpayers, all involved plans that 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, though in *Bogene* and *Epstein* the corporations also employed other employees who were not shareholders and who were not covered by the plans.

The plan in *American Foundry*, where the plan was found to not be a plan for employees, covered only two of five active officers of a family corporation.[5]

1. *Deming v. Comm.*, 9 TC 383 (1947), *acq*. 1948-1 CB 1.
2. IRC Sec. 105(e).
3. *Larkin v. Comm.*, 48 TC 629 (1967), *aff'd* 394 F.2d 494 (1st Cir. 1968); *Levine v. Comm.*, 50 TC 422 (1968); *Smithback v. Comm.*, TC Memo 1969-136; *Est. of Leidy v. Comm.*, 77-1 USTC ¶9144 (4th Cir. 1977).
4. *Bogene, Inc. v. Comm.*, TC Memo 1968-147, *acq*. 1968 AOD LEXIS 272; *Smith v. Comm.*, TC Memo 1970-243, *acq*. 1970 AOD LEXIS 245; *Seidel v. Comm.*, TC Memo 1971-238, *acq*. 972 AOD LEXIS 15; *Epstein v. Comm.*, TC Memo 1972-53, *acq*. 1972 AOD LEXIS 124; *Oleander Co., Inc. v. United States*, 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.
5. *American Foundry v. Comm.*, 76-1 USTC ¶9401 (9th Cir. 1976), acq. 1974-2 CB 1.

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The plan in *Sturgill* covered four officer-stockholders of a family corporation. Two of the four were not active or compensated as officer-employees and the plan was held not to be one for employees.[1]

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.

8741. 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, rather than employer-provided health insurance, usually apply. Partners and sole proprietors, are, therefore, entitled to deduct 100 percent of amounts paid during a taxable year for insurance that provides medical care for the individual, 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" for this purpose is defined to include a taxpayer's child, 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.

In additional, certain premiums paid for long-term care insurance are eligible for this deduction.[2]

A partner or sole proprietor is not entitled to this deduction for any calendar month in which the partner or proprietor is eligible to participate in any subsidized health plan maintained by any employer of the self-employed individual or 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, and plans that do not include that coverage and are not those kinds of contracts.[3]

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 means, 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.

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

1. *Charlie Sturgill Motor Co. v. Comm.*, TC Memo 1973-281, *acq.* 1974 AOD LEXIS 151.
2. IRC Secs. 162(l); 213(d)(1).
3. IRC Sec. 162(l).

(2) net-earnings from self-employment for the purpose of determining the tax on self-employment income.[1]

Additional considerations may apply in the case of a partnership. 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). As such, the premiums are deductible by the partnership under IRC Section 162, subject to IRC Section 263, and must be included in partners' income under IRC Section 61.

A partner is not entitled to 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 self-pay the premiums, 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 self-pays the premiums, 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.

The IRS has found that the cost of consumer medical cards purchased for partners is not deductible by the partners under either IRC Section 162(l) or IRC Section 213. This conclusion was based on the rationale that consumer medical cards that provide discounts on certain medical services and items are not actually insurance products.[3]

The IRS has also concluded that payments from a self-funded medical reimbursement plan set up by a partnership, and made to partners and their dependents, are excludable from partners' income. 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]

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

The IRS has issued settlement guidelines addressing 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. 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.

However, the IRS will closely examine the situation to determine whether an employee-spouse qualifies as a bona fide employee. 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]

8742. How is health insurance coverage taxed for S corporation shareholders?

A shareholder-employee who owns more than 2 percent of the outstanding stock or voting power of an S corporation (based on direct ownership as well as attributed ownership) will be treated as a partner, not an employee (see Q 8741 for the rules applicable to partners).[2] Therefore, 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. The result is that an S corporation can deduct premiums under IRC Section 162 and a shareholder-employee must include premium payments in income under IRC Section 61. The shareholder-employee cannot exclude them under IRC Section 106, but may deduct the cost of the premiums to the extent permitted by IRC Section 162(l), as discussed in Q 8741.[3]

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

8743. What is a health reimbursement arrangement (HRA) and how is it taxed?

The IRS defines an HRA as 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.

A taxpayer is entitled to carry forward any unused amounts in the individual's account 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 (2013) "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]

Reimbursements for medicine are limited to doctor-prescribed drugs and insulin for tax years beginning after December 31, 2010. Consequently, over-the counter medicines are no longer qualified expenses unless prescribed by a doctor after 2010.[2]

An HRA is not permitted to offer cash-outs at any time, even on an employee's termination of service or retirement. However, it may continue to reimburse former employees for medical care expenses after such events even if the employee does not elect COBRA continuation coverage.[3] An HRA is a group health plan and, thus, is subject to COBRA continuation coverage requirements.

HRAs may, on a one-time basis per HRA, make a qualified HSA distribution. A qualified HSA distribution is a rollover made before January 1, 2012 to a health savings account (see Q 8744), of an amount not exceeding the balance in the HRA as it existed on September 21, 2006.[4]

HRAs may not be used to reimburse expenses that were either incurred before the HRA was in existence or 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.[5]

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.[6]

An employee may not be reimbursed for the same medical care expense by both an HRA and an IRC Section 125 health FSA (see Q 8753). Technically, ordering rules from the IRS specify that the HRA benefits must be exhausted before FSA reimbursements may be made. Despite this, HRAs 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 FSA coverage, because FSA funds may only be carried over if the FSA specifically permits a carry over (and even then only up to $500 per year can be carried forward), before tapping into HRA coverage, which can be carried over.[7]

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 connection with

1. Notice 2002-45, 2002-2 CB 93; Rev. Rul. 2002-41, 2002-2 CB 75.
2. IRC Sec. 106(f), as added by PPACA 2010.
3. Notice 2002-45, above.
4. IRC Sec. 106(e).
5. Notice 2002-45, 2002-2 CB 93.
6. Notice 2006-69, 2006-31 IRB 107; Rev. Proc. 2003-43, 2003-21 IRB 935, supplemented by Rev. Proc. 2007-62; 2007-2 CB 786. See also Notice 2007-2, 2007-2 IRB 254.
7. Notice 2002-45, 2002-2 CB 93.

