

**EXCLUSION FOR EMPLOYER-PROVIDED HEALTH BENEFITS  
AND OTHER HEALTH-RELATED PROVISIONS OF  
THE INTERNAL REVENUE CODE:  
PRESENT LAW AND SELECTED ESTIMATES**

Scheduled for a Public Hearing  
Before the  
HOUSE COMMITTEE ON WAYS AND MEANS  
on April 14, 2016

Prepared by the Staff  
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## INTRODUCTION

The House Committee on Ways and Means has scheduled a public hearing for April 14, 2016, on the tax treatment of health care. The Internal Revenue Code of 1986 (the “Code”)<sup>1</sup> provides a broad exclusion from gross income for employer-provided health benefits. In addition, the Code includes numerous other health-related provisions applicable with respect to employer-provided health benefits, individual taxpayers, and businesses.

Part One of this document,<sup>2</sup> prepared by the staff of the Joint Committee on Taxation, provides a description of present-law health-related provisions throughout the Code. The discussion generally notes when a Code provision was enacted or modified by the Affordable Care Act (the “ACA”).<sup>3</sup> Part Two presents estimates of the value of certain tax subsidies for health and the value of receipts from certain taxes enacted in the ACA. These estimates generally follow Joint Committee staff conventions for estimating tax expenditures with three important deviations: the estimates do not account for “tax form behavior”; they do include payroll tax effects; and they measure expenditures and receipts in a single calendar year, rather than multiple fiscal years.

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<sup>1</sup> All section references are to the Internal Revenue Code of 1986, as amended, unless otherwise identified.

<sup>2</sup> This document may be cited as follows: Joint Committee on Taxation, *Exclusion for Employer-Provided Health Benefits and Other Health-Related Provisions of the Internal Revenue Code: Present Law and Selected Estimates*, (JCX-25-16), April 12, 2016. This document can also be found on the Joint Committee on Taxation website at [www.jct.gov](http://www.jct.gov).

<sup>3</sup> For purposes of this document, the Affordable Care Act, or the ACA, refers to the combination of the Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111-148, and the Healthcare and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111-152.

## **PART ONE: PRESENT LAW**

### **I. EMPLOYER-PROVIDED HEALTH BENEFITS**

#### **A. Exclusion for Employer-Provided Health Benefits**

##### **1. In general**

Present law provides a broad exclusion from gross income for employer-provided health benefits, including insurance premiums and other employer contributions to provide coverage, as well as the payment or reimbursement of medical expenses not covered by insurance and contributions to certain health-related accounts.<sup>4</sup> The exclusion applies with respect to health benefits provided to a current or former employee, including a retiree, and an employee's family members (discussed further below).<sup>5</sup> Health benefits provided by an employer to the surviving family members of a deceased employee are also eligible for the exclusion.

Amounts paid by an employee for health benefits, such as an employee's share of premiums for health insurance, are not considered employer-provided benefits eligible for the exclusion. However, under the cafeteria plan rules, discussed below, an employee may elect to have amounts withheld from the employee's compensation for medical expenses, and those amounts are treated as provided by the employer for purposes of the exclusion.

Employer-provided health benefits are also excluded from wages for purposes of taxes under the Federal Insurance Contributions Act ("FICA"), the Railroad Retirement Tax Act ("RRTA"), and the Federal Unemployment Tax Act ("FUTA").<sup>6</sup> To the extent that

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<sup>4</sup> Secs. 105(b) and 106. An arrangement under which an employer provides health benefits to employees is commonly called an accident or health plan, defined generally under Treas. Reg. sec. 1.105-5(a) as an arrangement for the payments of amounts to employees in the event of personal injuries or sickness. This concept is thus broader than a plan that provides health benefits, for example, it includes a plan that provides disability benefits. Under Treas. Reg. sec. 1.105-2, in order for medical expense payments or reimbursements to be excluded from gross income, the medical expenses must be substantiated, and an employee must be entitled to receive payments or reimbursements only if he or she incurs medical expenses.

Health benefits provided to active members of the uniformed services, military retirees, and their dependents are excludable from gross income under section 134. Section 134 provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect. Health benefits come within that exclusion.

<sup>5</sup> Employers generally are not required to cover an employee's family members under a health plan, but commonly do. However, see Part I.B.1 relating to shared responsibility of employers regarding health coverage. If health benefits are provided to beneficiaries other than the employee's family members, the benefits are generally includable in gross income.

<sup>6</sup> These taxes are governed by sections 3101-3128 (FICA), 3201-3241 (RRTA), and 3301-3311 (FUTA). Sections 3501-3510 provide additional rules. Exclusions for employer-provided health benefits are provided at sections 3121(a)(2), 3231(e)(1) and 3306(a)(2).

employer-provided health benefits are excluded from income, they are not subject to income tax withholding.<sup>7</sup>

Except in the case of salary reduction contributions to a health flexible spending account under a cafeteria plan, discussed below, no limit applies to the amount of employer-provided health benefits that may be excluded from gross income and wages.<sup>8</sup>

For purposes of many of the Code rules relating to employer-provided health benefits, such as nondiscrimination rules and rules based on the size of an employer, members of a controlled group, a group under common control, or an affiliated service group are treated as a single employer.<sup>9</sup>

Health plans maintained in connection with employment are also referred to as group health plans and, as such, are subject to various requirements discussed below in Part I.B.2.

## **2. ACA changes to scope of exclusion**

### **Extension of exclusion to adult children**

For purposes of the exclusion, family members include an employee's spouse and dependents. Before the ACA, the exclusion applied to an employee's children who were dependents. The ACA revised the exclusion to apply to benefits for all children up to age 26, regardless of whether the children are dependents. Thus, after the ACA, family members include the employee's spouse, dependents and children up to age 26.

### **Definition of medical care**

Employer-provided health benefits consist of amounts paid for "medical care" expenses. Medical care generally is defined broadly to include amounts paid for: (1) the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; (2) transportation primarily for and essential to medical care referred to in (1); (3) qualified long-term care services; or (4) insurance (including Medicare premiums) covering medical care referred to in (1) and (2) or for any qualified long-term care insurance contract.<sup>10</sup>

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<sup>7</sup> The rules for income tax withholding are provided in sections 3401-3404 and 3501-3510. Under Rev. Rul. 56-632, 1956-2 C.B. 101, employer-provided health benefits that are excluded from gross income are not subject to income tax withholding.

<sup>8</sup> See Part I.B.3 for a discussion of an excise tax that may apply if the cost of employer-provided health benefits exceeds a certain amount.

<sup>9</sup> These rules are found at sections 414(b), (c), (m) and (o) and are often referred to as employer aggregation rules.

<sup>10</sup> Sec. 213(d). This is the definition applicable for purposes of the individual deduction for unreimbursed medical expenses, discussed in Part II.A.2 below, and generally applies also for purposes of the exclusion of employer-provided benefits. However, under section 213(b), for purposes of the individual deduction, an amount

Before the ACA, under an employer-provided health plan, amounts paid for medicine available without a prescription (“over-the-counter medicine”), as well as for prescribed drugs, were treated as medical care, and reimbursements for such amounts were excludible from gross income.<sup>11</sup> The ACA amended the rules for excludible employer-provided health benefits to provide that reimbursements for expenses incurred for a medicine or drug are treated as reimbursements for medical care expenses only if the medicine or drug is a prescribed drug (determined without regard to whether the drug is available without a prescription) or is insulin.<sup>12</sup> Thus, excludible reimbursements of over-the-counter medicines may not be made under an employer-provided health plan unless the medicine is prescribed.

### **3. Types of employer-provided health benefit arrangements**

#### **Overview**

Various types of arrangements, discussed below, are used in connection with employer-provided health benefits. Some of these arrangements, such as health flexible spending arrangements and health savings accounts, are sometimes referred to as “consumer-driven” arrangements in that, compared with traditional health insurance, they may enable an employee to better target the use of employer-provided health benefits to the employee’s particular needs.

Besides benefits provided under a health plan maintained directly by an employer, the exclusion applies also to other health plans maintained in connection with employment, such as multiemployer plans and plans maintained by an employee organization.<sup>13</sup>

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paid for medicine or drugs is explicitly deductible as a medical expense only if the medicine or drug is a prescribed drug or is insulin. For this purpose, a prescribed drug is a drug that requires a prescription from a physician for the drug’s use by an individual. Thus, an amount paid for medicine available without a prescription is not deductible as a medical expense. See Rev. Rul. 2003-58, 2003-1 C.B. 959.

<sup>11</sup> Rev. Rul. 2003-102, 2003-2 C.B. 559. Under section 105(b), employer-provided reimbursements for medical care within the meaning of section 213(d) are excluded from gross income. The definition of medical care in section 213(d), as cross-referenced in section 105(b), does not include the prescribed drug limitation in section 213(b).

<sup>12</sup> Sec. 106(f).

<sup>13</sup> As defined in section 414(f), a multiemployer plan is generally a plan to which more than one employer is required to contribute and that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer. Under section 3(4) of the Employee Retirement Income Security Act of 1974 (“ERISA”), an employee organization means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any employees’ beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

## **Insured and self-insured health plans**

As discussed above, the exclusion applies with respect to health insurance premiums paid by an employer. A health plan under which benefits are provided through health insurance is referred to as an “insured” plan. In some cases, rather than purchasing insurance, an employer may pay the benefits provided under a plan from its own funds, referred to as a “self-insured” (or “self-funded”) plan.<sup>14</sup> Health flexible spending arrangements and health reimbursement arrangements, discussed below, are examples of self-insured health plans. In some cases, employer-provided health benefits may be provided through a combination of insurance and a self-insured plan.

A self-insured health plan is subject to nondiscrimination requirements that prohibit the plan from discriminating in favor of highly compensated individuals, both as to eligibility for coverage under the plan (“nondiscriminatory eligibility requirement”) and benefits provided under the plan (“nondiscriminatory benefits requirement”).<sup>15</sup> For this purpose, a highly compensated individual is an individual who is one of the five highest-paid officers of the employer, a shareholder who owns more than 10 percent in value of the stock of the employer, or among the highest-paid 25 percent of all employees (other than excludable employees who are not plan participants).

