SELECT TAX PROVISIONS OF THE AFFORDABLE CARE ACT

Allegheny Tax Society

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In 2010 new health care reform laws were passed, H.R. 3590, the Patient Protection and Affordable Care Act (Health Care Act, PL 111-148, 03/23/2010), and H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act, P.L. 111-152, 03/30/2010), jointly referred to as the Affordable Care Act or ACA. The Affordable Care Act has significant federal tax implications including, a universal health care coverage mandate, health related revenue raisers, industry related revenue raisers and non-health related revenue raisers.

The following is a summary of select provisions of the ACA found under the Internal Revenue Code of 1986, as amended ("Code") and which generally impacts individuals, employers and certain industry groups.

I. Individual Mandate: Code Section 5000A.

A. **Requirements:** Beginning in 2014, the Individual mandate provisions of the ACA, sometimes referred to "Shared Responsibility" requires each individual to:

1. Have minimum essential coverage for each month,
2. Qualify for a mandate exemption, or
3. Pay the shared responsibility payment.

Individuals must have signed up for coverage by March 31, 2014 to avoid 2014 penalties. In subsequent years, individuals must sign up for coverage before the end of the applicable open enrollment period (February 15, 2015).

B. **Minimum Essential Coverage or MEC:** Includes coverage under:

1. Medicare, Medicaid, CHIP, Tricare, veteran's plan, or Peace Corps volunteer plan;
2. An employer sponsored plan (whether fully insured or self-insured);
3. A health plan offered in the individual market within a State (including fully-insured student health insurance);
4. A grandfathered health plan;
5. State health benefits risk pool, or other health benefits coverage recognized by the Secretary of HHS for purposes of this requirement (for 2014 and after 2014 only if recognized as MEC by HHS); and
6. Self-insured student health insurance (for 2014 and after 2014 only if recognized as MEC by HHS).

MEC does not include the following HIPAA excepted benefits:

1. Limited scope dental and vision provided in a standalone plan;
2. Most flexible spending account plans;
3. Long-term, nursing home, home health, or community based care in a standalone plan;
4. Accident only, disability, liability, workers compensation, automobile medical payment, credit-only insurance, on-site medical clinics;
5. Coverage for a specified disease or illness, hospital indemnity or other fixed indemnity if under separate policy and no coordination with group health plan;
6. Medicare supplemental health if separate policy; and
7. Employee assistance plans (EAPs) (and probably most wellness programs).

C. **Coverage Exceptions:** Exemptions from individual penalties include:

1. Financial Hardship (determined by Secretary of HHS);
2. Religious objections;
3. American Indians;
4. An individual who is not lawfully present in the U.S.;
5. Individuals eligible for foreign-earned income exclusions or residents of Territories;
6. Incarcerated individuals;
7. Those for whom the lowest cost plan option on the Health Insurance Exchange ("Exchange") exceeds 8% of an individual's household income;
8. Those with incomes below the tax filing threshold (in 2014 the threshold for single filler taxpayers under age 65 was $10,150 and $20,300 for married filing jointly); and
9. Individuals who would have been eligible for Medicaid had their State expanded Medicaid.

Note that there is no exemption for aliens who are lawfully present in the U.S.

D. **Penalty:** The annual penalty is the greater of a flat dollar amount per individual or a percentage of the individual's taxable income:

1. Flat dollar amount per individual is $95 in 2014; $325 in 2015; and $695 in 2016. After 2016, it is indexed to inflation. The flat dollar penalty is capped at 300% of the flat dollar amount.
2. Percentage penalty is 1% in 2104; 2% in 2015; and 2.5% in 2015. The percentage penalty is a percentage of household income minus the tax filing threshold.

The penalty is half for dependents under the age 18.

Examples for 2014:

Single: Those with income above the filing threshold of $10,150 but at or below $19,500 will pay the $95 flat amount, those with income above $19,500 and below the cap at the national average premium for bronze-level coverage will pay 1% of applicable income.