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a cafeteria plan. Where an HRA is offered in connection with another accident or health plan funded by a salary reduction plan, 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 an unlimited amount of 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]

8744. What is a health savings account (HSA) and how is it taxed?

A health savings account (HSA) is a trust created exclusively for the purpose of paying the qualified medical expenses of an account beneficiary.[3]

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

(1) except in the case of certain rollover contributions, no contribution will be accepted:

a. unless it is in cash;

b. 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 for administering the trust;

(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.[4]

1. 2002-2 CB 75.
2. Notice 2002-45, 2002-2 CB 93.
3. IRC Sec. 223(d)(1).
4. IRC Sec. 223(d)(1).

HSAs are available to any employer or individual for an account beneficiary who participates in a high deductible health insurance plan. An eligible individual or an employer may establish an HSA with a qualified HSA custodian or trustee without IRS permission or authorization. As mentioned above, any insurance company or bank can act as a trustee and, 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]

HSAs are similar to IRAs in some respects although 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] Contributions made by an employer are excluded from the employee's income.[4] The HSA itself is also exempt from income tax as long as it remains an HSA.[5] HSA contributions may be made through a cafeteria plan under IRC Section 125 (see Q 8743).[6]

HSA distributions used exclusively to pay qualified medical expenses are not includable in gross income. Distributions used for other purposes are includable in gross income and may be subject to a penalty, with some exceptions.[7]

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

According to IRS guidance, 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) on the amount of the levy unless the taxpayer has attained age sixty-five or is disabled at the time of the levy.[10]

8745. Who is an eligible individual for purposes of maintaining an HSA?

An "eligible individual" for purposes of maintaining an HSA 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 HDHP.[11]

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. CCA 200927019.
11. IRC Sec. 223(c)(1)(A).

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Individuals who are enrolled in Medicare Part A or Part B are not eligible to contribute to an HSA.[1] Mere *eligibility* for Medicare does not preclude HSA contributions.[2]

If an individual has received medical benefits through the Department of Veterans Affairs within the previous three months, the individual may not contribute to an HSA for the current month. Mere eligibility for VA medical benefits will not disqualify an otherwise eligible individual from making HSA contributions.[3]

If an individual is covered by a separate prescription drug plan that provides any benefits before a required high deductible is satisfied, the individual normally does not qualify as an eligible individual.[4] Despite this general rule, 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]

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

Certain types of insurance are not considered 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 (such as the account number, name and address

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, modified by Rev. Proc. 2004-22; 2004-1 CB 727.
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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of trustee or custodian, etc.) as well as the method by which the account information will be provided (whether in writing, by e-mail, on a certain form, etc.).[1]

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.[2]

8746. Can an individual participate in both an HSA and a health FSA?

The IRS has issued guidance providing that taxpayers who participate in health flexible spending accounts (FSAs) that reimburse all qualified medical expenses are ineligible to also contribute to health savings accounts (HSAs) because participation in the FSA constitutes "other coverage" prohibited by the rules applicable to HSAs. This is the case even if the individual only participates in the FSA during the tax year because of a permitted carryover from the prior tax year.

In order to be eligible to contribute to an HSA, a taxpayer must have a high deductible health plan (HDHP), and can also have certain other types of permitted insurance and coverage, as well as preventative care coverage, but not "other coverage." For these purposes, a taxpayer is not eligible to contribute to an HSA if he or she is covered under a health plan that is not an HDHP that provides coverage for any benefit covered under the HDHP. A health FSA that reimburses for all qualified medical expenses falls within this prohibition.

This is the result even if participation in the FSA for the year is only because of a permitted carryover of up to $500 from the preceding tax year. The ineligibility for HSA contributions continues throughout the entire tax year, even if the carried over amounts are exhausted early in the year.

However, a taxpayer can elect to have unused FSA funds carried over into an HSA-compatible FSA (which is either a limited purpose FSA, a post-deductible FSA or a combination of the two). In this case, a taxpayer will be eligible to contribute to an HSA for the year.[3]

8747. What is a high deductible health plan for purposes of an HSA?

The requirements for a high deductible health plan ("HDHP") differ depending on whether individual or family coverage is provided. In this context, family coverage includes any coverage other than self-only coverage.[4]

For 2013 and 2014, an HDHP is a plan with an annual deductible of not less than $1,250 for self-only coverage ($1,300 in 2015), or $2,500 for family coverage ($2,600 for 2015), but annual out-of-pocket expenses that do not exceed $6,450 for self-only coverage ($6,650 for 2015), or $12,700 for family coverage ($12,900 for 2015).[5] These annual deductible amounts and out-of-pocket expense amounts are adjusted for cost of living. Increases are made in multiples of $50.[6]

1. Treas. Reg. §54.4980G-4 A-14(c).
2. TD 9393, 2008-20 IRB.
3. ILM 201413005.
4. IRC Sec. 223(c)(5).
5. Rev. Proc. 2012-26; Rev. Proc. 2013-25, 2013-21 IRB 1; Rev. Proc. 2014-30, 2014 IRB LEXIS 313.
6. IRC Sec. 223(g).

