PUBLICATION

Health Care Reform – Tax Law Changes

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In addition to making fundamental changes in the way health care is delivered, the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) have made far-reaching changes in the Internal Revenue Code (Code). At present, it remains to be seen whether the Internal Revenue Service (IRS) will be able to handle the many responsibilities which will be imposed on it under these Acts. Some initial estimates are that the IRS will add more than 15,000 Agents to administer the legislation, in addition to untold Health and Human Services (HHS) and other agency additions.

This alert addresses only certain of the most prominent tax changes made by the Acts to the Code. Most of the changes will not take effect for several years. Note that many of the dollar amounts indicated in the following material are the initially effective amounts, and are subject to adjustment in later years for a cost of living or other index.

Individual Coverage Mandate. Effective in 2014, non-exempt U.S. citizens and legal residents will be required to have "minimum essential coverage" or pay a penalty. Minimum essential coverage is a very complex and controversial concept, but the coverage must include a variety of listed categories of coverage which are considered essential. The penalty, per adult, for not having such coverage will be phased in as a dollar amount or a percentage of household income, whichever is greater, according to the following schedule:

Year	Dollar Penalty	Percentage of Household Income
2014	$95	1%
2015	$325	2%
2016	$695	2.5%

The penalty will be applied on a month by month basis. Household income will be determined under special rules. The penalty for persons under age 18 is 50% of the adult penalty then in effect. The total household penalty cannot exceed 300% of the adult fee then in effect (e.g., $2,085 in 2016) or the national average cost of basic ("bronze") state exchange insurance, if greater.

Exemptions from the coverage requirement include those whose required contribution to employer-sponsored insurance exceeds 8% of household income, religious reasons, hardship, short coverage gaps, persons with income below the federal tax return filing level, and those residing outside of the country.

The law requires states to establish insurance exchanges. The states will not insure benefits, but will act as coverage coordinators for commercial carriers. States may offer their own exchange or group together and form multistate exchanges.

Beginning in 2014, *refundable* tax credits will be available for purchasing insurance through a state exchange, for individuals and families whose income is up to four times the federal poverty level (currently, up to $43,420 for individuals and $88,200 for families), provided the individuals are not eligible for other adequate coverage such as Medicare or an affordable and adequate employer-sponsored plan. The amount of the credit is determined on a sliding scale. The credit amount is determined and will be paid by the IRS in advance, directly to the insurer to obtain coverage through the state exchange. The individual pays the difference in the cost of coverage, through payroll deduction for employed persons. Beginning immediately, "cost-sharing subsidies" will be available to help low income persons by reducing out of pocket limits on a sliding scale based on income relative to the poverty line. HHS will notify the plan that the person is eligible for a reduction in plan costs. These credits and subsidies will not count as income for purposes of disqualifying or reducing other federal program benefits, nor state or local programs which are financed at all with federal funds. In addition to other penalties, a person who negligently provides incorrect information in order to qualify for a credit or subsidy is subject to a penalty of up to $25,000 per year.

Employer Mandate. Equally controversial is the non-deductible excise tax on "large employers" who either do not maintain affordable and adequate essential insurance or who offer a plan which pays less than 60% of total benefit costs. A "large employer" is one who, on average, had at least 50 employees for at least 120 business days in the preceding calendar year. A full time employee is a person who averages at least 30 hours per week. The monthly hours of part-time employees are totaled and divided by 120 to add additional full-time employee equivalents. In determining size, familiar principles of tax law require employers under common control to be aggregated. The excise tax is triggered if even one employee obtains health insurance through a state exchange with respect to which a tax credit or cost-sharing subsidy is available. The excise tax is $166.67 times the number of full time employees over 30, determined monthly and regardless of how many more employees than one actually qualify for the credit or subsidy.