Under the nondiscriminatory eligibility requirement, the plan must benefit either (1) a certain percentage of employees,<sup>16</sup> or (2) employees who qualify under a classification set up by the employer and found not to be discriminatory in favor of highly compensated individuals. In applying this requirement, the following groups of employees may be disregarded (referred to as “excludable employees”): employees who have not completed three years of service or who have not attained age 25; part-time and seasonal employees; employees not covered by the plan who are covered by collective bargaining agreement; and employees who are nonresident aliens and who receive no earned income from within the United States. Under the nondiscriminatory benefits requirement, all benefits provided for participants in the plan who are highly compensated individuals must be provided for all other participants.

If a plan fails either of these nondiscrimination requirements, “excess reimbursements” provided under the plan to highly compensated individuals are included in income. In the case of a plan that fails the nondiscriminatory benefits requirement by providing benefits to highly compensated individuals but not all other participants (“discriminatory benefits”), excess reimbursements are the total amount of discriminatory benefits provided to a highly compensated individual. In the case of a plan that fails the nondiscriminatory eligibility requirement, the

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<sup>14</sup> Under sec. 105(h)(6), an arrangement under which an employer reimburses employees for medical care expenses not covered by insurance is called a self-insured medical reimbursement plan.

<sup>15</sup> Sec. 105(h).

<sup>16</sup> Two options apply as to the percentage of employees who must benefit under the plan. Either (1) 70 percent or more of all employees must benefit, or (2) if 70 percent or more of all employees are eligible for the plan, 80 percent or more of the employees who are eligible for the plan must benefit.

amount of excess reimbursements is determined by multiplying all the benefits provided to the highly compensated individual, other than discriminatory benefits, by a fraction. The numerator of the fraction is the amount of benefits, other than discriminatory benefits, provided to the highly compensated individual, and the denominator is the total amount of benefits, other than discriminatory benefits, provided to all participants.

### **Cafeteria plans and health flexible spending arrangements**

#### Cafeteria plans

As mentioned above, the exclusion from income and wages for employer-provided health benefits applies also with respect to health benefits provided through a cafeteria plan.<sup>17</sup> A cafeteria plan is a plan under which employees may choose among cash (or certain other taxable benefits) and at least one qualified benefit, such as employer-provided health benefits.<sup>18</sup> If an employee elects a qualified benefit that is otherwise excludible from income, it is excludible under the cafeteria plan rules, even though the employee had the option to receive cash or another taxable benefit. The amount of cash that an employee does not receive as a result of the election is referred to as a salary reduction contribution. In the case of employer-provided health benefits provided through a cafeteria plan, an employee's salary reduction contributions are used for medical care expenses of the employee (and family members, if applicable).

Among the requirements applicable to a cafeteria plan is that benefits attributable to salary reduction contributions generally must be provided by the end of the plan year (referred to as the "use-it-or-lose-it" rule).<sup>19</sup> Limited exceptions apply with respect to employer-provided health benefits under which a plan may either allow employees to carry up to \$500 over to the next year or may allow employees to use the salary reduction amounts from one year for reimbursement of medical expenses incurred within the first 2½ months of the next year (referred to as a "grace period").<sup>20</sup> Other than these exceptions, amounts that are not used by the end of the plan year must be forfeited.

In addition to any nondiscrimination requirements applicable to qualified benefits under a cafeteria plan, such as the requirements for self-insured health plans, nondiscrimination requirements apply also to a cafeteria plan itself. These requirements prohibit discrimination in favor of highly compensated individuals as to eligibility for benefits and as to actual contributions and benefits provided. If these requirements are violated, benefits provided to highly compensated individuals through the cafeteria plan may be includible in income.

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<sup>17</sup> Secs. 125, 3121(a)(5)(G), 3231(e)(1), and 3306(b)(5)(G).

<sup>18</sup> Besides employer-provided health benefits, other qualified benefits include, for example, group-term life insurance excludible under section 79 and dependent care assistance excludible under section 129.

<sup>19</sup> The use-it-or-lose-it rule results from the prohibition under section 125(d)(2)(A) on providing deferred compensation through a cafeteria plan.

<sup>20</sup> Notice 2013-71, 2013-2 C.B. 532, and Notice 2005-42, 2005-1 C.B. 1204.

## Health FSAs

A health flexible spending arrangement (“health FSA”) is an arrangement under which medical care expenses of an employee (and family members, if applicable) that are not covered by insurance may be paid or reimbursed.<sup>21</sup> The funds available to an employee through a health FSA generally consist of the employee’s salary reduction contributions under a cafeteria plan and may also include funds provided by the employer (often called “flex credits”). Health FSAs funded through a cafeteria plan are subject to the general requirements for cafeteria plans, including the use-it-or-lose-it rule.

A flexible spending arrangement is subject to a special rule as to the relationship between the value of the coverage provided for a year and the maximum amount of reimbursement reasonably available during the same period. Under this rule, a health flexible spending arrangement provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to reimbursement maximums and other conditions), and the maximum amount of reimbursement reasonably available to an employee for the coverage is less than 500 percent of the value of the coverage.<sup>22</sup>

### ACA changes to the cafeteria plan and health FSA rules

Limit on health FSA salary reduction contributions.—Before the ACA, the Code did not limit the dollar amount of salary reduction contributions that could be made to a health FSA under a cafeteria plan.<sup>23</sup> Under the ACA, in order for a health FSA to be a qualified benefit under a cafeteria plan, an employee’s salary reduction contributions cannot exceed a dollar limit (\$2,550 for 2016).<sup>24</sup>

Purchase of qualified health plans through cafeteria plans.—Under the ACA, premiums for qualified health plans in the individual insurance market offered through an Exchange established under the ACA cannot be paid on a pretax salary reduction basis through a cafeteria plan.<sup>25</sup> However, in the case of a cafeteria plan of a small employer, qualified health plans offered through a Small Business Health Options Program (“SHOP”) Exchange may be provided through a cafeteria plan.

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<sup>21</sup> Although health insurance premiums may be paid on a pretax basis through a cafeteria plan, a health FSA may not be used to pay health insurance premiums.

<sup>22</sup> Sec. 106(c)(2).

<sup>23</sup> As a matter of plan design, an employer may include a limit on the amount of salary reduction contributions that can be made to a health FSA.

<sup>24</sup> Sec. 125(i). The dollar limit is indexed to CPI-U, with any increase that is not a multiple of \$50 rounded to the next lowest multiple of \$50.

<sup>25</sup> Sec. 125(f)(3). Specifically, coverage under a qualified health plan is not a qualified benefit that may be provided through a cafeteria plans. Qualified health plans and Exchanges are discussed further in Part II.A.3.

Nondiscrimination safe harbor for SIMPLE cafeteria plans.—The ACA added a safe harbor plan design called a SIMPLE cafeteria plan for eligible small employers.<sup>26</sup> An eligible small employer is generally an employer that employed an average of 100 or fewer employees on business days during either of the two preceding years. The safe harbor applies for purposes of the nondiscrimination requirements for cafeteria plans and the nondiscrimination requirements for self-insured medical expense reimbursements (and group-term life insurance and dependent care assistance) provided through the cafeteria plan. SIMPLE cafeteria plans requirements apply with respect to employee eligibility under the plan and minimum employer contributions for nonhighly compensated employees in addition to any salary reduction contributions.

## **Health reimbursement arrangements and employer payment plans**

### In general

A health reimbursement arrangement (“HRA”) is a general term for an arrangement under which funds are provided by an employer to be used for medical care expenses of employees (and family members, if applicable).<sup>27</sup> The main distinguishing characteristic of an HRA is that salary reduction contributions under a cafeteria plan are not permitted. As a result, an HRA is not subject to the use-it-or-lose-it rule. Thus, the terms of the arrangement may allow amounts remaining at the end of a year to be carried over to the next year and indefinitely, including after retirement or other termination of employment. An arrangement similar to an HRA is an arrangement under which, without salary reduction contributions, an employer pays or reimburses an employee for premiums for health insurance purchased by the employee in the individual market (referred to as an “employer payment plan”).<sup>28</sup>

### ACA changes

Before the ACA, HRAs were often provided in conjunction with comprehensive employer-provided coverage (“integrated” HRA) or alone in which case insurance premiums could be a permissible use of the funds (“stand-alone” HRA). Guidance implementing changes made by the ACA to the group health plan requirements (discussed in Part I.B.2 below) holds that an HRA for current employees fails to meet certain group health plan requirements unless the HRA is provided in conjunction with employer-sponsored coverage that meets those requirements.<sup>29</sup> As a result, HRAs for current employees must be integrated with comprehensive employer-provided coverage. Stand-alone HRAs cannot be provided to current employees, or

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<sup>26</sup> Sec. 125(j).

<sup>27</sup> Notice 2002-45, 2002-2 C.B. 93; Rev. Rul. 2002-41, 2002-2 C.B. 75.

<sup>28</sup> Notice 2013-54, 2013-2 C.B. 287; Rev. Rul. 61-146, 1961-2 C.B. 25.

<sup>29</sup> Notice 2015-17, 2015-14 I.R.B. 845; Notice 2013-54; and Department of Labor Technical Release No. 2013-03, available at <http://www.dol.gov/ebsa/newsroom/tr13-03.html>. Notice 2015-17 provides relief for periods before July 1, 2015, for certain small employers from the excise tax that could apply for a violation of the group health plan requirements (discussed below).

the employer may be subject to an excise tax of \$100 a day per employee.<sup>30</sup> However, stand-alone HRAs are permitted for retirees (and other former employees). This guidance also holds that an employer payment plan for current employees fails to meet the group health plan requirements.

## **Health savings arrangements and Archer MSAs**

### In general

An individual with a high deductible health plan generally may make deductible contributions (subject to limits) to a health savings account (“HSA”) or an Archer MSA (or “medical savings account”), which is a tax-exempt trust or custodial account.<sup>31</sup> Employer contributions to Archer MSAs and HSAs on behalf of employees are excluded from income and wages, including Archer MSA and HSA contributions made with salary reduction contributions through a cafeteria plan.<sup>32</sup>

### HSAs

For 2016, a high deductible health plan for purposes of HSA eligibility is a health plan with an annual deductible of at least \$1,300 in the case of self-only coverage and at least \$2,600 in the case of family coverage. In addition, for 2016, the sum of the deductible and the maximum out-of-pocket expenses with respect to allowed costs must be no more than \$6,550 in the case of self-only coverage and no more than \$13,100 in the case of family coverage. A plan does not fail to qualify as a high deductible health plan for HSA purposes merely because it does not have a deductible for preventive care.