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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 the longer period into account.[1]

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.[2] 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.[3]

An HDHP may provide preventive care coverage without application of the annual deductible.[4] The IRS has provided guidance and safe harbor guidelines on what constitutes preventive care. Pursuant to the IRS 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.[5]

Notice 2013-57 clarifies that a health plan will not fail to qualify as an HDHP merely because it provides preventative services under the ACA without requiring a deductible.[6]

For months before January 1, 2006, a health plan would not fail to qualify as an HDHP solely based upon its compliance with state health insurance laws that mandate coverage without regard to a deductible or before the high deductible is satisfied.[7] 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.[8]

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.[9]

8748. What are the contribution limits to an HSA?

An eligible individual may deduct the aggregate amount paid in cash into an HSA during the taxable year up to the annual limitation amount. In 2014, an individual can deduct up to $3,300 for self-only coverage and $6,550 for family coverage.[10] For 2015, these contribution limits increase to $3,350 for self-only coverage, and $6,650 for family coverage.[11]

1. Notice 2004-50, 2004-2 CB 196, A-24.
2. Notice 2004-50, 2004-2 CB 196, A-14.
3. Notice 2004-50, 2004-2 CB 196, A-17.
4. IRC Sec. 223(c)(2)(C).
5. Notice 2004-50, 2004-2 CB 196, A-27; Notice 2004-23, 2004-1 CB 725.
6. 2013 IRB LEXIS 465.
7. Notice 2004-43, 2004-2 CB 10
8. Notice 2005-83, 2005-2 CB 1075.
9. Notice 2004-2, 2004-1 CB 269, A-3; Notice 96-53, 1996-2 CB 219, A-4.
10. IRC Secs. 223(a), 223(b)(2); Rev. Proc. 2012-26.
11. Rev. Proc. 2013-25, 2013-21 IRB 1; Rev. Proc. 2014-30, 2014 IRB LEXIS 313.

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For years prior to 2007, the allowable 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.[1]

The determination of whether a plan offers self-only or 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. See Q 8749 for a discussion of the individual requirements for HSA eligibility. An example illustrating calculation of the HSA contribution limit is provided below.

> *Example*: Lola has self-only coverage under an HDHP in 2014 and wishes to contribute to an HSA. She has been an eligible individual for all of 2014, so her monthly contribution for self-only coverage is calculated by dividing the 2014 annual limit ($3,300) by the 12 months in her eligibility period. Lola can contribute $275 per month in 2014. If Lola was only an eligible individual for the first eight months of 2014, she still must first calculate her monthly contribution based on a 12-month year. However, her annual contribution limit is prorated to $2,200 (her monthly $275 limit multiplied by the eight months of eligibility). Although the annual contribution level is determined for each month, Lola is entitled to contribute her entire annual contribution amount in a single payment, if desired.[2] If Lola had been an eligible individual for the last month of 2014, she would have been treated as though she were an eligible individual for the entire year.

Individuals who attain age fifty-five before the close of a taxable year are eligible for an additional "catch-up" 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.[3] In 2015, this would allow individuals age fifty-five and older to contribute up to $4,350 and the total contribution for a family would be $7,650.

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 is 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 2015 would be able to contribute the full $3,350 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.[4]

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. If both spouses have family coverage under different plans, both spouses are treated as having only the family coverage with the lowest deductible.[5]

An HSA may be offered in conjunction with a cafeteria plan. Both a HDHP and an HSA are qualified benefits under a cafeteria plan.[6]

1. IRC Sec. 223(b)(2), prior to amendment by TRHCA 2006.
2. IRC Sec. 223(b); Notice 2004-2, 2004-1 CB 269, A-12.
3. IRC Sec. 223(b)(3).
4. IRC Sec. 223(b)(8).
5. IRC Sec. 223(b)(5).
6. IRC Sec. 125(d)(2)(D).

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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.[1] Further, an employee is not required to include any amount in income simply because the employee may choose between employer contributions to an HSA and employer contributions to another health plan.[2]

An individual may not deduct any amount paid into an HSA. Instead, that amount is excludable from gross income under IRC Section 106(d).[3]

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 (on dependency exemptions) for the taxable year.[4] See Q 8749 to Q 8753 for the rules governing employer contributions to employee HSAs. See Q 8756 for a discussion of the treatment of HSA distributions.

8749. What rules govern employer contributions to employee HSAs? Must an employer who offers HSAs to its employees contribute the same amount for each employee?

An employer offering HSAs to its employees is required to make comparable contributions to the HSAs for all comparable participating employees for each coverage period during the calendar year.[5] IRC Section 4980G incorporates the comparability rules of IRC Section 4980E by reference.[6]

"Comparable contributions" for this purpose are contributions that either are the same amount or the same percentage of the annual deductible limit under a high deductible health plan ("HDHP").[7] "Comparable participating employees" include 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.[8] Category of coverage refers to self-only coverage 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 an employer may not contribute less to a category of family coverage with more covered persons than to another category with fewer covered persons.[9]

For years beginning in 2007 and thereafter, participating highly compensated employees may not be treated as comparable to non-highly compensated employees.[10]

1. IRC Sec. 106(d)(1).
2. IRC Secs. 106(b)(2), 106(d)(2).
3. See IRC Sec. 223(b)(4).
4. IRC Sec. 223(b)(6).
5. IRC Secs. 4980E, 4980G.
6. Treas. Reg. §54.4980G-1, A-1.
7. IRC Sec. 4980E(d)(2); Treas. Reg. §54.4980G-4, A-1.
8. Treas. Reg. §54.4980G-3, A-5.
9. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-1, A-2, 54.4980G-4, A-1.
10. IRC Sec. 4980G(d), as added by TRHCA 2006.

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Employer contributions made to HSAs through a cafeteria plan, including matching contributions, are not subject to the comparability rules, but are instead subject to IRC Section 125 nondiscrimination rules.[1]

An employer may make contributions to HSAs of all eligible employees either:

(1) at the beginning of a calendar year;

(2) monthly, on a pay-as-you-go basis; or

(3) 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.[2]

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 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.[3] See Q 8750 for a detailed discussion of the rules that apply when an employee does not participate in the employer's HSA for the entire year.