Family: Assume family of 4 with 2 children under age 18: those with income above the filing threshold (filing jointly threshold of $20,300) but at or below $48,500 will pay the $285 flat dollar amount, those with income above $48,500 and below the cap at the national average premium for bronze-level family coverage will pay 1% of applicable income.

In calculating the penalty for a family, each of the components of the formula increases including the filing threshold, flat dollar amount, and the cost of a bronze-level plan. However, the flat dollar amount for a family cannot be greater than three times the amount for an individual. For example the flat dollar amount is limited to three times $95, or $285. The flat dollar amount is one-half for children under 18, so that a married couple with two children under 18, a single parent with four children under 18, as well as larger families are all subject to the same flat dollar maximum amount. However, these families may still pay larger penalties, if they have higher incomes.

E. **Individual Health Insurance Subsidies- Premium Assistance Tax Credit and Cost Sharing: - Code Section 36B.** Starting in 2014, individuals and families can take a new premium tax credit and Exchange subsidies to help them afford health insurance coverage purchased through an Exchange. Recent court cases call into question the availability of subsidies. The Supreme Court has agreed to hear King v. Burwell, a challenge to the provision of subsidies for individuals who purchase health insurance through the Federal Exchange rather than in an exchange established by a state, .King v. Burwell, (4th Cir. 07/22/2014), 114 AFTR 2d 2014-5259; cert. granted 11/07/2014).

1. Premium assistance tax credit - Individuals and families earning between 100% and 400% federal poverty level (FPL) are eligible for subsidies to reduce the cost of coverage purchased on an Exchange. Refundable (available even if an individual has no tax liability) can be used at the time insurance is purchased to reduce premiums or taken as a tax credit.

2. Cost sharing assistance - Individuals and families earning between 100% and 250% FPL are eligible for additional subsidies to reduce their out-of-pocket expenses (co-pays, deductibles, and co-insurance). This amount is automatically applied to Exchange rates. Directly impacts the actuarial value of the Exchange coverage.

3. Exchange subsidies in the form of premium assistance tax credits and cost sharing are available for individuals who meet three criteria:

   a) the employee purchases coverage on an Exchange; and

   b) the employee's household income is between 100% - 400% of the federal poverty level; and EITHER:
      i. the employer does not offer minimum essential coverage (coverage under a group health plan offered to an employee by an employer, whether grandfathered or non-grandfathered) OR
      ii. the employer offers coverage that is not affordable for the employee or that does not provide minimum value, and the employee does not enroll in such coverage.

Employees are not eligible for subsidies (regardless of meeting specific income requirements) if:

a) enrolled in employer coverage which is affordable or provides "minimum value";

b) an employer offers "affordable," "minimum value" coverage (regardless if the employee elects coverage);

c) a family member has access to "affordable" "minimum value" self-only coverage, the rest of the family cannot qualify for subsidies if they are also eligible for that coverage; or

d) is eligible for public plans (e.g. Medicaid).

4. The premium assistance tax credit is calculated based on:

- premium cost of the second-lowest-cost "Silver" plan offered through a state health benefit exchange (Silver coverage Plan pays 70% of cost and individual pays 30%) provides for; and

- income level of the applicant.

Income Level (% above federal poverty level)	Maximum Premium as % of income that person has to pay
Up to 133%	2.0%
133-150%	3-4%
150-200%	4-6.3%
200-250%	6.3-8.05%
250-300%	8.05-9.5%
300-400%	9.5%

The 2013 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

Persons in Family	Poverty Guideline	133%	400%
1	$11,490	$15,281,70	$45,960
2	$15, 510	$20,628.30	$62,040
3	$19, 530	$25,974.90	$78,120
4	$23, 550	$31,321.50	$94,200
5	$27,570	$36,668.10	$110,280
6	$31,590	$42,014.70	$126,360
7	$35,610	$47,361.30	$142,440
8	$39,630	$52,707.90	$158,520

5. The ACA sets maximum out-of-pocket (OOP) spending limits. Without the cost-sharing subsidy, the out-of-pocket maximum may be no more than $6,600 for an individual and $13,200 for two or more people in 2015. (This is the highest a plan may set the OOP max, but plans frequently come with a lower OOP max). The table below presents the reduced out-of-pocket maximums and increased actuarial values after cost-sharing subsidies are applied, within each income range.