For 2016, the maximum aggregate annual contribution that can be made to an HSA is \$3,350 in the case of self-only coverage and \$6,750 in the case of family coverage. The annual contribution limits are increased by \$1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). The maximum amount that an individual make contribute is reduced by the amount of any contributions to the individual’s Archer MSA and any excludable HSA contributions made by the individual’s employer. In some cases, an individual may make the maximum HSA contribution, even if the individual is covered by the high deductible health plan for only part of the year.

### Archer MSAs

Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. The main differences include: (1) only self-employed individuals and employees of small employers are eligible to

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<sup>30</sup> Sec. 4980D, discussed in Part I.B.2.

<sup>31</sup> Secs. 223 and 220. The deduction is discussed further in Part II.A.2.

<sup>32</sup> Sec. 106(b) and (d). Employer contributions are subject to the same limits as individual contributions and reduce the amount of contributions that the individual can make.

have an Archer MSA; (2) for Archer MSA purposes, a high deductible health plan is a health plan with (a) an annual deductible for 2016 of at least \$2,250 and no more than \$3,350 in the case of self-only coverage and at least \$4,450 and no more than \$6,700 in the case of family coverage and (b) maximum out-of-pocket expenses for 2016 of no more than \$4,450 in the case of self-only coverage and no more than \$8,100 in the case of family coverage; and (3) the contribution limits are 65 percent of the annual deductible for self-only coverage and 75 percent of the annual deductible for family coverage. After 2007, no contributions can be made to Archer MSAs except by or on behalf of individuals who previously had made Archer MSA contributions and employees who are employed by a participating employer.

#### Tax treatment of distributions and ACA changes

Distributions from an HSA or Archer MSA that are used for qualified medical expenses are excludible from gross income. Qualified medical expenses generally include amounts paid for medical care for the individual or the individual's spouse or dependents, but generally does not include health insurance premiums. Before the ACA, qualified medical expenses included over-the-counter medicines. However, as discussed above with respect to employer-provided health benefits, the ACA amended the definition of qualified medical expenses to include an amount paid for a medicine or drug only if it is a prescribed drug (determined without regard to whether the drug is available without a prescription) or is insulin.

Distributions from an HSA or an Archer MSA that are not used for qualified medical expenses are includible in gross income and are generally subject to an additional tax. The additional tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (that is, age 65). Before the ACA, the additional tax on HSA distributions not used for qualified medical expenses was 10 percent of the distributed amount, and the additional tax on Archer MSA distributions not used for qualified medical expenses was 15 percent of the distributed amount. The ACA increased the additional tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses to 20 percent of the distributed amount.

A distribution from an HSA may be rolled over on a nontaxable basis to another HSA and does not count against the contribution limits. A distribution from an Archer MSA may be rolled over on a nontaxable basis to another Archer MSA or an HSA and does not count against the contribution limits.

#### Failure of employer to make comparable Archer MSA or HSA contributions

An employer is not required to contribute to the Archer MSAs or the HSAs of its employees. In general, however, if an employer makes contributions to any employee's Archer MSA or HSA, the employer must make available comparable contributions to the Archer MSAs or HSAs of all comparable participating employees.<sup>33</sup> If employer contributions do not satisfy the comparability rules for a calendar year, the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to Archer MSAs or HSAs for that

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<sup>33</sup> Secs. 4980E (Archer MSAs) and 4980G (HSAs).

period. However, if the failure is due to reasonable cause (and not to willful neglect), all or part of the tax may be waived to the extent that the payment of the tax would be excessive relative to the failure involved.

Comparable contributions means contributions that are the same amount or the same percentage of the annual deductible limit under the high deductible health plan covering the employees.<sup>34</sup> Comparable participating employees means all employees who (1) are eligible individuals covered under any high deductible health plan of the employer, and (2) have the same category of coverage (that is, self-only or family coverage). The definition of comparable participating employees is applied separately to part-time employees and other employees. For this purpose, part-time employee means any employee who is customarily employed for fewer than 30 hours per week.

### **Retiree health accounts and premiums of public safety officers under pension plans**

#### Retiree health accounts

A qualified defined benefit plan may include accounts through which employer-provided health benefits are provided to retirees.<sup>35</sup> Benefits provided through these accounts are excluded from income.<sup>36</sup> If certain conditions are met, defined benefit plan assets otherwise required to be used to provide pension benefits to plan participants may be transferred to the retiree health accounts.<sup>37</sup>

#### Pension distributions for premiums of public safety officers

Distributions from tax-favored employer-sponsored retirement plans are generally included in gross income.<sup>38</sup> However, an annual income exclusion of up to \$3,000 applies for distributions from retirement plans maintained by governmental employers that are used to pay for health insurance premiums for eligible retired public safety officers and their spouses and dependents.<sup>39</sup> An eligible retired safety officer is an individual who, by reason of disability or attainment of normal retirement age, is separated from service as a public safety officer with the employer that maintains the retirement plan from which the distributions are made.

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<sup>34</sup> Under section 4980G(b), the comparability requirements and related rules applicable to Archer MSA contributions under section 4980E apply to HSA contributions. See also Treas. Reg. sec. 54.4980G-1 through -6 for the requirements applicable to HSAs.

<sup>35</sup> Sec. 401(h).

<sup>36</sup> Treas. Reg. sec. 1.402(a)-1(e)(2).

<sup>37</sup> Sec. 420.

<sup>38</sup> See, *e.g.*, sec. 402(a).

<sup>39</sup> Sec. 402(l).

#### **4. Reporting of employer-provided health benefits on Form W-2**

An employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages paid by the employer to the employee and the taxes withheld from such wages during the calendar year.<sup>40</sup> The statement, made on the Form W-2, Wage and Tax Statement, must be provided to each employee by January 31 of the succeeding year.

Although excludible compensation generally is not required to be reported on Form W-2, employer-provided health benefits must be reported as an information item (Box 12 of Form W-2), regardless of whether excluded from income. Specifically, the amount of Archer MSA contributions, the amount of HSA contributions, and, as a result of the ACA, the cost of other employer-provided health benefits (other than salary reduction contributions to a health FSA) generally must be reported.<sup>41</sup>

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<sup>40</sup> Sec. 6051. Employers send Form W-2 information to the Social Security Administration, which records information relating to Social Security and Medicare and provides a copy of the information to the Internal Revenue Service (“IRS”).

<sup>41</sup> Sec. 6051(a)(11), (12) and (14). Notice 2012-9, 2012-1 C.B. 315, provides guidance on the ACA requirement that the cost of employer-provided health benefits be reported on Form W-2, including temporary exceptions, such as an exception for employers required to file fewer than 250 Forms W-2 for the preceding calendar year.

## **B. Additional Requirements Relating to Employer-Provided Health Benefits**

### **1. Shared responsibility for employers regarding health coverage**

#### **In general**

Under the ACA, an applicable large employer, as defined below, may be subject to a tax, called an “assessable payment,” for a month if one or more of its full-time employees is certified to the employer as receiving for the month a premium assistance credit for health insurance purchased on an Exchange established under the ACA or reduced cost-sharing for the employee’s share of expenses covered by such health insurance (commonly referred to as the “employer mandate”).<sup>42</sup> As discussed below, the amount of the assessable payment depends on whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under a group health plan sponsored by the employer and, if it does, whether the coverage offered is affordable and provides minimum value.

#### **Definitions of full-time employee and applicable large employer**

For purposes of applying these rules, full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours of service per week. Hours of service are to be determined under regulations, rules, and guidance prescribed by the Secretary of the Treasury, in consultation with the Secretary of Labor, including rules for employees who are not compensated on an hourly basis.<sup>43</sup>

Applicable large employer generally means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.<sup>44</sup> Solely for purposes of determining whether an employer is an applicable large employer (that is, whether the employer has at least 50 full-time employees), besides the number of full-time employees, the employer must include the number of its full-time equivalent employees for a month, determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. In addition, in determining whether an employer is an applicable large employer, members of the same controlled group, group under common control, and affiliated service group are treated as a

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<sup>42</sup> Sec. 4980H. Treas. Reg. secs. 54.4980H-1 through -5 provide guidance on this provision. Premium assistance credits for health insurance purchased on an Exchange established under the ACA are provided under section 36B. Reduced cost-sharing for an individual’s share of expenses covered by such health insurance is provided under section 1402 of PPACA. Premium assistance credits and cost-sharing subsidies are described in Part II.A.3.

<sup>43</sup> Treas. Reg. sec. 54.4980H-3 provides rules for determining hours of service and status as a full-time employee for purposes of section 4980H.

<sup>44</sup> Additional rules apply, for example, in the case of an employer that was not in existence for the entire preceding calendar year.

single employer.<sup>45</sup> If the group is an applicable large employer under this test, each member of the group is an applicable large employer even if any member by itself would not be an applicable large employer.<sup>46</sup>

## **Assessable payments**

### **In general**

If an applicable large employer does not offer its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is so certified to the employer, the employer may be subject to an assessable payment of \$2,160 (for 2016)<sup>47</sup> (divided by 12 and applied on a monthly basis) multiplied by the number of its full-time employees in excess of 30, regardless of the number of full-time employees so certified. For example, in 2016, Employer A fails to offer minimum essential coverage and has 100 full-time employees, 10 of whom receive premium assistance credits for the entire year. The employer's assessable payment is \$2,160 for each employee over the 30-employee threshold, for a total of \$151,200 (\$2,160 multiplied by 70, that is, 100 minus 30).

Generally an employee who is offered minimum essential coverage under an employer-sponsored plan is not eligible for a premium assistance credit or reduced cost-sharing unless the coverage is unaffordable or fails to provide minimum value.<sup>48</sup> However, if an employer offers its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is certified as receiving a premium assistance credit or reduced cost-sharing (because the coverage is unaffordable or fails to provide minimum value), the employer may be subject to an assessable payment of \$3,240 (for 2016) (divided by 12 and applied on a monthly basis) multiplied by the number of such full-time employees. However, the assessable payment in this case is capped at the amount that would apply if the employer failed to offer its full-time employees and their dependents minimum essential coverage. For example, in 2016, Employer B offers minimum essential

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<sup>45</sup> The rules for determining controlled group, group under common control, and affiliated service group under section 414(b), (c), (m) and (o) apply for this purpose.