8750. What are the contribution rules for employers who establish HSAs for employees when an employee has not established an HSA at the time the employer makes contributions or is not eligible to participate for the entire year?

If there are employees who have not established an HSA at the time the employer makes contributions, the employer must provide each such eligible employee a written notice containing certain information no later than January 15. The notice must explain that if the employee, by the last day of February, (a) establishes an HSA and (b) notifies the employer that he or she has done so, the employee will receive a comparable contribution to that HSA for the prior calendar year. This notice may be delivered electronically.

The employer must then make comparable contributions by April 15, taking into account each month that the employee was a comparable participating employee, for each eligible employee that notifies an employer that he or she has established an HSA. These retroactive comparable contributions must also include reasonable interest.[4]

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

1. Notice 2004-50, 2004-2 CB 196, A-47; IRC Sec. 125 (b), (c), and (g); Treas. Reg. §1.125-1, A-19.
2. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-4, A-4.
3. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-4, A-15.
4. IRC Sec. 4980E(d)(3); Treas. Reg. §§54.4980G-4, A-14.

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to HSAs of all employees who are eligible individuals on the first day of the last month of the employees' taxable year. This rule also applies to 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.[1]

Employers are only required to provide 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.[2]

Similarly, 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.[3]

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 does 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.[4]

8751. Are there any exceptions to the comparability rules that govern employer contributions to employee HSAs?

Yes, the IRC provides an exception to comparability rules 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.[5]

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.[6] However, the reverse does not apply: 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.[7]

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

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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.[1]

8752. Is there a penalty if an employer fails to meet the HSA comparability requirements with respect to contributions to employee HSAs?

If an employer fails to meet comparability requirements (see Q 8749), 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.[2]

8753. Can employers allow employees to roll funds into their HSAs from HRAs or FSAs? What is a qualified HSA distribution?

Employers may offer a rollover, known as a qualified HSA distribution, from a health reimbursement arrangement (HRA) or a health flexible spending arrangement (FSA) for any employee. However, if the employer offers a rollover option to one employee, it 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.[3]

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.[4]

8754. What is the penalty for making excess contributions to an HSA? How does an excess contribution impact the taxation of distributions from the 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 the following are true:

1. Treas. Reg. §54.4980G-6, Q&A-1.
2. 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).
3. IRC Sec. 106(e)(5).
4. Treas. Reg. §54.4980G-7, Q&A-1.

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(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.[1]

Excess contributions to an HSA are subject to a 6 percent tax. However, the penalty tax may not exceed 6 percent of the value of the account, as determined at the close of the taxable year.[2]

Excess contributions are defined, for this purpose, as the sum of the following:

(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) the amount calculated in (1), above, 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.[3]

For these purposes, any excess contributions distributed from an HSA are treated as amounts not contributed.[4]

8755. How are funds accumulated in an HSA taxed prior to distribution?

Funds accumulated in an HSA are generally exempt from income tax unless the account ceases to be an HSA.[5]

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[6] and those regarding the effect of pledging an account as security[7] apply to HSAs. Any amounts treated as distributed under these rules will be treated as not used to pay qualified medical expenses.[8]

8756. How are amounts distributed from HSAs taxed?

If a distribution from an HSA is used exclusively to pay the qualified medical expenses of an account holder, the distributed amount is not includable in gross income.[9] In contrast, 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.[10]

1. IRC Sec. 223(f)(3)(A).
2. IRC Sec. 4973(a).
3. IRC Sec. 4973(g).
4. IRC Sec. 4973(g).
5. IRC Sec. 223(e)(1).
6. See IRC Sec. 408(e)(2).
7. See IRC Sec. 408(e)(4).
8. IRC Sec. 223(e)(2).
9. IRC Sec. 223(f)(1).
10. IRC Sec. 223(f)(2).

In addition, a penalty tax applies to any distribution that is includable in income because it was not used to pay qualified medical expenses.[1] The penalty tax is 10 percent of includable income for a distribution from an HSA.[2] For distributions made after December 31, 2010, the additional tax on nonqualified distributions from HSAs is increased to 20 percent of includable income.[3]

The penalty tax does not apply to 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.[4]

"Qualified medical expenses" are amounts paid by the account holder for medical care[5] for the individual, his or her spouse, and any dependent to the extent that expenses are not compensated by insurance or otherwise.[6] For tax years beginning after December 31, 2010, medicines constituting qualified medical expenses are limited to doctor-prescribed drugs and insulin. As a result, over-the counter medicines are no longer qualified expenses unless prescribed by a doctor after 2010.[7]

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[8] or a health plan paid for during a period in which the individual is receiving unemployment compensation.[9]

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 a cafeteria plan. Amounts of qualified long-term care insurance premiums that constitute qualified medical expenses are limited to the following age-based limits in 2014, which are adjusted annually:[10]

(1) for persons age forty or less, the limit is $370,

(2) for ages forty-one through fifty, the limit is $700;

(3) for ages fifty-one through sixty, the limit is $1,400;

(4) for ages sixty-one through seventy, the limit is $3,720; and

(5) for those over age seventy, the limit is $4,660.[11]

The age is the individual's attained age before the close of the taxable year.

1. IRC Sec. 223(f)(4)(A).
2. IRC Sec. 223(f)(4)(A).
3. IRC Sec. 223(f)(4)(A), as amended by PPACA 2010, as further amended by HCERA 2010.
4. IRC Secs. 223(f)(4)(B), 223(f)(4)(C).
5. As defined in IRC Section 213(d).
6. IRC Sec. 223(d)(2).
7. IRC Sec. 106(f), as added by PPACA 2010.
8. As defined under IRC Section 7702B(b).
9. IRC Sec. 223(d)(2).
10. Notice 2004-50, 2004-2 CB 196, A-40.
11. Rev. Proc. 2013-35, 2013-47 IRB 537.

