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CHECKPOINT®

TIMELINE OF 2013–2018 TAX CHANGES IN HEALTH CARE REFORM LEGISLATION

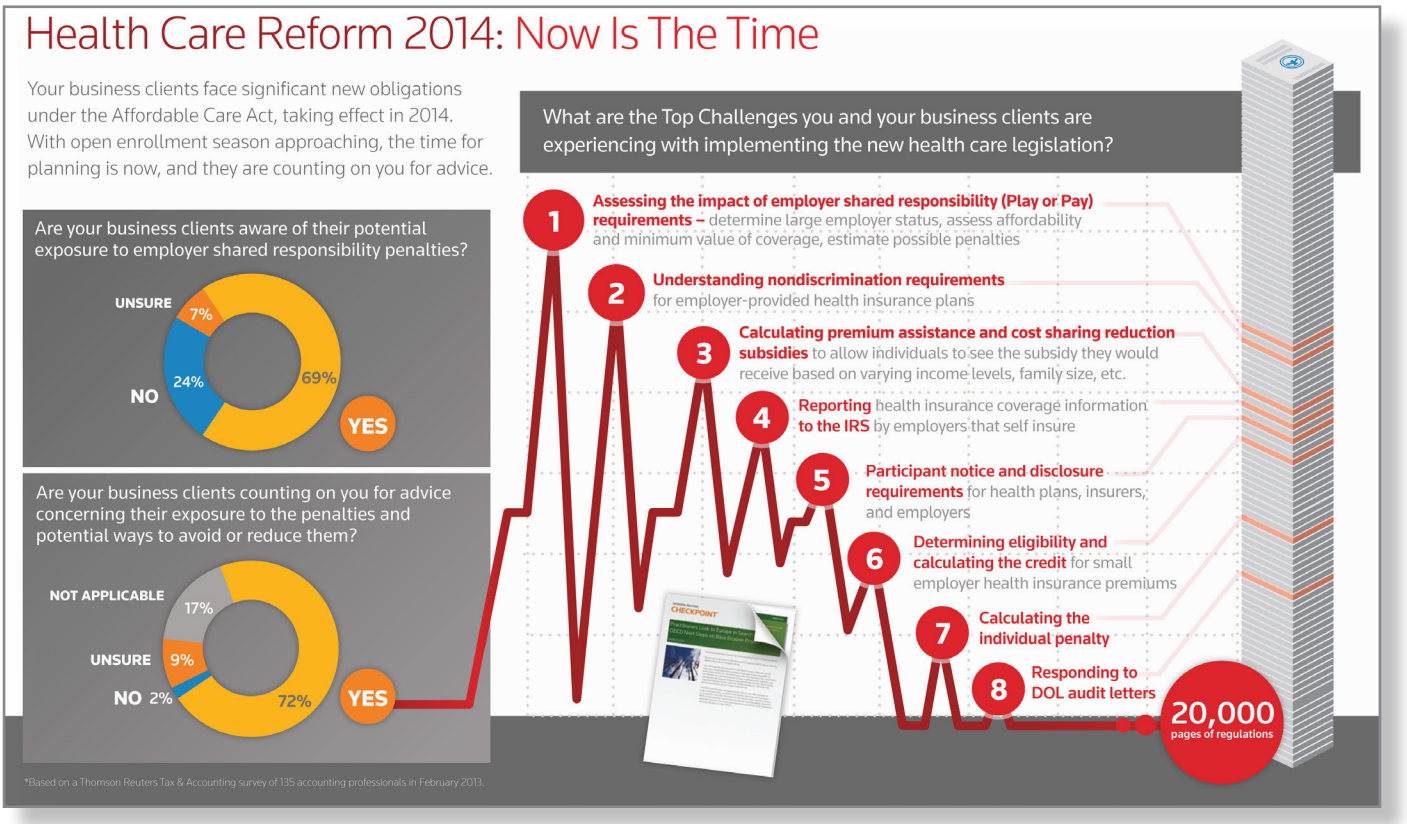
MAY 2013

President Obama's signature on the Health Care and Education Reconciliation Act of 2010 completed a massive overhaul of the U.S. health care system that was started with the enactment of the Patient Protection and Affordable Care Act, which contained the bulk of the health reform law. The sweeping changes in these two new laws affect nearly all taxpayers, many employers, and many elements of the health care industry.