<sup>46</sup> In addition, in determining assessable payments under section 4980H, only one 30-employee reduction in full-time employees applies to the group and is allocated among the members ratably based on the number of full-time employees employed by each member.

<sup>47</sup> For calendar years after 2014, the dollar amounts (which were initially \$2,000 and \$3,000) are increased by the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary of HHS no later than October 1 of the preceding calendar year) exceeds the average per capita premium for 2013 (as determined by the Secretary of HHS), rounded down to the next lowest multiple of \$10.

<sup>48</sup> Under section 36B(c)(2)(C), coverage under an employer-sponsored plan is unaffordable if the employee's share of the premium for self-only coverage exceeds 9.66 percent of household income, and the coverage fails to provide minimum value if the plan's share of total allowed cost of provided benefits is less than 60 percent of such costs. Treas. Reg. sec. 1.36B-2(c)(3)(vi) provides guidance on the determination of whether coverage provides minimum value.

coverage and has 100 full-time employees, 20 of whom receive premium assistance credits for the entire year. The employer's assessable payment before consideration of the cap is \$3,240 for each full-time employee receiving a credit, for a total of \$64,800. The cap on the assessable payment is the amount that would have applied if the employer failed to offer coverage, or \$151,200 (\$2,160 multiplied by 70, that is, 100 minus 30). In this example, the cap therefore does not affect the amount of the assessable payment, which remains at \$64,800.

#### Certification that an employee has received a premium assistance credit or a cost-sharing reduction

An employer must be notified by the Exchange established under the ACA if one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction because the employer does not provide minimal essential coverage through an employer-sponsored plan, or the employer does offer such coverage but it is not affordable or the plan's share of the total allowed cost of benefits is less than 60 percent.<sup>49</sup> The notice must include information about the employer's potential liability for payments under section 4980H. The employer must also receive notification of the appeals process established for employers notified of potential liability for assessable payments. An employer is generally not entitled to information about its employees who qualify for the premium assistance credit or cost-sharing reductions; however, the appeals process must provide an employer the opportunity to access the data used to make the determination of an employee's eligibility for a premium assistance credit or cost-sharing reduction, to the extent allowable by law.

#### Time for payment, deductibility of excise taxes, restrictions on assessment

The assessable payments are payable on an annual, monthly or other periodic basis as the Secretary of the Treasury may prescribe. The assessable payments are not deductible as a business expense. The restrictions on assessment of deficiencies<sup>50</sup> are not applicable to the excise taxes imposed under the provision.

The Secretary is required to prescribe rules, regulations or guidance for the repayment of any assessable payment (including interest) if the payment is based on the allowance or payment of a premium assistance credit or cost-sharing reduction with respect to an employee that is subsequently disallowed and with respect to which the assessable payment would not have been required to have been made in the absence of the allowance or payment.

#### **Shared responsibility reporting requirements**

The ACA adds a reporting requirement under which, each applicable large employer subject to the employer shared-responsibility requirement for a calendar year must file a return reporting certain health insurance coverage information to the IRS, and furnish a statement

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<sup>49</sup> Sec. 1411(e)(4)(B)(ii) and (C) of PPACA.

<sup>50</sup> Sec. 6213.

reporting the information to each of its full-time employees, for the calendar year.<sup>51</sup> In the case of an applicable large employer that is a governmental unit, or any agency or instrumentality thereof, the reporting requirement applies to the person or employee appropriately designated for purposes of making the returns and statements required by the provision.<sup>52</sup>

The information required to be reported on the return for a calendar year with respect to each full-time employee includes: (1) the name, address and employer identification number of the employer; (2) the name and telephone number of employer's contact person, (3) the calendar year for which the information is reported; (4) a certification as to whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan, by calendar month; (5) the months during the calendar year for which minimum coverage was available; (6) each full time employee's share of the lowest cost monthly premium (self only) for coverage providing minimum value offered to that full-time employee under an eligible employer-sponsored plan, by calendar month; (7) the number of full-time employees of the employer for each month during the calendar year; (8) the name, address and taxpayer identification number of each full-time employee employed by the employer during the calendar year and the number of months, if any, during which the employee (and any dependents) was covered under the plan; and (9) any other information specified in forms, instructions, or published guidance.<sup>53</sup>

The applicable large employer is required to file the return with the IRS by February 28 (March 31 if filed electronically), and furnish the statement to the employee by January 31, of the year following the calendar year.<sup>54</sup> The forms for the return are Form 1094-C and Form 1095-C.<sup>55</sup> The statement furnished to each full-time employee reporting the above information must also include the name, address and contact information of the reporting employer. Rules are provided in the regulations for when a provider is permitted to furnish the statement to an individual electronically, including a requirement for affirmative consent.<sup>56</sup>

An employer that fails to comply with these new reporting requirements is subject to the penalties for failure to file an information return and failure to furnish payee statements, respectively.

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<sup>51</sup> Sec. 6056.

<sup>52</sup> Sec. 6056(e); Treas. Reg. sec. 301.6056-1(d).

<sup>53</sup> Treas. Reg. sec. 301.6056-1(d)(1).

<sup>54</sup> In Notice 2016-4, 2016-3 I.R.B. 279, the IRS extended the deadline for reporting to the IRS for 2015 to May 31, 2016 (June 30, 2016 for electronic filing), and the deadline for furnishing the report to an individual to March 31, 2016.

<sup>55</sup> Treas. Reg. sec. 301.6056-1(d)(2). The same form is used for reporting under section 6055 individuals provided minimum essential coverage. Thus, an applicable large employer is able to combine this reporting of its offer of minimum essential coverage with the reporting required under sections 6055 and 6056.

<sup>56</sup> Treas. Reg. sec. 301.6056-2(k) provides special rules for governmental units.

Alternative reporting methods are provided for applicable large employer members that satisfy certain eligibility requirements.<sup>57</sup> Simplified reporting applies for an employer that make a qualifying offer which is an offer to one or more of its full-time employees for all months during the year of minimum essential coverage for employee-only coverage at an employee cost not exceeding 9.5 percent of the mainland single federal poverty level, and that includes an offer of minimum essential coverage to the employees' spouses and dependents. Under an alternative reporting method for an applicable large employer that certifies that it offered minimum essential coverage providing minimum value that was affordable to at least 98 percent of its employees (and their dependents), the employer is not required to identify whether a particular employee is full-time or report the total number of its full-time employees for the year.

## **2. Requirements for group health plans**

### **In general**

A group health plan is a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.<sup>58</sup>

Group health plans are subject to various requirements under the Code.<sup>59</sup> Governmental plans are generally exempt from these requirements.<sup>60</sup> Church plans are generally exempt from these requirements or subject to special rules.<sup>61</sup>

### **Continuation coverage requirements**

Group health plans are generally required to offer an employee, spouse or dependent child covered by the plan ("qualified beneficiaries") the opportunity to continue coverage under the plan for a specified period of time after the occurrence of certain events that otherwise would have terminated the coverage ("qualifying events").<sup>62</sup> These continuation coverage

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<sup>57</sup> Treas. Reg. sec. 1.6056-1(j).

<sup>58</sup> Sec. 5000(b)(1).

<sup>59</sup> Parallel requirements generally apply under ERISA, which is within the jurisdiction of the Department of Labor, to group health plans of private employers and under the Public Health Service Act ("PHSA"), which is in the jurisdiction of the Department of Health and Human Services, to group health plans of governmental employers and, in some cases, to health insurance.

<sup>60</sup> Governmental plan is defined in section 414(d).

<sup>61</sup> Church plan is defined in section 414(e).

<sup>62</sup> Sec. 4980B(a) and (f). Sec. 4980B(d)(1) provides an exception to the excise tax if, during the calendar year immediately preceding the calendar year in which a qualifying event occurs, all employers maintaining the plan normally employed fewer than 20 employees on a typical business day.

requirements are often referred to as “COBRA continuation coverage” or “COBRA” requirements.<sup>63</sup>

In the case of a failure to comply with the COBRA continuation coverage requirements under the Code, an excise tax may apply to the employer maintaining the group health plan or, in the case of a multiemployer group health plan, to the plan.<sup>64</sup> Generally, the excise tax is \$100 per qualified beneficiary for each day in the “noncompliance period.”<sup>65</sup> The noncompliance period begins on the date the failure occurs and ends when the failure is corrected, or, if earlier, six months after the last date on which the employer could have been required to provide COBRA coverage (without regard to the possible cessation of coverage for nonpayment of premiums). A failure to satisfy the COBRA continuation coverage requirements is corrected if the failure is retroactively undone to the extent possible and the qualified beneficiary is placed in a financial position as good as if the failure had not occurred.<sup>66</sup>

Various exceptions to the excise tax may apply, for example, if none of the persons liable for the tax knew, or exercising reasonable diligence would have known, of the plan’s failure to comply or if a failure is due to reasonable cause (and not to willful neglect) and corrected within a certain period.<sup>67</sup> An overall limitation on the excise tax applies for failures during the taxable year that are due to reasonable cause (and not to willful neglect). For an employer, the overall limit is \$500,000, or if less, 10 percent of the amount the employer paid or incurred during the preceding taxable year for group health plans. For a multiemployer plan, the overall limit is \$500,000, or if less, 10 percent of the amount paid or incurred by the plan during the taxable year to provide medical care. All or part of the excise tax may be waived if a failure is due to reasonable cause (and not to willful neglect) and payment of the tax would be excessive relative to the failure involved.

### **Additional group health plan requirements and ACA changes**

Beginning with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”),<sup>68</sup> various requirements in addition to the COBRA requirements (“additional group health plan requirements”) have applied to group health plans.<sup>69</sup> These group health plan

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<sup>63</sup> The COBRA requirements were originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272.

<sup>64</sup> Sec. 4980B(e). In some circumstances, a person (other than an employee) responsible for administering or providing benefits under the plan may be liable.

<sup>65</sup> Sec. 4980B(b). If more than one qualified beneficiary is involved in the same qualifying event, the amount is generally \$200 per day with respect to all the qualified beneficiaries.

<sup>66</sup> Sec. 4980B(g)(4).

<sup>67</sup> Sec. 4980B(c).