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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.[1]

HSA trustees, custodians, and employers need not determine whether a distribution is used for qualified medical expenses. This responsibility falls on individual account holders.[2]

8757. What is the Affordable Care Act? When do its provisions become effective?

The Affordable Care Act is a comprehensive health care reform law that President Obama signed into law on March 23, 2010.[3] The Patient Protection and Affordable Care Act significantly amends the IRC, ERISA, and the Public Health Service Act. The new law, known as the PPACA, ACA, or 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 described in Q 8758 to Q 8764.

In many ways, the ACA is only a broad outline of the reforms that will take place over the coming years, with the details expected to be filled in by regulators. The Department of Labor, the Department of Treasury, the IRS, and the Department of Health & Human Services have all proposed regulations, or will propose regulations, that outline the more detailed requirements of the ACA.

The ACA goes into effect between 2010 and 2018. The bulk of the provisions are effective beginning in 2011 through 2014. One provision, the tax on so-called "Cadillac" health care plans, goes into effect in 2018.

8758. What kinds of health plans are governed by the Affordable Care Act?

The ACA covers insured and self-funded comprehensive medical health plans. In effect, the ACA governs major medical insurance and self-insured major medical plans.

Certain 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, are generally not regulated under the ACA.

Similarly, plans that only impact retirees ("retiree-only plans") are not impacted by the ACA. Although the ACA 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.

1. Notice 2004-50, 2004-2 CB 196, A-39.
2. Notice 2004-2, 2004-1 CB 269, A-29, A-30.
3. Patient Protection and Affordable Care Act (P.L. 111-148).

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Federal regulators have determined that, with respect to retiree-only and excepted benefit plans, even though those provisions were removed by the ACA, they will read the PHS Act as if an exemption for retiree-only and excepted benefit plans were 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 ACA mandates on all fully insured plans.

8759. What tax credit is available for employers who purchase health insurance? When does the credit become available?

The health insurance tax credit applies to for-profit and non-profit employers meeting certain requirements (see Q 8760). 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.[1]

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.[2]

8760. What employers are eligible for the new tax credit for health insurance under the Affordable Care Act?

The new health insurance tax credit[3] 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 both:

(1) have twenty-four or fewer eligible full time equivalent (FTE) employees, and

(2) pay wages averaging under $50,000 per employee per year.[4]

IRC Section 45R provides a tax credit beginning in 2010 for a business with twenty-five 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. As a result, the compensation of owners and family members is not counted in determining average compensation, and the health insurance cost for these people is not eligible for the health insurance tax credit.[5]

1. http://www.ncsl.org/documents/health/SBtaxCredits.pdf (last accessed June 5, 2014). See also 2013 IRB LEXIS, 2013-38 IRB 211 (modifying IRS Notice 2010-44, 2010-22 IRB 717; IRS Notice 2010-82, 2010-51 IRB 1).
2. http://www.ncsl.org/documents/health/SBtaxCredits.pdf (last accessed June 5, 2014).
3. IRC Sec. 45R.
4. http://www.irs.gov/newsroom/article/0,,id=223666,00.html (last accessed June 5, 2014).
5. http://www.irs.gov/newsroom/article/0,,id=220839,00.html (last accessed June 5, 2014).

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The credit is largest if there are ten or fewer employees and average wages do not exceed $25,000. 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.[1]

> *Example*: In 2015, 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 the employer's state, and otherwise meets the requirements for the credit. The credit for 2015 equals $37,500 (50 percent x $75,000).[2]

8761. How does the Affordable Care Act impact the use of health savings accounts (HSAs)?

The ACA amended IRC Section 223(d)(2)(A) with respect to health savings accounts (HSAs), which now provides that, for amounts paid after December 31, 2010, a distribution from an HSA 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 for any medicine or drug that does not satisfy these requirements, the amounts are treated as though they were distributed to pay for nonqualified medical expenses. Nonqualified medical expenses are includable in gross income and generally are subject to a 20 percent additional tax. This change does not affect HSA 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.

The IRS has provided guidance which makes it clear that these rules 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.[3]

1. http://www.irs.gov/newsroom/article/0,,id=220839,00.html (last accessed June 5, 2014).
2. Additional examples can be found online at http://www.irs.gov/pub/irs-utl/small_business_health_care_tax_credit_scenarios.pdf.
3. Treas. Reg. §1.213-1(e)(1)(ii).

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8762. What penalties are imposed by the Affordable Care Act Act for employers who violate the health insurance nondiscrimination rules?

The health insurance nondiscrimination rules (see Q 8733 to Q 8735), 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 those applicable to 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.[1]

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 beginning on or after September 23, 2010, 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.[2]

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.[3]

8763. What is the penalty if an employer fails to provide the required health insurance under the Affordable Care Act?

As of the date of publication, the shared responsibility provisions outlined below had been delayed by the administration by one year. Therefore, these penalty provisions will not become effective until January 1, 2015, absent further government action. This delay is a result of the corresponding delay in the information reporting requirements applicable to certain employers, because that information was to be used to calculate the amount of an employer's shared responsibility payment.[4]

1. IRC Sec. 4980D.
2. IRC Sec. 4980D(d)(1).
3. IRC Sec. 4980D(c)(3).
4. Notice 2013-45, 2013 IRB Lexis 372.

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Employers with at least fifty full-time equivalent employees (FTEs) must offer health insurance coverage meeting specified requirements or pay a $2,000 per full-time worker penalty (after its first thirty employees) if any of its FTEs 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 FTEs that offer some type insurance coverage that is not sufficient to meet federal requirements. In this case, the penalty is $3,000 per full-time employee who gets government assistance and buys coverage through an exchange, subject to a maximum penalty of $2,000 times the number of full-time employees in excess of the first thirty. Proposed regulations provide that an employer with a non-calendar year plan in existence on December 27, 2012 that offers employees affordable coverage, which satisfies the minimum value requirement by the first day of the plan year starting in 2014, will not be assessed a shared responsibility penalty for any period in 2014 prior to the beginning of the next plan year.[1]

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*,[2] upheld the constitutionality of the Affordable Care Act, with only minor changes to certain Medicaid provisions.