Income (% Federal Poverty Level)	Actuarial Value of a silver plan	OOP Max for Individual/Family 2014	OOP Max for Individual/Family 2015
Under 100%	70%	$6,350 / $12,700	$6,600 / $13,200
100% –150%	94%	$2,250 / $4,500	$2,250 / $4,500
150% – 200%	87%	$2,250 / $4,500	$2,250 / $4,500
200% – 250%	73%	$5,200 / $10,400	$5,200 / $10,400
Over 250%	70%	$6,350 / $12,700	$6,600 / $13,200

II. Employer Shared Responsibility Provisions: - Code Section 4980H.

A. **Requirements:** An employer is not required to provide health coverage, however, starting in 2015, a large employer will be subject to a penalty if it does not offer full-time employees health coverage that is affordable and provides minimum value or pay a penalty if at least one full-time employee enrolls in Exchange coverage and receives a premium tax credit.

Large employers may be subject to a penalty tax (also called an "assessable payment") for:

1. Failing to offer minimum essential health care coverage to at least 95% of all full-time employees (and their dependents). For 2015 the 95% threshold is

lowered to 70% - **(Subsection (a) penalty)**; or

2. Offering minimum essential coverage to at least 95% of all full-time employees (and their dependents) but such coverage is not "affordable" (exceeds a specified percentage of the employee's household income) or does not offer "minimum value" (the plan's share of the total allowed cost of benefits is not at least 60%) - **(Subsection (b) penalty)**.

Controlled group rules are not applicable for purposes of application of the employer penalties, but are applicable to determine Large Employer status.

B. **Large Employer:** An employer with 50 or more fulltime employees (including full-time equivalents).

1. Large employer status is determined based on average number of employees in previous calendar year.

2. For 2015, look to 2014 to determine status. A month to month determination.

3. Common ownership rules (control group and affiliated company rules) apply.

C. **Penalties:**

1. Subsection (a) Penalty -Employer Does not Offer Coverage
    a. $166.67/month ($2,000/ annual) (indexed) non-deductible penalty for each full-time employee (excluding the first 30 – for 2015 excluding the first 80) for not offering MEC to at least 95% (70% for 2015) of all employees and their dependents and if at least one full time employee receives an Exchange subsidy

MEC has same meaning as individual mandate - includes coverage under an employer-sponsored plan

No minimum employer subsidy level required

Penalty amount increased for inflation for years after 2015

2. Subsection (b) Penalty – Large Employer Provides Coverage

    a. $250/month ($3,000/annual) (indexed) non-deductible penalty for each full-time employee who enrolls in Exchange coverage and receives an Exchange subsidy if:

i. the employee's contribution for single coverage under the plan is not affordable (e.g. exceeds 9.5% of his or her W-2 income); or

ii. the plan does not provide minimum value (the plan pays for less than 60% of all plan benefits, without regard to co-pays, deductibles, co-insurance, and employee premium contributions).

Maximum Penalty not to exceed Subsection (a) non-deductible penalty

Affordable coverage – employee-only contribution not greater than 9.5% of employee household income

Coverage provides "minimum value" if its actuarial value is at least 60%, e.g. the plan would pay for at least 60% of medical expenses on average for a standard population and for allowable charges.

b. IRS guidance suggests three potential safe harbor approaches:

i. Actuarial value (AV) calculator (based on standard population for qualified health plans) or minimum value (MV) calculator (based on standard population for self-insured employer plans).

ii. Design-based safe harbors in the form of checklists.

iii. For plans with nonstandard features (e.g. non-quantitative limits on any of four core categories of benefits), certification by a certified actuary.

Most large employer plans are in 85 – 95% AV range, and typical high deductible health plan (HDHP) is not below 75% AV.