<sup>68</sup> Pub. L. No. 104-191.

<sup>69</sup> Chapter 100 (secs. 9801-9834).

requirements have been revised and expanded periodically, for example, by the Taxpayer Relief Act of 1997 (adding to the Code requirements under the Newborns' and Mothers' Health Protection Act of 1996), the Genetic Information Nondiscrimination Act of 2008 ("GINA"), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and Michelle's Law,<sup>70</sup> as well as the ACA. These Code requirements are generally enforced through an excise tax, described below.

These additional group health plan requirements do not apply for a plan year if, on the first day of the plan year, a group health plan has fewer than two participants who are current employees.<sup>71</sup> Thus, for example, the requirements do not apply to a group health plan covering only retirees. The requirements also do not apply to a group health plan in relation to its provision of certain types of benefits (generally referred to as "excepted benefits"), such as disability income insurance and limited scope dental or vision benefits provided under a separate policy, certificate, or contract of insurance.<sup>72</sup>

The additional group health plan requirements are:<sup>73</sup>

- No preexisting condition exclusions and no waiting periods of more than 90 days,\*<sup>74</sup>
- No discrimination based on health status or genetic information and standards for programs to promote health or prevent disease (commonly referred to as "wellness" programs),\*<sup>75</sup>
- Guaranteed renewability under multiemployer plans and multiple employer welfare arrangements ("MEWAs"),<sup>76</sup>

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<sup>70</sup> Pub. L. No. 105-34; Pub. L. No. 110-233; Pub. L. No. 110-343; and Pub. L. No. 110-381. Before the ACA, the requirements under Chapter 100 were often referred to as the HIPAA requirements, even though some were added by laws after HIPAA.

<sup>71</sup> Sec. 9831(a)(2).

<sup>72</sup> Secs. 9831(b)-(c) and 9832(c).

<sup>73</sup> Requirements marked with an asterisk were revised or added by the ACA. The specifics of the requirements added by the ACA are contained in the PHS Act and apply under the Code by cross-reference in Code section 9815 (and under ERISA by cross-reference in ERISA section 715). Under the ACA (section 1251 of PPACA, as amended by section 10103 of PPACA and section 2301(a) of HCERA), a group health plan in which an individual was enrolled on March 23, 2010, the date of enactment of PPACA (a "grandfathered" plan), is excepted from the following requirements, including with respect to the enrollment of new employees and their families: wellness standards added by the ACA; coverage of preventive health services with no cost-sharing; consistent coverage for individuals participating in approved clinical trials; prohibition on discrimination under an insured plan in favor of highly compensated individuals; additional choice of health care providers and access to certain services; consistent treatment of health care providers; required appeals process for benefit denials; and access to additional data about the particular health coverage.

<sup>74</sup> Limited preexisting condition exclusions were permitted before the ACA.

<sup>75</sup> The ACA added statutory standards for wellness programs.

- Standards relating to benefits for mothers and newborns,
- Parity in mental health and substance use disorder benefits,
- Coverage of dependent students on medically necessary leave of absence,
- Coverage of children up to age 26,\*
- Coverage of preventive health services with no cost-sharing (that is, no deductibles or and co-pays),\*
- No annual or lifetime limits on benefits,\*
- Consistent coverage for individuals participating in approved clinical trials,\*
- No discrimination under an insured group health plan in favor of highly compensated individuals,\*<sup>77</sup>
- Additional choice of health care providers and access to certain services,\*
- Consistent treatment of health care providers,\*
- Use of a uniform explanation of coverage and standardized definitions (commonly referred to as a summary of benefits and coverage or “SBC” and a uniform glossary),\*
- Required appeals process for benefit denials, including an internal appeal and external review,\*
- No rescission of coverage, except in the case of fraud or intentional misrepresentation of material fact, and required advance notice of cancellation of coverage,\*
- Premium rebates for purchasers of health insurance (not self-insured coverage) unless a specified percentage of premiums is spent on health care and activities that improve health care quality (commonly referred to as medical loss ratio or “MLR” rebates),\* and
- Access to additional data about the particular health coverage, such as claims denials.\*

An excise tax may be imposed under the Code if a group health plan fails to comply with these requirements.<sup>78</sup> The excise tax is imposed on (1) the employer maintaining the plan, or

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<sup>76</sup> MEWA is defined in section 3(40) of ERISA.

<sup>77</sup> This requirement does not apply to self-insured health plans, which, as discussed in Part I.A, are subject to separate nondiscrimination requirements under section 105(h). Under IRS Notice 2011-1, 2011-2 I.R.B. 259, compliance with the ACA nondiscrimination prohibition for insured plans is not required until regulations or other guidance has been issued.

<sup>78</sup> Sec. 4980D(a). Section 4980D(d)(1) provides an exception to the excise tax for a plan of a small employer providing health coverage solely through a contract with a health insurance issuer if the failure is solely because of the health insurance coverage offered by the issuer. For this purpose, a small employer is one that

(2) the plan in the case of a multiemployer plan or a failure related to guaranteed renewability under a MEWA.<sup>79</sup>

Generally, the amount of the excise tax is \$100 per day of noncompliance for each individual to whom the failure relates.<sup>80</sup> Exceptions, limitations, and waivers similar to those applicable with respect to the excise tax for failures to comply with the COBRA requirements apply also with respect to this excise tax.<sup>81</sup>

### **Nonconforming group health plans and Medicare secondary payor requirements**

The Social Security Act imposes certain secondary payor requirements on group health plans, under which, in the case of an employee or family member eligible for Medicare, Medicare must be the secondary payor for items and services covered by a group health plan.<sup>82</sup> The particular requirements generally depend on the size of the employer and the basis upon which the individual qualifies for Medicare. A group health plan that fails to comply with these requirements is referred to as a “nonconforming” group health plan.

An excise tax is imposed on any employer (including a self-employed person) or employee organization that contributes to a nonconforming group health plan.<sup>83</sup> The tax is equal to 25 percent of the employer's, or employee organization's, expenses incurred during the calendar year for each group health plan to which the employer (including a self-employed person), or employee organization, contributes. The tax does not apply to an employer that is a Federal or other governmental entity.

## **3. High cost employer-sponsored health coverage**

### **In general**

Under ACA, effective for years beginning after December 31, 2019, an excise tax is imposed on the provider of applicable employer-sponsored health coverage (the “coverage provider”) if the aggregate cost of the coverage for an employee (including a former employee, surviving spouse, or any other primary insured individual) exceeds a threshold amount (referred

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employed an average of at least two, but no more than 50, employees on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year, applied by treating members of a controlled group, group under common control, or affiliated service group are treated as one employer. This exception does not apply to self-insured plans.

<sup>79</sup> Sec. 4980D(e).

<sup>80</sup> Sec. 4980D(b).

<sup>81</sup> Sec. 4980D(c).

<sup>82</sup> Sec. 1862(b) of the Social Security Act.

<sup>83</sup> Sec. 5000.

to as “high cost health coverage”).<sup>84</sup> The tax is 40 percent of the amount by which aggregate cost exceeds the threshold amount (the “excess benefit”). The excise tax is determined on a monthly basis, by reference to the aggregate cost of applicable employer-sponsored coverage for the month and 1/12 of the annual threshold amount.

### **Threshold amounts**

Although the excise tax is not effective until 2020, the annual threshold amount is initially provided for 2018 and is \$10,200 for self-only coverage or \$27,500 for other coverage (such as family coverage), multiplied by a one-time health cost adjustment percentage. The health cost adjustment percentage is 100 percent plus the excess, if any, of (1) the percentage by which the cost of “standard FEHBP coverage” (described below) for 2018 (determined according to specified criteria) exceeds the cost of standard FEHBP coverage for 2010, over (2) 55 percent. This threshold is then adjusted annually by an age and gender adjusted excess premium amount. The age and gender adjusted excess premium amount is the excess, if any, of (1) the premium cost of standard FEHBP coverage for the type of coverage provided to an individual if priced for the age and gender characteristics of all employees of the employer, over (2) the premium cost of standard FEHBP coverage if priced for the age and gender characteristics of the national workforce. The threshold amounts are increased by an additional threshold amount in the case of certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines. The addition threshold amount for 2018 is \$1,650 for self-only coverage or \$3,450 for other coverage.

For years after 2018, the threshold amounts (after application of the health cost adjustment percentage) and the additional threshold amounts are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) (CPI-U increased by one percentage point for 2019 only), rounded to the nearest \$50. For these threshold calculations, standard FEHBP coverage means the per employee cost of Blue Cross/Blue Shield standard benefit coverage under the Federal Employees Health Benefit Program.

### **Applicable employer-sponsored coverage and determination of cost**

Subject to certain exceptions, applicable employer-sponsored coverage is coverage under any group health plan offered to an employee by an employer that is excludible from the employee’s gross income, as discussed in Part I.A., or that would be excludible if it were employer-sponsored coverage.<sup>85</sup> Applicable employer-sponsored coverage includes both insured and self-insured health coverage, including coverage in the form of reimbursements under a

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<sup>84</sup> Sec. 4980I. The effective date for section 4980I was changed from years after 2017 to years after 2019 by section 101 of Division P of the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, enacted December 18, 2015, but the amount of the threshold amounts for 2020 and later years continue to be calculated using the 2018 threshold amounts, as adjusted, under section 4980I.

<sup>85</sup> Thus, applicable employer-sponsored coverage includes coverage for which an employee pays on an after-tax basis.

health FSA or an HRA and employer contributions to an HSA or Archer MSA.<sup>86</sup> (As discussed in Part I.A, salary reduction contributions under a cafeteria plan, including salary reduction contributions under a health FSA or to an HSA or Archer MSA, are treated as amounts provided by the employer for purposes of the exclusion for employer-provided health benefits.) Applicable employer-sponsored coverage includes coverage under any group health plan established and maintained primarily for its civilian employees by the Federal government or any Federal agency or instrumentality, or the government of any State or political subdivision thereof or any agency or instrumentality of a State or political subdivision. In the case of a self-employed individual, coverage is treated as applicable employer-sponsored coverage if the self-employed individual is allowed a deduction for all or any portion of the cost of coverage.<sup>87</sup>

For purposes of the excise tax, the cost of applicable employer-sponsored coverage is generally determined under rules similar to the rules for determining the applicable premium for purposes of COBRA continuation coverage,<sup>88</sup> except that any portion of the cost of coverage attributable to the excise tax is not taken into account. Cost is determined separately for self-only coverage and other coverage. Special valuation rules apply to certain retiree coverage, health FSAs, and contributions to HSAs and Archer MSAs.