8764. What is the penalty if an individual fails to obtain the required health insurance under the Affordable Care Act?

Health care reform requires most Americans to have health insurance beginning in 2014, or there is a monetary penalty.

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 as follows:

(1) $95 or 1 percent of income in 2014;

(2) $325 or 2 percent of income in 2015; and

(3) $695 or 2.5 percent of income in 2016.[3]

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.

1. 78 Fed. Reg. 218 (2013).
2. 132 S. Ct. 2566 (2012).
3. IRC Sec. 5000A(c).

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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.[1]

8765. When may a taxpayer be exempt from the rule that every taxpayer must obtain a certain level of health coverage or pay a penalty?

Beginning in 2014, taxpayers must obtain a certain minimum level of health coverage or pay a penalty (known as the shared responsibility provision) for failure to obtain minimum essential coverage unless the individual is statutorily exempted from this requirement. In general, the following exemptions may be applicable:

1. *Religious Exemption*. A taxpayer will be exempt from the shared responsibility provision if (a) a member of a recognized religious sect, the teachings of which render the taxpayer conscientiously opposed to accepting benefits provided by any public or private insurance provider that makes payments toward the expenses of obtaining medical care and (b) adheres to the established tenets or teaching of that sect.[2] The religious sect must have been in existence on December 31, 1950 and must be recognized by the Social Security Administration as one that is conscientiously opposed to accepting insurance benefits, including Medicare and Social Security.

2. *Foreign Persons Exemption*. A taxpayer will be exempt from the shared responsibility provision if not a citizen or national of the United States or an alien lawfully present in the United States.[3]

3. *Exemption for Incarcerated Individuals*. A taxpayer will be exempt from the shared responsibility provision during any month incarcerated, other than incarceration while awaiting the disposition of the charges that are pending against the taxpayer.[4]

4. *Affordability Exemption*. If an individual's required contribution for health coverage for the month exceeds 8 percent of the taxpayer's household income for the year (see Q 8768), the taxpayer will not be subject to the shared responsibility provision.[5]

5. *Exemption for Individuals not Required to File a Tax Return*. Individuals who are not required to file a federal tax return for the year because their income does not exceed the applicable filing thresholds (see Q 8501) are not subject to the shared responsibility provision.[6]

1. IRC Sec. 5000A(d), (e).
2. IRC Secs. 5000A(d)(2), 1402(g)(1).
3. IRC Sec. 5000A(d)(3).
4. IRC Sec. 5000A(d)(4).
5. IRC Sec. 5000A(e)(1).
6. IRC Sec. 5000A(e)(2).

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6. *Membership in an Indian Tribe*. Members of recognized Indian tribes are not subject to the shared responsibility provision.[1]

7. *Exemption for Short Coverage Gaps*. An individual will not be subject to the shared responsibility provision if there is a gap in health coverage for a period that is less than three months. However, if there is more than one such gap in coverage during the tax year, the exemption applies only to the first coverage gap.[2]

8. *Hardship Exemption*. The Secretary of Health and Human Services may allow exemptions from the shared responsibility provision on a case-by-case basis if it is determined that an individual has suffered a hardship and is thereby unable to obtain the required coverage.[3]

Both children and senior citizens are subject to the shared responsibility provision. If a child who can be claimed as a dependent does not qualify for an exemption, the taxpayer who can claim that child as a dependent is required to make the shared responsibility payment with respect to the child's failure to obtain the requisite coverage.[4] See Q 8766 for information on how to claim an applicable exemption.

8766. How does a taxpayer who may be exempt from the Affordable Care Act requirements obtain the exemption?

An individual who may be exempt from the shared responsibility provision can often obtain a certificate of exemption from the health insurance exchanges. With respect to the religious and hardship exemptions, this is the only method of claiming the exemption. Individuals claiming the exemption based upon membership in an Indian tribe or incarceration may either obtain a certificate of exemption from the exchanges or claim the exemption on the federal tax return when the return is filed in the subsequent tax year. Exemptions for lack of affordable coverage, a short coverage gap, and certain hardships must be claimed on the taxpayer's federal income tax return.

Individuals who are exempt from the shared responsibility provision because their income for the year falls below the filing threshold, so that they are not required to file a federal tax return for the year, do not need to take any action in order to obtain the exemption.[5]

8767. What are the requirements to claim the premium assistance tax credit under the Affordable Care Act?

The premium assistance tax credit is a subsidy that can be claimed by certain low-to-moderate income taxpayers in order to offset the cost of health insurance coverage. In order to

1. IRC Sec. 5000A(e)(3).
2. IRC Sec. 5000A(e)(4).
3. IRC Sec. 5000A(e)(5).
4. IRS Q&A on the Individual Shared Responsibility Provision, available at: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision (last accessed June 10, 2014).
5. See IRS Q&A on the Individual Shared Responsibility Provision, available at: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision (last accessed June 10, 2014).