After 2013, employers who do offer minimum essential coverage must provide certain employees with a "free choice voucher". The voucher will be in the amount of the employer's cost for the coverage which is available to the employee, and the employee can use that voucher to obtain alternative coverage through an exchange. The value of the voucher is not income to the employee, but can be deducted by the employer as a compensation expense. Recipients would include employees whose required contribution is between 8% and 9.5% of household income and whose total household income does not exceed 400% of the applicable poverty level (determined with respect to family size). Employees who use a voucher are not eligible for the premium credit discussed above.

Tax Credits for Small Employers. Effective immediately, a "Qualified Small Employer" may be given a tax credit for employer contributions to purchase health insurance for employees. A Qualified Small Employer is one with no more than 25 full-time equivalent employees. The credit begins phasing out when the number of employees exceeds ten or $25,000 group average income and is eliminated when the number exceeds 25 employees or average income exceeds $50,000.

Through 2013, the credit is 35% of the premiums paid if the employer pays at least 50% of the premiums. Beginning in 2014, the credit increases to 50% and is available only if insurance is purchased through an exchange.

Employers will have to report additional information to the IRS on Form W-2, including the total value of the coverage and the premium cost borne by both the employer and the employee.

The employment limitation is dependent on full-time equivalent employees. Thus many small businesses who employ part time employees may qualify for the credit even though they have more than 25 employees.

The credit is claimed as part of the general business credit.

Children under Age 27. Every group health plan which offers coverage for children must continue to offer that coverage for children to age 26. A failure may result in an excise tax of $100 per day per person.

Effective immediately, the value of coverage of a child under age 27 by year-end is not includable in the child's or parent's income. A self-employed person will be able to deduct premiums for a child who is not 27 by year-end, even if they are no longer a dependent for tax purposes. Similar rules apply to medical accounts in retirement plans and Voluntary Employee Beneficiary Associations (VEBA).

Corporate Estimated Tax Deposits. Under the Reconciliation Act of 2010 (P.L. 111-152), employers with at least $1 billion in assets will be subject to new rules which require accelerated, front-loaded deposits of estimated corporate taxes.

Administration and Enforcement. The IRS is charged with administering both the individual mandate and the employer mandate. The Act generally says nothing about appeal rights and does not limit the remedies of the IRS. Presumably, the IRS will provide for basic due process rights.

Simple Cafeteria Plans. Beginning in 2011, small employers (those employing no more than 100 full time employees on the average in either of the two prior years, including all employers under common control) may offer a simplified cafeteria plan. No discrimination testing is required if the employer makes a nonelective contribution of either 2% of compensation to all eligible employees, or the lesser of 6% of pay or twice the employee deferral amount. Such plans may require one year of service and attainment of age 21 to be eligible. Collectively bargained employees may be excluded. Once a plan is established, it can continue until after the year in which the employer has an average of 200 employees.

New Taxes. Beginning in 2013, the Medicare tax is increased and extended to investment income for high income persons.

Single taxpayers having earned income over $200,000 and married taxpayers with joint earned income over $250,000 will pay an additional 0.9% over and above the present rate. The increase applies to the employee but not the employer. Employers will not be responsible for knowing the status or earned income of an employee's spouse for withholding purposes. Self employed persons will pay an additional 3.8% (1.45%+1.45%+0.90%). These rules may impose additional estimated tax deposit requirements on individuals who are married to a spouse with earned income because while neither alone may exceed the threshold income their combined earned incomes may be subject to the tax.

Single taxpayers with modified adjusted gross income over $200,000 and married taxpayers with modified adjusted gross income over $250,000 will for the first time be subject to a new 3.8% Medicare tax on *unearned* income. Income which is subject to the tax includes interest, rents, income from passive activities, gain on the sale of property (other than property used in a trade or business), in each case net of associated expenses. Income from retirement accounts, including individual retirement accounts, will not be subject to this tax. The tax is 3.8% of the lesser of net investment income or the excess of modified adjusted gross income over the $200,000 or $250,000 threshold amounts.