### **Calculation of excess benefit and imposition of excise tax**

In determining the excess benefit with respect to an employee (*i.e.*, the amount by which the cost of applicable employer-sponsored coverage for the employee exceeds the threshold amount), the aggregate cost of all applicable employer-sponsored coverage of the employee is taken into account. The threshold amount for self-only coverage generally applies to an employee. The threshold amount for other coverage applies to an employee only if the coverage provides minimum essential coverage to the employee and at least one other beneficiary and the benefits provided do not vary based on whether the covered individual is the employee or other beneficiary. For purposes of the threshold amount, any coverage provided under a multiemployer plan is treated as coverage other than self-only coverage.

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<sup>86</sup> Some types of coverage are not included in applicable employer-sponsored coverage, such as long-term care coverage, separate insurance coverage substantially all the benefits of which are for treatment of the mouth (including any organ or structure within the mouth) or of the eye, and certain excepted benefits. Excepted benefits for this purpose include (whether through insurance or otherwise) coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; and other similar insurance coverage (as specified in regulations), under which benefits for medical care are secondary or incidental to other insurance benefits. Applicable *employer*-sponsored coverage does not include coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance if the cost of the coverage is not excludible from an employee's income or deductible by a self-employed individual.

<sup>87</sup> As discussed in Part II.A.2, section 162(l) allows a deduction to a self-employed individual for the cost of health insurance.

<sup>88</sup> Sec. 4980B(f)(4).

The excise tax is imposed on the coverage provider.<sup>89</sup> In the case of insured coverage (*i.e.*, coverage under a policy, certificate, or contract issued by an insurance company), the health insurance issuer is liable for the excise tax. In the case of self-insured coverage, the person that administers the plan benefits (“plan administrator”) is generally liable for the excise tax. The person that administers the plan benefits includes the plan sponsor if the plan sponsor administers benefits under the plan. In the case of employer contributions to an HSA or an Archer MSA, the employer is liable for the excise tax.

The employer is generally responsible for calculating the amount of excess benefit allocable to each coverage provider and notifying each coverage provider (and the IRS) of the coverage provider’s allocable share. In the case of applicable employer-sponsored coverage under a multiemployer plan, the plan sponsor is responsible for the calculation and notification.<sup>90</sup>

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<sup>89</sup> The excise tax is allocated pro rata among the coverage providers, with each responsible for the excise tax on an amount equal to the total excess benefit multiplied by a fraction, the numerator of which is the cost of the applicable employer-sponsored coverage of that coverage provider and the denominator of which is the aggregate cost of all applicable employer-sponsored coverage of the employee.

<sup>90</sup> The employer or multiemployer plan sponsor may be liable for a penalty if the total excise tax due exceeds the tax on the excess benefit calculated and allocated among coverage providers by the employer or plan sponsor.

## C. Other Provisions Relating to Employer-Provided Health Benefits

### 1. Credit for small employer health insurance expenses

#### In general

The ACA provides a tax credit for an eligible small employer for nonelective contributions to purchase health insurance for its employees.<sup>91</sup> An eligible small employer for this purpose generally is an employer with no more than 25 full-time equivalent employees (“FTEs”) during the employer’s taxable year, whose average annual wages do not exceed \$51,800 (for 2016).<sup>92</sup> However, the full amount of the credit is available only to an employer with 10 or fewer FTEs whose average annual wages do not exceed \$25,900 (for 2016).

An employer’s FTEs are calculated by dividing the total hours worked by all employees during the employer’s tax year (up to 2,080 for any employee) by 2,080 (and rounding down to the nearest whole number of FTEs). Average annual wages are determined by dividing the total wages paid by the employer by the number of FTEs (and rounding down to the nearest \$1,000).

For purposes of the credit, the employer is determined by applying the aggregation rules for controlled groups, groups under common control, and affiliated service groups.<sup>93</sup> In addition, for purposes of the credit, the term “employee” includes a leased employee, that is, an individual who is not an employee of the employer, who provides services to the employer pursuant to an agreement between the employer and another person (a “leasing organization”) and under the primary direction or control of the employer, and who has performed such services on a substantially full-time basis for at least one year.<sup>94</sup>

Self-employed individuals (including partners and sole proprietors), two-percent shareholders of an S corporation, and five-percent owners of the employer are not employees for purposes of the credit with the result that they are disregarded in determining number of FTEs, average annual wages, and nonelective contributions for employees’ health insurance. Family members of these individuals and any member of the individual’s household who is a dependent for tax purposes are also not employees for purposes of the credit. In addition, the hours of service worked by and wages paid to a seasonal worker of an employer are not taken into account in determining number of FTEs and average annual wages unless the worker works for the employer on more than 120 days during the taxable year.

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<sup>91</sup> Sec. 45R and Treas. Reg. secs. 1.45R-0 through -5.

<sup>92</sup> Wages for this purpose is defined as under the Federal Insurance Contributions Act (“FICA”), sections 3101-3128, without regard to the dollar limit on FICA wages under section 3121(a). The wage amounts relevant for purposes of the credit are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) for years beginning after 2013.

<sup>93</sup> Sec. 414(b), (c), (m) and (o).

<sup>94</sup> Sec. 414(n)(2).

The credit is available only for nonelective contributions<sup>95</sup> for premiums for qualified health plans offered by the employer through a SHOP Exchange. The employer contributions must be provided under an arrangement that requires the eligible small employer to make, on behalf of each employee who enrolls in qualifying health insurance offered by the employer, a nonelective contribution equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualified health plan.

The credit is available for a maximum credit period of two consecutive taxable years beginning with the first taxable year in which the employer (or any predecessor) offers one or more qualified health plans to its employees through a SHOP Exchange.<sup>96</sup> The credit is available only to offset actual tax liability and is claimed on the employer's tax return. The credit is a general business credit and generally can be carried back for one year and carried forward for 20 years. The credit is available for tax liability under the alternative minimum tax. The dollar amount of the credit reduces the amount of employer contributions the employer may deduct as a business expense.

### **Calculation of credit amount**

Only nonelective contributions by the employer are taken into account in calculating the credit. The credit is equal to the lesser of the following two amounts multiplied by 50 percent: (1) the amount of contributions the employer made on behalf of the employees during the taxable year for the qualified health plan and (2) the amount of contributions the employer would have made during the taxable year if each employee with the qualified health plan had enrolled in insurance with the average premium for the small group market in the rating area in which the employee enrolls for coverage, as determined by the Secretary of Health and Human Services ("HHS").

The credit is reduced for an employer with between 10 and 25 FTEs. The credit is also reduced for an employer for whom the average annual wages per FTE is between \$25,900 and \$51,800 (for 2016). For an employer with both more than 10 FTEs and average annual wages in excess of \$25,900, the reduction is the sum of the amount of the two reductions.

### **Tax-exempt organizations**

For tax-exempt organizations, the applicable credit percentage the applicable credit percentage is limited to 35 percent. In addition, instead of a general business credit, the credit is

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<sup>95</sup> A nonelective contribution is an employer contribution other than an employer contribution pursuant to a salary reduction arrangement. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 is not a nonelective contribution for purposes of the credit.

<sup>96</sup> A somewhat different version of the credit applied for taxable years beginning before 2014. Taxable years beginning before 2014 are not taken into account for purposes of the two-year limit on the credit.

a refundable credit limited to the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.<sup>97</sup>

## **2. Subsidy for retiree prescription plans**

### **In general**

Sponsors of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of HHS with respect to a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").<sup>98</sup> A qualified retiree prescription drug plan is employment-based retiree health coverage that has an actuarial value at least as great as the Medicare Part D standard plan for the risk pool and that meets certain other disclosure and recordkeeping requirements. These qualified retiree prescription drug plan subsidies are excludible from the plan sponsor's gross income.<sup>99</sup>

### **ACA change**

In general, no deduction is allowed under any provision of the Code for any expense or amount that would otherwise be allowable as a deduction if the expense or amount is allocable to a class or classes of exempt income.<sup>100</sup> Thus, expenses incurred with respect to the subsidies excluded from income would generally not be deductible. However, before the ACA, the exclusion for the qualified retiree prescription drug plan subsidy specifically provided that the exclusion was not taken into account in determining a deduction with respect to covered retiree prescription drug expenses taken into account in determining the subsidy payment. Therefore, a taxpayer could claim a deduction for covered retiree prescription drug expenses notwithstanding that the taxpayer excluded from income qualified retiree prescription drug plan subsidies with respect to the expenses. The ACA eliminated the rule that the exclusion for subsidy payments is not taken into account in determining a deduction with respect to retiree prescription drug expenses. Thus, the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of excludable subsidy payments received.

## **3. Voluntary Employee Beneficiary Associations ("VEBAs")**

VEBAs are sometimes used as a vehicle for employer-provided health benefits, including insurance premiums, self-insured coverage, or a combination. A VEBA is a tax-exempt trust or fund that provides for the payment of life, sick, accident or other similar benefits to members of such association or their dependents or designated beneficiaries, as long as there is no private

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<sup>97</sup> For this purpose, "payroll taxes" means: (1) the amount of income tax required to be withheld from its employees' wages; (2) the amount of hospital insurance tax required to be withheld from its employees' wages; and (3) the amount of the hospital insurance tax imposed on the employer.

<sup>98</sup> Sec. 1860D-22 of the Social Security Act (SSA), 42 U.S.C. sec. 1395w-132.

<sup>99</sup> Sec. 139A.

<sup>100</sup> Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

inurement.<sup>101</sup> The employees eligible for coverage by a VEBA must share an employment-based common bond. Typically, eligibility is determined on the basis of (1) a common employer (or affiliated employers), (2) coverage under one or more collective bargaining agreements, (3) membership in a labor union, or (4) membership in one or more locals of a national or international labor union. In addition, employees of one or more employers engaged in the same line of business in the same geographic locale will be considered to share an employment-related bond.