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be eligible to claim the premium assistance tax credit, a taxpayer must meet all of the following requirements:[1]

1. The taxpayer must purchase health insurance through the health insurance marketplace (also known as the health insurance exchanges);

2. The taxpayer must have income that falls within certain ranges (see Q 8768);

3. The taxpayer must not be able to obtain affordable coverage through an employer-provided health plan that provides minimum value (see Q 8775 for a discussion of what constitutes "affordable coverage" and Q 8776 for a discussion of plans that provide "minimum value");

4. The taxpayer must be ineligible for government-sponsored health care programs, such as Medicaid and Medicare;

5. Generally, a taxpayer who is married must file a joint return (though exceptions exist for certain victims of domestic violence[2]);

6. No other person may claim a dependency exemption with respect to the taxpayer for the tax year.

Individuals with household income (see Q 8768) that falls between 100 and 400 percent of the poverty line (as adjusted based on family size) may be eligible for the premium tax credit. The federal poverty guidelines that exist as of the first day of the annual open enrollment period are used to determine whether an individual is eligible for the credit, so that the 2014 guidelines are used to determine a taxpayer's credit for 2015.[3] For example, in 2014 the federal poverty guidelines for the 48 contiguous states (including Washington, D.C.) are as follows:

- $11,670 (100 percent) to $46,680 (400 percent) for an individual;
- $15,730 (100 percent) to $62,920 (400 percent) for a family of two;
- $19,790 (100 percent) to $79,160 (400 percent) for a family of three;
- $23,850 (100 percent) to $95,400 (400 percent) for a family of four.[4]

The federal poverty line is modified for taxpayers living in Alaska and Hawaii. If a taxpayer's primary residence during the tax year changes to a state with a different federal poverty line, or if married taxpayers reside in states with different federal poverty lines, the poverty line that applies is the higher of the two guidelines.[5]

1. IRC Sec. 36B.
2. Notice 2014-23, 2014-16 IRB 942.
3. IRC Sec. 36B(d)(5).
4. See the Department of Health & Human Services website for the federal poverty guidelines that apply for families larger than four and the figures for Alaska and Hawaii, available at: http://aspe.hhs.gov/poverty/14poverty.cfm (last accessed June 11, 2014).
5. Treas. Reg. §36B-1(h).

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8768. What is "household income" and how does it determine whether an individual is eligible for a premium assistance tax credit?

For purposes of the premium assistance tax credit, household income is a taxpayer's modified adjusted gross income (MAGI, see below) plus the aggregate modified adjusted gross income of any other individual who was both (1) taken into account in determining the taxpayer's family size for purposes of determining qualification for the credit and (2) required to file a federal tax return for the tax year in question.[1] Because the taxpayer's family size is determined by counting any individual whom the taxpayer was entitled claim as a dependent to for the tax year,[2] it is essentially the case that any income of the taxpayer's dependents who are required to file a return for the year is included in calculating the taxpayer's MAGI.

A taxpayer's MAGI is the adjusted gross income shown on the taxpayer's federal income tax return for the year plus any excluded foreign income, nontaxable Social Security benefits and tax-exempt interest accrued or received during the tax year.[3] Supplemental Social Security income is not included in a taxpayer's MAGI.[4]

8769. If a taxpayer is eligible for the premium assistance tax credit, what happens if the household income level or family size changes during the tax year?

The amount of the allowable premium assistance tax credit varies based upon a taxpayer's annual household income and family size. If either the household income level or family size change throughout the tax year, the taxpayer's allowable credit will increase or decrease accordingly. This becomes important when a taxpayer has chosen to take the premium tax credit in advance (where the credit is paid directly to the insurance company to reduce premiums), rather than retroactively (where the credit is claimed on the taxpayer's federal income tax return for the year).[5]

If the actual allowable credit is less than the advance credit claimed, the difference will be deducted from the taxpayer's overpayment (tax refund) or added to the amount that the taxpayer owes to the IRS if no tax refund is forthcoming. If the actual allowable credit is more than the advance credit claimed, the reverse is true, so that the difference will be added to the taxpayer's refund or subtracted from the balance due to the IRS.[6]

The IRS has released guidance that advises taxpayers to notify the health insurance exchanges if any changes in circumstances have occurred that will alter the amount of the allowable credit in order to reduce the significance of the difference between the advance credit and actual allowable credit.[7] Changes in circumstances that can give rise to such a difference include the following:

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1. IRC Sec. 36B(d)(2).
2. IRC Sec. 36B(d)(1).
3. IRC Sec. 36B(d)(2)(B).
4. See IRS Questions and Answers on the Premium Tax Credit, available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit (last accessed May 28, 2014).
5. See IRS Pub. 5121 (2013).
6. Treas. Reg. §36B-4(a)
7. IRS Pub. 5120 (2013).

1. Increases or decreases in household income;
2. Marriage;
3. Divorce;
4. Birth or adoption of a child;
5. Gaining or losing eligibility for government or employer-sponsored health insurance.[1]

See Q 8768 for a discussion of how household income is calculated for purposes of the premium assistance tax credit.

8770. Can a taxpayer still qualify for a premium assistance tax credit if exempt from the shared responsibility penalty under the Affordable Care Act?

Whether a taxpayer who is otherwise exempt from the shared responsibility penalty remains eligible to claim the premium assistance tax credit depends upon the type of exemption that applies. According to IRS guidance, taxpayers who are exempt because they are incarcerated or not lawfully present in the U.S. are not eligible to claim the premium tax credit. This is the case, however, because these exempt individuals are not permitted to enroll in a health plan through the health insurance exchanges. Individuals who are exempt for other reasons, such as because a religious exemption or affordability exemption applies, will still be eligible to claim the premium tax credit if they otherwise meet the requirements for eligibility.[2]

See Q 8765 for a detailed discussion of the various exemptions that may apply. See Q 8767 for a discussion of the qualification requirements that apply in determining whether a taxpayer is generally eligible to claim the premium tax credit.

8771. Is a taxpayer eligible for a premium assistance tax credit if enrolled in an insurance plan offered through an employer?

No. According to IRS guidance, a taxpayer is not eligible to receive a premium assistance tax credit even if enrolled in an employer-sponsored plan that is unaffordable or fails to provide minimum value.[3]

8772. How does an eligible taxpayer obtain the premium assistance tax credit?

When a taxpayer applies for health coverage through an exchange, the exchange itself estimates the amount of credit that the taxpayer may be eligible to claim. The taxpayer then

1. See IRS Questions and Answers on the Premium Tax Credit, available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit (last accessed May 28, 2014).
2. See IRS Questions and Answers on the Individual Shared Responsibility Provision, available at: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision (last accessed June 10, 2014).
3. See IRS Questions and Answers on the Premium Tax Credit, available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit (last accessed May 28, 2014).