The $200,000 and $250,000 thresholds are not currently worded to be indexed for inflation, so presumably more and more people will become subject to the additional taxes over time.

Miscellaneous Changes. Beginning in 2013, the 7.5% floor on the deduction for itemized medical expenses under a personal federal income tax return is increased to 10%.

Effective in 2013, contributions to health flexible savings accounts will be capped at $2,500.

Effective in 2011, over the counter drugs not prescribed by a health care provider may not be reimbursed by a health savings account or flexible spending account.

Existing penalties on nonqualified distributions from Health Savings Accounts (HSA) and Archer HSAs will increase to 20%, from 10% and 15% respectively.

Cafeteria plans can cover expenses of a child who is not age 27 by year-end, even if the child is no longer a dependent for tax purposes.

Effective in 2010, the adoption tax credit is increased and made refundable.

Economic Substance Doctrine. The economic substance doctrine allows the Internal Revenue Service to recast a transaction in a manner that reflects its substance or to disregard a transaction that has no economic substance other than a tax result desired by the parties to the transaction. The federal courts have not always agreed on how to apply the doctrine, if at all. The Reconciliation Act of 2010 codifies the doctrine (which has no necessary relation to healthcare) for transactions after March 30, 2010.

The Reconciliation Act provides that a transaction has economic substance only if (1) the transaction changes in a meaningful way the taxpayer's economic position and (2) the taxpayer had a substantial purpose for entering into the transaction. That Act further provides that a profit potential is taken into account only if the present value of the expected pre-tax profit is substantial in relation to the present value of the expected net tax benefits from the transaction. Fees and transaction expenses must be taken into account as expenses.

The Act imposes a penalty of 20% of any underpayment arising from a transaction lacking economic substance. The penalty increases to 40% if the facts surrounding the transaction are not disclosed on a return. Disclosure cannot be made after the taxpayer is notified that the return is to be audited.

New Information Reporting Requirement. Current law requires that every person engaged in a trade or business is required to report payments to any individual in an aggregate amount of $600 or more. Payments to corporations have been exempt from this requirement. After 2011, payments to corporations will be subject to the same requirement.

Excise Tax on Sales of Medical Devices. For sales of medical devices after 2012, a 2.3% excise tax will be imposed on the sale of medical devices as defined in the Food, Drug and Cosmetic Act. Exceptions will exist for common "devices" like eyeglasses and contact lenses, and governmental use, nonprofit educational use, bloodbank use, use on vessels or aircraft, or sales for further manufacture or export.

Provider Issues. Beginning in 2018, a 40% excise tax will be imposed on any provider if the annual premium for individual coverage is more than $10,200 or family coverage is more than $27,500. The dollar limits will be adjusted for sex and age. This excludes the value of stand-alone dental and vision coverage. Somewhat higher amounts are allowed for high risk professions, as will be the case for retirees over age 55. Employers will have to report the value of health coverage for each person each year, so the IRS will have this information. The tax will be payable by the provider – either a commercial carrier or, if the plan is self-insured, the employer.

Top executives of insurance companies will have limits on deductible pay. If at least 25% of all premiums received do not meet minimum essential coverage rules, then no deduction is allowed for individual pay above $500,000.

Tax-Exempt Hospitals. Tax-exempt hospitals will be required to conduct community needs assessments at least every 3 years and adopt written financial aid policies. Persons who qualify for that aid will be billed on the same basis as a person who is insured. The IRS will be responsible for auditing compliance. A failure to satisfy these requirements can result in a penalty of $50,000 per year.

Retiree Drug Programs. An employer can provide prescription drug coverage to retirees over age 55 and receive a subsidy of 80% of the cost of the program between $15,000 and $90,000. The subsidy received is not includable in the employer's income, but must be used to reduce program costs to the retirees.

These Acts are very complex and amendments by Congress are likely. Should you wish to discuss any of these tax provisions, please contact of the following attorneys in the Firm's Tax Department.