The centerpiece of the health care reform legislation is the mandate for most residents of the U.S. to obtain health insurance. This mandate carries with it a host of new tax rules, such as new penalties for individuals who choose to remain uninsured, tax credits, and other sweeteners for participating in new insurance coverage, and new penalties for larger employers that don't provide insurance (or provide coverage deemed inadequate or unaffordable).

The health care legislation pays for its cost in a number of ways, including taxes, penalties and tougher rules for health care related exclusions and deductions. There are health care related revenue raisers such as tougher limits on medical expense deductions, a new limit on health FSA contributions under cafeteria plans, and a surtax on "Cadillac" employer health plans. There are also a number of industry specific revenue raisers and toughened rules including a new executive compensation deduction limit for insurance providers, and annual fees for pharmaceutical companies, manufacturers and importers of medical devices, and health insurance providers.

There are also non-health care related revenue raisers, such as higher HI taxes on wages, and an "unearned income Medicare contribution" surtax. As can be seen, the health care reform legislation not only revolutionizes the approach to employers' providing health care, it also includes significant provisions with an impact far beyond health care.



Timeline of 2013–2018 tax changes in health care reform legislation

Just over three years ago, Congress enacted legislation that overhauls the U.S. health care system and affects nearly all tax payers, many employers, and many elements of the health care industry (the Patient Protection and Affordable Care Act (PPACA, PL 111-148, 03/23/2010 and the Health Care and Education Reconciliation Act of 2010 (HCERA, PL 111-152, 03/30/2010). The legislation contains a host of tax changes, many of which are both complex and novel. Some already have gone into effect, some go into effect this year, and still others will be in place in 2014 and 2018.

This article helps practitioners get a fix on the rules newly effective this year, as well as those looming on the horizon, by presenting a timeline of 2013–2018 tax changes in the health care legislation, and a concise summary of each new tax provision.

Caution: These new requirements are a work in progress, particularly in light of the lengthy time span for their implementation. Some of the rules originally in PPACA and HCERA have been repealed, while the effective date of other rules has been modified (i.e., deferred, by IRS).

Tax Changes Taking Effect in 2013

Increased HI tax for high-earning workers and self-employed taxpayers. For tax years beginning after December 31, 2012, an additional 0.9% hospital insurance (HI) tax (i.e., a component of the Federal Insurance Contributions Act (FICA) payroll tax imposed on wages) applies under Code Sec. 3101(b)(2) to wages received with respect to employment in excess of: $250,000 for joint returns; $125,000 for married taxpayers filing a separate return; and $200,000 in all other cases. Under Code Sec. 1401(b)(2), the additional 0.9% HI tax also applies to self-employment income for the tax year in excess of the above figures.

Observation: Beginning in 2013, the employer portion of FICA consists of two parts, and the employee portion consists of three parts.

For 2013, an employer pays a 7.65% FICA tax, consisting of:

(a) 6.20% Social Security tax on the first $113,700 of an employee's wages (maximum tax is $7,049.40 [6.20% of $113,700]), plus

(b) 1.45% Medicare tax on the employee's total wages (no ceiling).

For 2013, an employee pays:

(a) 6.20% Social Security tax on the first $113,700 of wages (maximum tax is $7,049.40 [6.20% of $113,700]), plus

(b) 1.45% Medicare tax on the first $200,000 of wages ($250,000 for joint returns; $125,000 for married taxpayers filing a separate return), plus

(c) 2.35% Medicare tax (regular 1.45% Medicare tax + 0.9% additional Medicare tax) on all wages in excess of $200,000 ($250,000 for joint returns; $125,000 for married taxpayers filing a separate return). (Code Sec. 3101(b)(2))