D. Reporting – Code Sections 6056 and 6055:

Code section 6056 requires employers to report to the IRS information about their compliance with the employer shared responsibility provisions, including the type of health care coverage they offer to their employees. In addition, employers are required to furnish related benefit statements to employees to assist them in determining whether they can claim a premium tax credit on their tax return. This reporting is effective for 2015.

The IRS will not impose penalties under sections 6721 and 6722 for 2015 returns and statements filed and furnished in 2016 on reporting entities that can show

that they have made good faith efforts to comply with the information reporting requirements.

The IRS Form 1095-C (employee statement) and a Form 1094-C (transmittal) are the designated forms to be used for Section 6056 reporting. The report is filed on a calendar year basis and not plan year. The following information is included:

1. Name, address and employer ID of the employer;
2. Name and telephone number of a contact for employer:
3. The calendar year for which the report is filed;
4. Reporting on a calendar month basis of the following:
   - Certification as to whether the employee's full-time employees and their dependents, including spouses, are given an opportunity to enroll in MEC,
   - The number of FTEs employed by employer,
   - The months for which MEC was offered, and
   - The employee's share of the monthly premium for single health coverage that meets minimum value;
5. The name, address and taxpayer ID number for each full-time employee offered coverage.

Insurers, self-funded plans and other providers of MEC are required to report certain information to the IRS, known as IRC Section 6055 Reporting. The type of information required to be reported to the IRS on the Form 1095-B includes the following information for each calendar year:

1. Name, address, and EIN for the person required to file the return;
2. Name, address, and TIN, or date of birth of each individual covered under the policy or program; and
3. For each covered individual, the months for which the individual was enrolled in coverage and entitled to receive benefits.

In addition, information returns reporting MEC provided to an individual under an insured group health plan must report:

1. Name, address, and EIN of the employer sponsoring the plan; and
2. Whether the coverage is a qualified health plan enrolled in through the Small Business Health Options Program (SHOP) and the SHOP's unique identifier

III. Additional Health Related Revenue Raisers

A. **Increase in Medical Expense Deduction – Code Section 213(a):** For taxable years beginning after December 31, 2012, the threshold for the itemized

deduction for unreimbursed medical expenses under Code Section 213 is increased to 10% of adjusted gross income ("AGI") (up from 7.5% of AGI). The increase is temporarily waived if the taxpayer of taxpayer's spouse has attained age 65 before the end of the tax year.

B. **Additional Hospital Insurance Tax for High Wage Workers – Code Section 3101(b)(2):** For taxable years beginning after December 31, 2012, an additional 0.9% HI tax will be imposed on taxpayers (other than corporations, estates, or trusts) on wages received with respect to employment in excess of:

1. $250,000 for joint returns,

2. $125,000 for married taxpayers filing a separate return, and

3. $200,000 in all other cases.

For FICA withholding, an employer may disregard wages received from other employers or by the employee's spouse. If doing so results in under-withholding, the employee will be required to pay the additional FICA tax with the employee's tax return (Code Section 3102(f)).

C. **Net Investment Income Tax– Code Section 1411:** For taxable years beginning after December 31, 2012, an individual must pay an unearned income Medicare contribution tax equal to the lesser of:

1. 3.8% of net investment income; or

2. any excess of modified adjusted gross income over $250,000 for a joint return, $125,000 for a taxpayer who is married filing separately, or $200,000 for any other filing status (except for qualifying widow(er) with dependent child).

The tax applies to estates and trusts, as well as individuals. Qualified retirement trusts are exempt.

D. **Limitation on Health FSA Salary –Code Section 125(i):** Effective for plan years beginning after December 31, 2012 a $2,500 limit on annual salary reduction contributions to health FSAs offered under cafeteria plans applies.