Unlike most other types of tax-exempt organizations, a VEBA is generally subject to unrelated business income tax, other than on its exempt function income.<sup>102</sup> Exempt function income means contributions by employers and employees and, subject to limits, amounts set aside to provide for the payment of life, sick, accident, or other benefits and reasonable costs of administration.<sup>103</sup>

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<sup>101</sup> Sec. 501(c)(9).

<sup>102</sup> Sec. 512(a)(3).

<sup>103</sup> Treas. Reg. sec. 1.512(a)-5T, A-3.

## II. INDIVIDUAL PROVISIONS

### A. Exclusions, Deductions and Credits

#### 1. Exclusions from gross income

##### **Health expenses paid by insurance**

Payments or reimbursements received by an individual through health insurance for medical expenses are excluded from gross income.<sup>104</sup>

##### **Exclusion under the ACA of health benefits provided by Indian tribal governments**

Under the ACA, Indian tribe members may exclude from gross income the value of any qualified Indian health care benefit.<sup>105</sup> The exclusion applies to the value of: (1) health services or benefits provided or purchased by the Indian Health Service (“IHS”), either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the IHS;<sup>106</sup> (2) medical care (in the form of provided or purchased medical care services, accident or health insurance or an arrangement having the same effect, or amounts paid directly or indirectly, to reimburse the member for expenses incurred for medical care) provided by an Indian tribe or tribal organization to a member of an Indian tribe, including the member’s spouse or dependents; (3) accident or health plan coverage (or an arrangement having the same effect) provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, including the member’s spouse or dependents; and (4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for the programs and services provided by the Federal government to Indian tribes or Indians.

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<sup>104</sup> Sec. 104(a)(3). This exclusion does not apply if premiums for the insurance were paid by an employer and excluded from income. However, as discussed in Part I.A, other exclusions apply with respect to employer-provided health benefits.

<sup>105</sup> Sec. 139D. To qualify for the exclusion, the recipient must be a member of an Indian tribe, the spouse of a member, or a dependent of a member of an Indian tribe. Employment by an Indian tribe alone does not qualify a recipient for the exclusion, but the exclusion for employer-provided health coverage, discussed above, may apply.

<sup>106</sup> The term “Indian tribe” means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined by, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et. seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. Secs. 139D(c)(1), 45A(c)(6). The term “tribal organization” has the same meaning as such term in section 4(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(1)). Sec. 139D(c)(2).

## **2. Deductions**

### **HSAs and Archer MSAs**

Subject to limits, an individual with a high deductible health plan generally may contribute to an HSA or an Archer MSA.<sup>107</sup> Contributions made by an individual to an HSA or Archer MSA are deductible in determining adjusted gross income (that is, an above-the-line deduction).

### **Deduction for health insurance premiums of self-employed individuals**

A self-employed individual may take a deduction in determining adjusted gross income (that is, an above-the-line deduction) for the cost of health insurance for the individual and the individual's spouse, dependents and, under the ACA, children up to age 26.<sup>108</sup> The deduction is not available for any month in which the self-employed individual is eligible to participate in a subsidized health plan provided by an employer of the individual or a family member. The amount of the deduction may not exceed the individual's earned income.<sup>109</sup> The deduction applies only to insurance premiums; it does not apply to out-of-pocket expenses that are not reimbursed by insurance). The deduction does not apply for purposes of taxes under the Self-Employment Contributions Act, discussed below.<sup>110</sup>

### **Itemized deduction for medical expenses and ACA change**

Individuals may claim an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed a certain percentage of adjusted gross income.<sup>111</sup> Before the ACA, the percentage was 7.5 percent for all taxpayers.<sup>112</sup> The ACA generally changed the percentage to 10 percent. Thus, an individual claiming the itemized deduction may

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<sup>107</sup> Secs. 223 and 220. Subject to certain exceptions, an individual must be covered only by a high deductible health plan, and no other health plan, in order to be eligible to make HSA or Archer MSA contributions. An individual covered by Medicare is not eligible to make HSA or Archer MSA contributions. The contribution limits and other rules relating to HSAs and Archer MSAs are discussed in Part I.A.3. An individual may be subject to an excise tax under section 4973 if contributions exceeding the limits are made.

<sup>108</sup> Sec. 162(l). The exclusion for employer-provided health benefits, discussed in Part I.A, does not apply to self-employed individuals (that is, independent contractors, sole proprietors or partners of a partnership). Under section 1372, an employee of an S corporation who owns more than 2 percent of the S corporation ("2-percent shareholder") is treated as a partner for this purpose and for purposes of the deduction under section 162(l).

<sup>109</sup> Earned income is defined in section 401(c) and generally means the individual's trade or business income reduced by business expenses.

<sup>110</sup> Secs. 1401-1403.

<sup>111</sup> Sec. 213.

<sup>112</sup> Before the ACA, under section 56(b)(1)(B), the percentage was 10 percent for alternative minimum tax ("AMT") purposes.

deduct health insurance premiums only to the extent that aggregate unreimbursed medical expenses exceed 10 percent of adjusted gross income.

For taxable years beginning before January 1, 2017, the prior-law threshold of 7.5 percent (rather than the 10-percent threshold) applies in the case of taxpayers who have attained the age of 65 before the close of the taxable year.<sup>113</sup>

### **3. Refundable tax credits**

#### **Premium assistance credit**

##### Background on Exchanges under the ACA

The ACA provides for the establishment of Exchanges (also commonly called “Marketplaces”), through which individuals can purchase health insurance coverage.<sup>114</sup> A health insurance plan offered through an Exchange established under the ACA (a “qualified health plan”) must meet certain requirements, including offering certain specified benefits (“essential health benefits”).<sup>115</sup>

As part of the process of enrollment in a qualified health plan, an individual may apply and be approved in advance for a premium assistance credit (discussed below).<sup>116</sup> The individual must provide information on income, family size, and changes in marital or family status or income. Initial eligibility for the premium assistance credit is generally based on the individual’s income for the tax year ending two years prior to the enrollment period. If an individual is approved for a premium assistance credit, the Department of the Treasury pays the credit amount directly to the health plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the difference between the premium tax credit amount and the total premium charged for the plan. As part of the enrollment process, an individual who enrolls in a silver plan<sup>117</sup> may also apply and be approved for reduced cost-sharing.<sup>118</sup>

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<sup>113</sup> Sec. 213(f). In the case of married taxpayers, the 7.5 percent threshold applies if either spouse has obtained the age of 65 before the close of the taxable year. For these taxpayers, the percentage continues to be 10 percent for AMT purposes.

<sup>114</sup> Under section 1312(f)(3) of PPACA, an individual who is not a citizen or national of the United States or an alien lawfully present in the United States is not eligible to enroll in individual coverage through an Exchange. Under 1312(a)(2) and (f)(2) of PPACA, small employers can offer health insurance coverage to their employees through a SHOP Exchange, and, beginning 2017, States may allow coverage for employees of large employers to be offered.

<sup>115</sup> Secs. 1301 and 1302 of PPACA.

<sup>116</sup> Secs. 1411-1412 of PPACA.

<sup>117</sup> A qualified health plan is categorized by level (bronze, silver, gold or platinum), depending on its actuarial value, that is the percentage of the plan’s share of the total costs of benefits under the plan. Actuarial value is determined under section 1302(d) of PPACA. Under section 1302(d)(B) of PPACA, a silver level plan must have an actuarial value of 70 percent.

### Premium assistance credit provisions in general

A refundable tax credit (the “premium assistance credit”) is available for certain taxpayers who purchase a qualified health plan for themselves and their families through an Exchange established under the ACA.<sup>119</sup> The premium assistance credit, which, as described above, is payable in advance directly to the insurer, subsidizes the purchase of a qualified health plan through an Exchange established under the ACA.<sup>120</sup>

The premium assistance credit is available for taxpayers with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved who do not receive health insurance through an employer or a spouse’s employer, as discussed below, and are not eligible for certain other types of coverage, such as Medicare or Medicaid. Household income is defined as the sum of (1) the taxpayer’s modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining that taxpayer’s family size who are required to file a tax return for the taxable year. Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,<sup>121</sup> (2) any tax-exempt interest received or accrued during the tax year, and (3) an amount equal to the portion of the taxpayer’s social security benefits that is not included in gross income (that is, the amount of the taxpayer’s social security benefits that are excluded from gross income).<sup>122</sup> To be eligible for the premium assistance credit, taxpayers who are married must file a joint return. Individuals who are listed as dependents on a return are ineligible for the premium assistance credit.

Generally, a taxpayer who is an employee and is offered minimum essential coverage<sup>123</sup> under an employer-sponsored health plan is ineligible for the premium assistance credit.

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<sup>118</sup> Sections 1402 and 1411-1412 of PPACA provide for the cost-sharing subsidies. The reduced cost-sharing subsidy increases the plan’s share of total costs to (but not to more than) certain levels. The determination of a share (expressed as a percentage) of total costs is an actuarial value determination under section 1302(d) of PPACA. The levels of cost sharing are 94 percent for individuals with household income between 100 and 150 percent of FPL; 87 percent for those between 150 and 200 percent of FPL; and 73 percent for those between 201 and 250 percent of FPL. In addition, in the case of those between 251 and 400 percent of FPL, there is no cost sharing subsidy. Under a silver plan, the plan’s share of total costs is 70 percent. Reduced cost-sharing cannot increase the plan’s share of total costs to more than 70 percent. As discussed in Part I.B.1, if a full-time employee is approved for a premium assistance credit or reduced cost-sharing, the employer may be liable for an assessable payment under section 4980H. Under the ACA sections 1411(e)(4)(B)(ii) and (C) and (f)(2), an employer must be notified if one of its employees is determined to be eligible for a premium assistance credit or reduced cost-sharing and be provided with an appeals process.

<sup>119</sup> Sec. 36B.

<sup>120</sup> Sections 1411 and 1412 of PPACA provide rules relating to advance payment of the premium assistance credit.

<sup>121</sup> Sec. 911.

<sup>122</sup> The amount of Social Security benefits included in gross income is determined under section 86.

<sup>123</sup> Minimum essential coverage is defined in section 5000A(f).

However, if an employee’s share of the premium for self-only coverage exceeds 9.66 percent (for 2016) of the employee's household income, or the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent of such costs (called “minimum value”),<sup>124</sup> and the employee declines the employer-offered coverage, the employee may be eligible for the premium assistance credit.