Employers must begin withholding the additional 0.9% Medicare tax in the pay period in which wages are in excess of $200,000, and continue to withhold it until the end of the calendar year. The tax is only imposed on employees. All wages that are subject to Medicare tax are also subject to additional Medicare tax withholding if paid in excess of the $200,000 withholding threshold. (Form 941 (2013))

Observation: Under IRS guidance, an employer must begin withholding at the $200,000 threshold, even if the employee might not ultimately be liable for the tax— e.g., if a married employee who files jointly makes over $200,000, but the couple's combined income falls below the $250,000 threshold. In this case, any excess Medicare tax withheld will be credited against the total tax liability shown on the employee's return.

Caution: An individual must take the 0.9% additional tax on wages into account in figuring 2013 estimated taxes.

Surtax on unearned income of higher-income individuals. For tax years beginning after December 31, 2012, an unearned income Medicare contribution tax is imposed on individuals, estates, and trusts. (Code Sec. 1411) For an individual, the "net investment income tax" (NII tax, or surtax) is 3.8% of the lesser of either (1) net investment income or (2) the excess of modified adjusted gross income over the threshold amount ($250,000 for a joint return or surviving spouse, $125,000 for a married individual filing a separate return, and $200,000 for all others). The surtax doesn't apply to distributions from tax-favored retirement plans (e.g., qualified employer plans and IRAs) and excluded items, such as interest on tax-exempt bonds, veterans' benefits, and excluded gain from the sale of a principal residence.

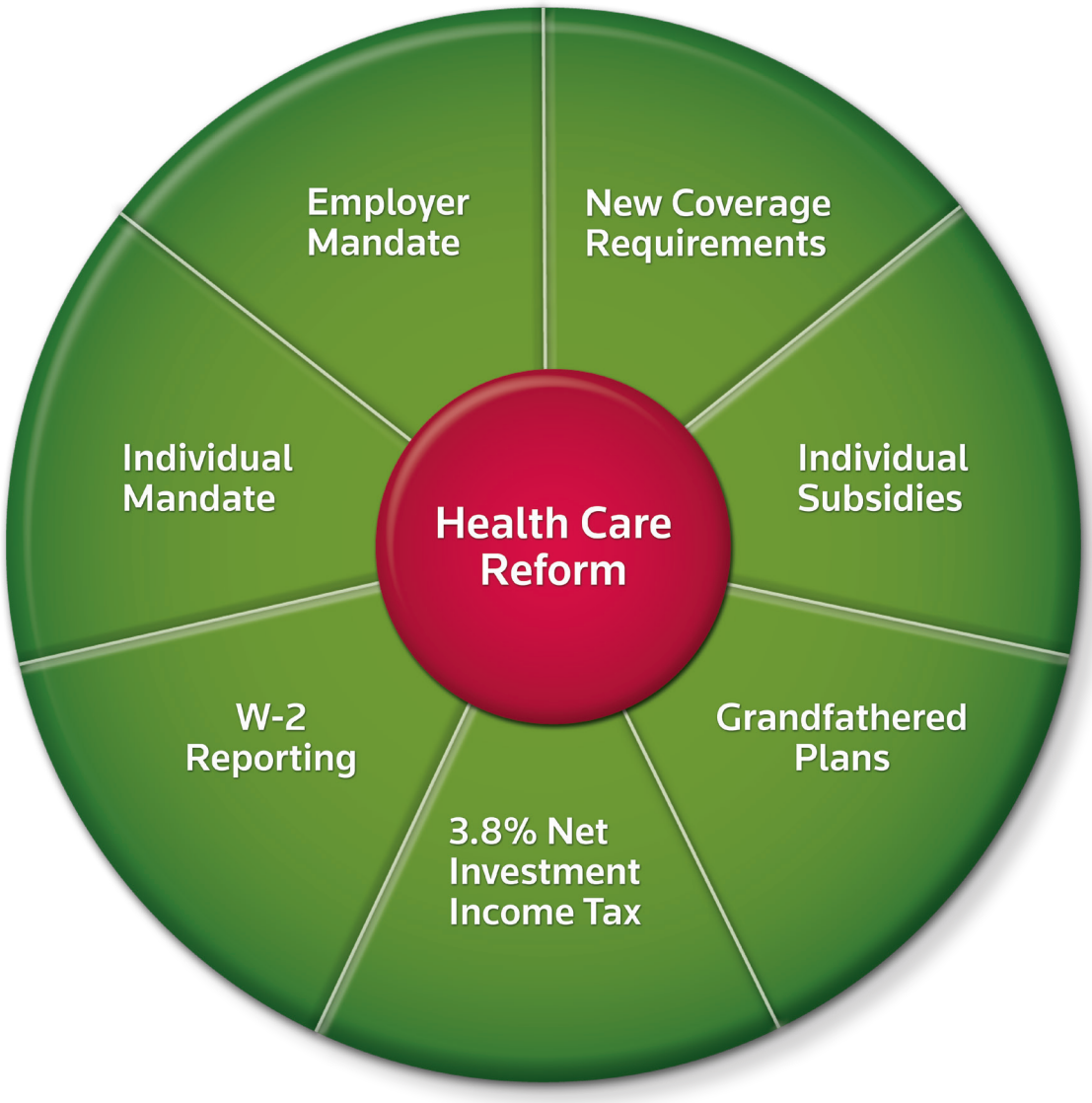
ILLUSTRATION: For 2013, a single taxpayer has net investment income of $100,000 and modified adjusted gross income of $220,000. He pays the surtax only on the $20,000 amount by which his modified adjusted gross income exceeds his threshold amount of $200,000, because that is less than his net investment income of $100,000. Thus, the surtax is $760 ($20,000 × 3.8%).