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determines whether to apply the credit in advance (meaning that it is sent directly to the insurance company in order to offset premium payments) or retroactively (meaning that the taxpayer claims the premium credit on the federal tax return for the year).[1]

A taxpayer who receives a premium tax credit is required to file a federal tax return for the year in order to claim the credit. This is true even if the taxpayer would not otherwise be required to file a return because income does not exceed the applicable filing threshold (see Q 8501) for the tax year.[2]

On this return, the taxpayer must report the amount of premiums paid and any advance premium tax credit payments that have been forwarded to the insurance company on the taxpayer's behalf. If the taxpayer enrolls in a health insurance plan through the exchanges, the exchange will send the taxpayer a document that shows the amount of the taxpayer's annual premiums and any advance credit payments by January 31 of the year following the year of coverage.[3]

8773. If taxpayer changes health coverage during a year and has a gap in coverage will the taxpayer be subject to the shared responsibility penalty?

A taxpayer is treated as having minimum essential health coverage for the month if covered for at least one day during that month. Therefore, if the coverage gap is less than one month, the taxpayer will not be treated as having a gap in coverage and will not be subject to the shared responsibility penalty.[4]

Further, an individual will not be subject to the shared responsibility penalty if the gap in coverage lasts for less than three months (see Q 8765). However, this exemption applies only to the first three-month gap in the tax year. If the taxpayer has more than one three-month coverage gap in the same tax year, he or she will be subject to the shared responsibility penalty with respect to the second coverage gap.[5]

8774. Are U.S. citizens who are not U.S. residents subject to the shared responsibility penalty?

In general, yes. However, if a taxpayer may be exempt if qualifying for the foreign earned income exclusion under IRC Section 911. Therefore, if a U.S. citizen who is living abroad has not been physically present in the U.S. for at least 330 full days within a 12 month period, the individual will be treated as having obtained minimum essential coverage for that 12 month period. Further, U.S. citizens who are bona fide residents of foreign countries for an entire tax year will be treated as having obtained minimum essential coverage for the year.[6]

1. See IRS Questions and Answers on the Premium Tax Credit, available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit (last accessed May 28, 2014).
2. IRS Pub. 5120 (2013).
3. See IRS Questions and Answers on the Premium Tax Credit, available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit (last accessed May 28, 2014).
4. See IRS Questions and Answers on the Individual Shared Responsibility Provision, available at: http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision (last accessed June 10, 2014).
5. IRC Sec. 5000A(e)(4).
6. IRC Sec. 911(d), TD 9632.

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U.S. citizens who do not meet the tests outlined above are required to maintain minimum essential health coverage (which can include group health coverage provided by a foreign employer), qualify for an otherwise applicable exemption (see Q 8765) or make the shared responsibility payment.

8775. What determines whether health coverage offered by an employer is "affordable" under the Affordable Care Act?

For purposes of the premium assistance tax credit (see Q 8767), employer-provided health coverage is deemed to be "affordable" if the taxpayer's required contribution toward the annual premium cost of self-only coverage does not exceed 9.5 percent of the taxpayer's household income (see Q 8768).[1] Any additional premium contributions that the taxpayer is required to make for family coverage are not included in determining whether the health coverage is affordable.

If an employer offers multiple health plan options, the affordability test applies to the lowest cost plan in which the taxpayer is eligible to participate.[2]

8776. When does employer-sponsored health coverage provide "minimum value" for purposes of the Patient Protection and Affordable Care Act?

Employer-sponsors health coverage provides "minimum value," so that it also provides minimum essential coverage, if the plan covers at least 60 percent of the total allowed costs of benefits provided under the plan.[3] Beginning in 2014, an employer that offers health coverage to its employees is required to provide each employee with a Summary of Benefits and Coverage, which is a document that explains the benefits provided under the plan and must also include a statement as to whether the plan provides minimum value.

If an employee enrolls in a plan that does not provide minimum value, that employee is ineligible to claim the premium assistance tax credit even though the plan fails to provide the required coverage.

8777. Is there any transition relief for individuals with respect to the shared responsibility penalty provisions effective in 2014?

Yes. If an individual is eligible to enroll in an employer-sponsored health plan that has adopted a plan year that is not a calendar year, the individual is eligible for transition relief from the shared responsibility penalty if the plan year begins in 2013 and ends in 2014. The transition relief begins in January 2014 and continues through the month in which the plan year ends.[4] This rule is particularly important because many employer-sponsored health plans do not allow an employee to enroll in a plan after the beginning of the plan year. In the case of a 2013-2014 non-calendar year health plan, eligible employees would not be permitted to obtain the employer-sponsored coverage until after the start of 2014, when the shared responsibility penalty provision

1. IRC Sec. 38B(c)(2)(C)(i).
2. IRS Questions and Answers on the Premium Tax Credit, available at: http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit (last accessed May 28, 2014).
3. IRC Sec. 38B(c)(2)(C)(ii).
4. Notice 2013-42, 2013-29 IRB 61.

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has already become effective. The transition relief prevents these taxpayers from becoming liable for the shared responsibility provision until the next plan year begins in 2014.

The IRS has also provided relief for taxpayers who are covered under certain limited-benefit government-sponsored health plans which may not provide minimum essential coverage (examples of this type of coverage include optional family planning coverage and pregnancy-related services that are offered through Medicaid). This transition relief applies to months in 2014 in which an individual is covered by one of the specifically enumerated plans that does not provide minimum essential coverage.[1]

1. Notice 2014-10, 2014-9 IRB 605.

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