E. **Excise Tax on High Cost Employer Sponsored Health Coverage – Cadillac Tax – Code Section 4980I:** For tax years beginning after December 31, 2017, insurers will be subject to a nondeductible excise tax of 40% of the "excess benefit" if the aggregate value of employer sponsored health insurance coverage for an employee (or former employee or other primary insured individual) exceeds the threshold amount:

SELECT TAX PROVISIONS OF THE AFFORDABLE CARE ACT

1. **Plans subject to excise tax.** The excise tax on high-cost health coverage only applies to "applicable employer-sponsored coverage" that is made available to an employee by an employer and that either:

   a. is actually excludable from gross income under Code Section106; or
   b. would be excludable if it was employer-provided coverage (within the meaning of Code Section 106).

   Coverage that is not considered coverage under a group health plan for purposes of the excise tax includes:

   a. coverage for long-term care;
   b. coverage only for accident, or disability income insurance, or any combination thereof;
   c. coverage issued as a supplement to liability insurance;
   d. liability insurance, including general liability insurance and automobile liability insurance;
   e. workers' compensation or similar insurance;
   f. automobile medical payment insurance;
   g. credit-only insurance;
   h. other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
   i. stand-alone dental or vision coverage, which provides benefits substantially all of which are for treatment of the mouth (and any organ or structure in it) or the eye; and
   j. Specific disease, illness or hospital indemnity coverage.

2. **Excess Benefit.** An employee's excess benefit is simply the sum of the employee's monthly excess amounts for the taxable period.

3. **Threshold Amount**. The annual limitation applicable to a particular employee's coverage, sometimes referred to as the threshold amount, is based on a statutory dollar amount which is subject to a variety of adjustments. The 2018 threshold amounts are $10,200 for self-only coverage and $27,500 for coverage other than self-only. In the case of retirees over age 55 and individuals employed in high-risk professions, these thresholds are increased to $11,850 and $30,950 for individuals and families, respectively.

The thresholds may increase depending on actual medical inflation between 2010 and 2018 using a measure that is linked to the Federal Employees Health Benefits (FEHB) Program.

ON FRIDAY, JANUARY 16TH, 2015, IRS ISSUED TWO NEW REVENUE PROCEDURES TO CLARIFY THE PROCEDURES FOR CHANGE IN ACCOUNTING METHOD.

Revenue Procedure 2015-13

The IRS has updated and revised the general procedures under Code Section 446(a) and Reg. §1.446-1(e) to obtain the advance and automatic consent to change a method of accounting for federal income tax purposes. Generally, this procedure is effective for Forms 3115 filed on or after January 16, 2015, for a year of change ending on or after May 31, 2014.

This revenue procedure in conjunction with Rev. Proc. 2015-14, I.R.B. 2015-5, amplifies, clarifies, and modifies Rev. Proc. 2011-14, I.R.B. 2011-4, 220. Rev. Proc.2011-14 as amplified, clarified, and modified is superseded in part. The second sentences of sections 14.01 and 14.02, and sections 14.04, 14.05, 14.06, and 14.07 remain in effect. All other sections of Rev. Proc. 2011-14 are superseded.

Rev. Proc. 97-27 is clarified and modified and, as clarified and modified, is superseded.

Revenue Procedure 2015-14

The IRS has provided the list of accounting methods to which the automatic change procedures in Rev. Proc.2015-13, I.R.B.2015-5 apply. This revenue procedure is effective for a Form 3115 filed on or after January 16, 2015, for a year of change ending on or after May 31, 2014, that is filed under the automatic change procedures of Rev. Proc. 2015-13. Transition rules are also provided. This revenue procedure, in conjunction with Rev. Proc. 2015-13 amplifies, clarifies, and modifies Rev. Proc. 2011-14, I.R.B. 2011-4, and as amplified, clarified and modified, is superseded in part.

These Revenue Procedures

1) Update the guidance of Rev. Proc. 2011-14 and Rev. Proc. 97-27, which due to the recently issued tangible property regulations, were outdated.
2) The automatic and advance consent change procedures are combined in one document
3) This listing of automatic method changes are now listed in a separate document, currently Rev. Proc. 2015-14. Future automatic method changes will be added to this listing, and not require the replacement of the entire method change revenue procedure.

It is also expected that IRS will soon issue a new Form 3115.