Observation: Gain on a sale of a home that isn't covered by the Code Sec. 121 homesale exclusion ($500,000 for joint filers)—such as the gain on the sale of a second home—is subject to the NII tax.

Caution: An individual must take the 3.8% NII tax into account in figuring 2013 estimated taxes.

Higher threshold for deducting medical expenses. For tax years beginning after December 31, 2012, unreimbursed medical expenses are deductible by taxpayers under age 65 only to the extent they exceed 10% (rather than 7.5%) of adjusted gross income (AGI) for the tax year. (Code Sec. 213(a)) If the taxpayer or his or her spouse has reached age 65 before the close of the tax year, a 7.5% floor applies through 2016 and a 10% floor applies for tax years ending after December 31, 2016. (Code Sec. 213(f))

Observation: The 7.5% floor will apply to a married taxpayer for 2013 through 2016 if either the taxpayer or the taxpayer's spouse is 65, whether they file a joint return or separate returns. This is significant, because spouses can sometimes benefit by filing separate returns in order to deduct a larger portion of medical expenses. Even if a spouse who files a separate return is under age 65, the 7.5% floor will apply to that spouse for 2013 through 2016 if the other spouse is age 65 or over.



Dollar cap on contributions to health FSAs. For tax years beginning after December 31, 2012, for a health FSA (flexible spending account) to be a qualified benefit under a cafeteria plan, the maximum amount available for reimbursement of incurred medical expenses of an employee (and dependents and other eligible beneficiaries) under the health FSA for a plan year (or other 12-month coverage period) can't exceed $2,500. (Code Sec. 125(i)) This is a maximum limit only, as in the past, an employer may establish its own plan limitation, as long as the plan limit doesn't exceed this statutory limit.

Observation: The $2,500 limit only applies to health FSAs.

It doesn't apply to health savings accounts (HSAs), Archer medical savings accounts (Archer MSAs), or any contributions an employee makes toward health insurance premiums.

Observation: The new health FSA limit applies on an employee-by-employee basis. If two people are married, and each has the opportunity to participate in a health FSA, whether through the same employer or through different employers, each may contribute up to $2,500.

Observation: If a plan provides a grace period (a period of up to two months and 15 days after the end of the plan year during which employees can use up their FSA balance), unused salary reduction contributions to the health FSA that are carried over into the grace period will not count against the $2,500 limit for the subsequent plan year.

Deduction eliminated for retiree drug coverage. Sponsors of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of Health and Human Services (HHS) for a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy"). These qualified retiree prescription drug plan subsidies are excludable from the taxpayer's (plan sponsor's) gross income for regular income tax and alternative minimum tax (AMT) purposes. For tax years beginning before 2013, a taxpayer may claim a business deduction for covered retiree prescription drug expenses, even though it excludes qualified retiree prescription drug plan subsidies allocable to those expenses. But for tax years beginning after December 31, 2012, under Code Sec. 139A, the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of the excludable subsidy payments received.

Observation: The elimination of the exclusion results in treating the subsidy the same as most items that may be excluded from income. Thus, for example, while medical insurance reimbursements aren't included in a taxpayer's income, they also aren't deductible as medical expenses under Code Sec. 213.

Fee on health plans. The Patient-Centered Outcomes Research Institute was established under PPACA to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing comparative clinical effectiveness research. It's funded in part by fees paid by issuers of health insurance policies and sponsors of self-insured health plans. For each policy year ending after September 30, 2012, each specified health insurance policy and each applicable self-insured health plan will have to pay a fee equal to the product of $2 ($1 for policy years ending during 2013) multiplied by the average number of lives covered under the policy. The issuer of the health insurance policy or the self-insured health plan sponsor is liable for and must pay the fee. (Code Sec. 4375, Code Sec. 4376, and Code Sec. 4377)

$500,000 compensation deduction limit for health insurance issuers. For tax years beginning after December 31, 2012, for services performed during that year, a covered health insurance provider isn't allowed a compensation deduction for an "applicable individual" (officers, employees, directors, and other workers or service providers such as consultants) in excess of $500,000. A health insurance provider is covered if at least 25% of its gross premium income from health business derives from health insurance plans that meet certain minimum requirements. (Code Sec. 162(m)(6)(A))

The are no exceptions for performance-based compensation, commissions, or remuneration under existing binding contracts. Also, in the case of remuneration that relates to services that an applicable individual performs during a tax year but that is not deductible until a later year, such as nonqualified deferred compensation, the unused portion (if any) of the $500,000 limit for the year is carried forward until the year in which the compensation is otherwise deductible, and the remaining unused limit is then applied to the compensation.

Proposed reliance regs provide, among other things, that an employer isn't a covered health insurance provider solely because it maintains a "self-insured medical reimbursement plan." IRS has also provided a de minimis rule, under which an employer isn't treated as a covered health insurance provider if the premiums received for providing health insurance coverage that are from providing minimum essential coverage for the tax year are less than 2% of the employer's gross revenues for that tax year.

Information reporting of health insurance coverage. Employers filing 250 or more Forms W-2 for 2011, were required to report the aggregate cost of the applicable employer-sponsored health insurance coverage (as defined in Code Sec. 4980I(d)(1)) provided to employees during 2012 on the Form W-2, Wage and Tax Statement, filed before the end of January, 2013, and then filed with the Social Security Administration (SSA). The reporting to employees is for their information only. It is intended to inform them of the cost of their health care coverage, and doesn't cause excludable employer-provided health care coverage to become taxable. (Code Sec. 6051(a)(14), Notice 2012-9, 2012-4 IRB 315.

Observation: For small employers (i.e., those required to file fewer than 250 Forms W-2 for the preceding calendar year), Code Sec. 6051(a)(14) reporting is optional for health coverage provided through 2012, or until further guidance is issued by IRS. Thus, these employers won't have to report the cost of health care coverage on any forms required to be furnished to employees before January, 2014, at the earliest.

Observation: For tax years beginning after December 31, 2017, Form W-2 reporting of health insurance coverage will take on practical importance. Under Code Sec. 4980I, a 40% nondeductible excise tax will be levied on insurance companies and plan administrators for employer-sponsored health coverage to the extent that annual premiums exceed certain thresholds.

Excise tax on medical device manufacturers. For sales after December 31, 2012, a 2.3% excise tax applies under Code Sec. 4191 to sales of taxable medical devices intended for humans. The excise tax, paid by the manufacturer, producer, or importer of the device, doesn't apply to eyeglasses, contact lenses, hearing aids, and any other medical device determined by IRS to be of a type that is generally purchased by the general public at retail for individual use.

Observation: There have been recent proposals in both the House and Senate to repeal this tax, but as of press time, it currently remains in effect.

Tax Changes Taking Effect in 2014

Larger employers not offering affordable health insurance coverage must pay penalty. For months beginning after December 31, 2013, an applicable large employer is liable for an annual assessable payment if any full-time employee is certified to the employer as having bought health insurance through an Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee, and either the employer:

(1) fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage (MEC) under an eligible employer-sponsored plan (Code Sec. 4980H(a) liability); or

(2) offers its full-time employees (and their dependents) the opportunity to enroll in MEC under an eligible employer-sponsored plan that, for a full-time employee who has been certified to the employer as having enrolled in a qualified health plan for which an applicable premium tax credit or cost-sharing reduction is allowed or paid, either is unaffordable or does not provide minimum value as these terms are defined in Code Sec. 36B(c)(2)(C) (Code Sec. 4980H(b) liability).

Observation: If none of the employees of an employer are eligible for health coverage assistance (i.e., because the minimum essential coverage offered by the employer is affordable), then the employer isn't subject to an excise tax.

Proposed regs provide that an employee is an individual who is an employee under the common law standard, and an employer is the person that is the employer of an employee under that standard (which essentially looks to whether the person for whom the services are performed has the right to control and direct the person performing the services, both in respect to what is done and how it is done). Leased employees aren't considered employees for Code Sec. 4980H purposes. In addition, a sole proprietor, partner in a partnership, or 2% S corporation shareholder isn't considered an employee for this purpose.

The payment under Code Sec. 4980H(a) is based on all (excluding the first 30) full-time employees, while the payment under Code Sec. 4980H(b) is based on the number of full-time employees who receive a premium tax credit or cost-sharing reduction. A full-time employee for any month is an employee who is employed on average at least 30 hours of service per week.

An applicable large employer for a calendar year is an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year. For determining whether an employer is an applicable large employer, full-time equivalent employees (FTEs), which are determined based on the hours of service of employees who are not full-time, are taken into account. (Code Sec. 4980H(c)(2))

Observation: Thus, to be a large employer subject to the employer mandate, an employer must employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50.

ILLUSTRATION: In 2014, Employer A fails to offer minimum essential coverage and has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in a state Exchange-offered plan. For each employee over the 30-employee threshold, the employer owes $2,000, for a total penalty of $140,000 ($2,000 × 70 (100 - 30)). This penalty is assessed on a monthly basis. (JCX-18-10)

Observation: While part-time employees are included in the FTE calculation to determine if an employer is considered "large," they aren't included in the penalty calculations. An employer won't pay a penalty for any part-time worker, even if that part-time employee receives a premium credit.

Code Sec. 4980H ties into Code Sec. 36B, which is designed to use a subsidy/tax credit mechanism to make health insurance affordable for individuals with modest incomes. Under Code Sec. 36B(c)(2)(B), a coverage month for an individual (i.e., a month for which the health care subsidy is available) doesn't include a month in which he is eligible for MEC, as defined in Code Sec. 5000A(f), other than coverage offered in the individual market. MEC may be government-sponsored coverage, such as Medicare or Medicaid, or certain employer-sponsored plans.

An individual is eligible for employer-sponsored MEC only if the employee's share of the premiums is "affordable" and the coverage provides "minimum value" (i.e., at least 60% of the plan's total allowed cost of benefits provided). In general, under Code Sec. 36B(c)(2)(C)(i), an employer-sponsored plan is not affordable if the employee's required contribution with respect to the plan exceeds 9.5% of his household income for the tax year. This percentage may be adjusted after 2014. Under a safe harbor, employers can use the employee's W-2 income for the 9.5% calculation (since information on an employee's household income typically isn't readily available to an employer). (Notice 2011-73, 2011-40 IRB 474)

Individuals not carrying health insurance face a penalty. For tax years beginning after December 31, 2013, nonexempt U.S. citizens and legal residents must pay a penalty if they do not maintain minimum essential coverage, which includes government sponsored programs (e.g., Medicare, Medicaid, Children's Health Insurance Program), eligible employer-sponsored plans, plans in the individual market, certain grandfathered group health plans and other coverage as recognized by HHS in coordination with IRS. (Code Sec. 5000A) This requirement is sometimes referred to as the "individual mandate." There are a number of exceptions, such as one for certain lower-income individuals.

Refundable tax credit for low- or moderate-income families buying certain health insurance. For tax years ending after December 31, 2013, a new refundable tax credit (the "premium assistance credit") under Code Sec. 36B applies to qualifying taxpayers who get health insurance coverage by enrolling in a qualified health plan through a State Exchange.

Observation: This credit is also sometimes referred to as the "premium tax credit" or the "health care affordability tax credit."

Caution: Controversy has surrounded the regs on this credit because while the Code language refers to "an Exchange established by the State," the regs issued under Code Sec. 36B provide that the premium tax credit also includes federally-facilitated Exchanges. (Reg § 1.36B-1(k)) Whether a successful challenge to these regs materializes remains to be seen.

"Qualified health plans" may be offered through cafeteria plans by "qualified employers." For tax years beginning after December 31, 2013, a reimbursement (or direct payment) for the premiums for coverage under any "qualified health plan" through a health insurance Exchange is a qualified benefit under a cafeteria plan if the employer is a qualified employer (generally, smaller businesses). (Code Sec. 125(f)(3)(B)) In very broad terms, a qualified health plan is one that meets certain certification requirements, provides "an essential health benefits package," and is offered by an insurer meeting detailed requirements. And a health insurance "Exchange" is a federally supervised marketplace for health insurance policies meeting specific eligibility and benefit criteria, to be made available not later than January 1, 2014, to qualifying individuals and employer groups of graduated sizes.

New information reporting of employer-provided health coverage. For periods beginning after December 31, 2013, new information reporting and related statement obligations apply under Code Sec. 6056 for (1) certain applicable large employers required to offer their full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and (2) offering employers (those offering minimum essential coverage to employees and paying any portion of the such coverage, but only if the required employer contribution of any employee exceeds 8% of the employee's wages). Further, under Code Sec. 6055, insurers (including employers who self-insure) that provide minimal essential coverage to any individual during a calendar year must report certain health insurance coverage information to both IRS and the covered individual for coverage provided on or after January 1, 2014 (the first information returns will be filed in 2015).

Excise tax on health insurance providers. For calendar years beginning after December 31, 2013, an annual fee applies to health insurance providers. The aggregate annual flat fee for the industry (e.g., $8 billion for 2014) will be allocated based on a health provider's market share of net premiums written for a U.S. health risk for calendar years beginning after December 31, 2012. The fee will not apply to companies whose net premiums written are $25 million or less. For purposes of the fee, health insurance does not include: coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; insurance for long-term care; or any Medicare supplemental health insurance. (PPACA Sec. 9010, as amended by HCERA Sec. 10905, as further amended by HCERA Sec. 1406)

Tax Change Taking Effect in 2018

Excise tax applies to high-cost employer provided health insurance coverage. For tax years beginning after December 31, 2017, a 40% nondeductible excise tax will be levied on insurance companies and plan administrators for employer-sponsored health coverage to the extent that annual premiums exceed $10,200 for single coverage and $27,500 for family coverage. (Code Sec. 4980I) An additional threshold amount of $1,650 for single coverage and $3,450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

Observation: The stated purpose of this excise tax, which was widely labeled as a tax on "Cadillac plans" by the press, is to get health insurers to offer, and employers to purchase, policies that cost less than the threshold amounts that would trigger the tax.

Observation: The effective date for this provision is quite far off, and there are many open issues. It will be a "wait and see approach" to see how exactly it is applied.

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