Amount of premium assistance credit

The premium assistance credit amount is generally the lower of (1) the premium for the qualified health plan in which the individual or family enrolls and (2) the premium for the second lowest cost silver plan in the rating area where the individual resides, reduced by the individual’s or family’s share of premiums.<sup>125</sup> As shown in Table 1 below, an individual’s or family’s share of premiums is a certain percentage of household income. The percentage is 2.03 percent for household income up to 133 percent of FPL and is determined on a sliding scale in a linear manner as household income rises from 133 percent of FPL to 400 percent of FPL.

**Table 1.—Taxpayer’s Share of Premiums  
(for 2016)<sup>126</sup>**

<i>Household income (expressed as a percent of FPL)</i>	<i>Initial percentage of household income</i>	<i>Final percentage of household income</i>
100% up to 133%	2.03	2.03
133% up to 150%	3.05	4.07
150% up to 200%	4.07	6.41
200% up to 250%	6.41	8.18

<sup>124</sup> Treas. Reg. sec. 1.36B-2(c)(3)(vi) provides guidance on the determination of whether coverage under a plan provides minimum value.

<sup>125</sup> The premium assistance amount is determined on a monthly basis and the credit for a year is the sum of the monthly amounts.

<sup>126</sup> Rev. Proc. 2014-62, 2014-2 C.B. 948. The percentages are indexed to the excess of premium growth over income growth for the preceding calendar year. After 2018, if the aggregate amount of premium assistance credits (and cost-sharing reductions under section 1402 of PPACA) exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year.

<i>Household income (expressed as a percent of FPL)</i>	<i>Initial percentage of household income</i>	<i>Final percentage of household income</i>
250% up to 300%	8.18	9.66
300% up to 400%	9.66	9.66

Reconciliation of advance payment on return

A taxpayer on whose behalf advance payments of the premium assistance credit for a taxable year are made is required to file an income tax return to reconcile the advance payments with the credit to which the taxpayer is entitled for the taxable year.<sup>127</sup>

If the advance payments of the premium assistance credit exceed the amount of credit to which the taxpayer is entitled, the excess (“excess advance payments”) is treated as an additional tax liability on the taxpayer’s income tax return for the taxable year, subject to a limitation on the amount of liability in some cases.<sup>128</sup> For persons with household income below 400 percent of FPL, the liability for the overpayment for a taxable year is limited to a specific dollar amount (the “applicable dollar amount”) as shown in Table 2 below.

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<sup>127</sup> A taxpayer is not required to apply for advance payments and may instead just claim the credit on his or her income tax return.

<sup>128</sup> As discussed below, section 35 provides an advanceable, refundable credit for the purchase of health insurance, the health coverage tax credit, for certain individuals. Section 35(g)(12) provides rules for coordination between HCTC and premium assistance credit eligibility and advance payments.

**Table 2.—Reconciliation Limit on Additional Tax Liability  
(for 2016)<sup>129</sup>**

<i>Household income (expressed as a percent of FPL)</i>	<i>Applicable dollar amount</i>
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,550

If the advance payments of the premium assistance credit for a taxable year are less than the amount of the credit to which the taxpayer is entitled, the additional credit amount is also reflected on the taxpayer’s income tax return for the year.

**Health Coverage Tax Credit**

Eligible coverage months

In the case of an eligible individual, a refundable tax credit is provided for 72.5 percent of the individual’s premiums for qualified health insurance of the individual and qualifying family members for each eligible coverage month beginning in the taxable year.<sup>130</sup> The credit is commonly referred to as the health coverage tax credit (“HCTC”). The credit is available only with respect to amounts paid by the individual for the qualified health insurance.

Eligibility for the credit is determined on a monthly basis. In general, an eligible coverage month is any month if, as of the first day of the month, the individual is an eligible individual, is covered by qualified health insurance, the premium for which is paid by the individual, does not have other specified coverage, and is not imprisoned under Federal, State, or local authority. In the case of a joint return, the eligibility requirements are met if at least one spouse satisfies the requirements.

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<sup>129</sup> Rev. Proc. 2015-53, 2015-44 I.R.B. 615. The applicable dollar amounts are indexed to reflect cost-of-living increases, with the amount of any increase rounded down to the next lowest multiple of \$50. One-half of the applicable dollar amount shown in Table 2 applies to an unmarried individual who is not a surviving spouse or a head of household.

<sup>130</sup> Sec. 35. Qualifying family members are the individual’s spouse and any dependent for whom the individual is entitled to claim a dependency exemption. Any individual who has certain specified coverage is not a qualifying family member.

The HCTC was originally available for coverage months beginning after 2001<sup>131</sup> and, as a result of later legislation, expired for coverage months beginning after 2013. As described below, advance payment of the credit was also available. The HCTC was reinstated in 2015, retroactive to coverage months beginning after 2013 with a direction to the Secretary of the Treasury to establish, no later than one year after date of enactment of the reinstatement of the credit, a new program for making advance HCTC payments to providers of insurance on behalf of enrolled eligible individuals.<sup>132</sup> The program is to only provide retroactive advance payments of the credit for coverage months occurring after the end of such one year period.

### Election of HCTC

In order to coordinate eligibility for the premium assistance credit with eligibility for HCTC, to be eligible for the HCTC for any eligible coverage month during a taxable year after 2013, the eligible individual must elect the HCTC. Further, except as the Secretary of the Treasury may provide, the election applies for that coverage month and all subsequent eligible coverage months during the taxable year, must be made no later than the due date, with any extension, for filing his or her income tax return for the year, and is irrevocable.<sup>133</sup> Further, the period for assessing any deficiency attributable to the election (or revocation of the election, if permitted) does not expire before one year after the date on which the Secretary of the Treasury is notified of the election (or revocation). The taxpayer is not entitled to the premium assistance credit for any coverage month for which the individual elects the HCTC.

### Eligible individuals

An eligible individual is an individual who is (1) an eligible Trade Adjustment Assistance (“TAA”) recipient, (2) an eligible alternative TAA recipient or an eligible reemployment TAA recipient, or (3) an eligible Pension Benefit Guaranty Corporation (“PBGC”) pension recipient. In general, an individual is an eligible TAA recipient for a month if the individual (1) receives for any day of the month a trade readjustment allowance under the Trade Act of 1974 or would be eligible to receive such an allowance but for the requirement that the individual exhaust unemployment benefits before being eligible to receive an allowance and (2) with respect to such allowance, is covered under a required certification. An individual is an eligible alternative TAA recipient or an eligible reemployment TAA recipient for a month if the individual participates in a certain program under the Trade Act of 1974 and receives a related benefit for the month. Generally, an individual is an eligible PBGC pension recipient for any month if the individual

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<sup>131</sup> The HCTC was originally added to the Code by the Trade Adjustment Assistance Reform Act of 2002, Pub. L. No. 107-210, secs. 201(a), 202 and 203 (2002).

<sup>132</sup> The HCTC was reinstated retroactively on June 29, 2015, by section 407 of the Trade Preferences Extension Act of 2015, Pub. L. No. 114-27.

<sup>133</sup> For any taxable year beginning after December 31, 2013, and before the date of reinstatement of the HCTC (June 29, 2015), the election to claim the HCTC may be made any time on or after the date of enactment and before the expiration of the 3-year period of limitation with respect to such taxable year and may be made on an amended income tax return. Notice 2016-02, 2016-2 I.R.B. 265, provides guidance for taxpayers claiming the HCTC for 2014 and 2015.

(1) is age 55 or over as of the first day of the month and (2) receives a benefit for the month, any portion of which is paid by the PBGC. A person who may be claimed as a dependent on another person's tax return is not an eligible individual. In addition, an otherwise eligible individual is not eligible for the credit for a month if, as of the first day of the month, the individual has certain specified coverage, such as certain employer-provided coverage or coverage under certain governmental health programs.<sup>134</sup>

### Qualified health insurance

Qualified health insurance eligible for the credit is: (1) coverage under a COBRA continuation provision;<sup>135</sup> (2) State-based continuation coverage provided by the State under a State law that requires such coverage; (3) coverage offered through a qualified State high risk pool; (4) coverage under a health insurance program offered to State employees or a comparable program; (5) coverage through an arrangement entered into by a State and a group health plan, an issuer of health insurance coverage, an administrator, or an employer; (6) coverage offered through a State arrangement with a private sector health care coverage purchasing pool; (7) coverage under a State-operated health plan that does not receive any Federal financial participation; (8) coverage under a group health plan that is available through the employment of the eligible individual's spouse; (9) coverage under individual health insurance, provided the coverage is not purchased through an Exchange established under the ACA;<sup>136</sup> and (10) coverage under an employee benefit plan funded by a VEBA<sup>137</sup> established pursuant to an order of a bankruptcy court (or by agreement with an authorized representative).<sup>138</sup>

Qualified health insurance does not include any State-based coverage (*i.e.*, coverage described in (2)-(7) in the preceding paragraph) unless the State has elected to have such coverage treated as qualified health insurance and such coverage meets certain consumer-protection requirements.<sup>139</sup> Such State coverage must provide that each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs eligibility certificate and pays the remainder of the premium. In addition, the State-based coverage cannot impose any pre-existing condition limitation with respect to qualifying individuals. State-based coverage cannot require a qualifying individual to pay a

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<sup>134</sup> See section 35(f) for a description of certain specified coverage.

<sup>135</sup> COBRA continuation provision is defined by section 9832(d)(1).

<sup>136</sup> For this purpose, "individual health insurance" means any insurance that constitutes medical care offered to individuals other than in connection with a group health plan. The requirement that, in order to be qualified health insurance based on being individual health insurance, the health plan not be purchased through an Exchange does not apply to coverage months in taxable years beginning before 2016.

<sup>137</sup> See Part I.C.3 for a discussion of VEBAs.

<sup>138</sup> See 11 U.S.C. sec. 1114.

<sup>139</sup> For guidance on how a State elects a health program to be qualified health insurance for purposes of the credit, see Rev. Proc. 2004-12, 2004-1 C.B. 528.

premium or contribution that is greater than the premium or contribution for a similarly situated individual who is not a qualified individual. Finally, benefits under the State-based coverage must be the same as (or substantially similar to) benefits provided to similarly situated individuals who are not qualifying individuals.

A qualifying individual for this purpose is an eligible individual who seeks to enroll in the State-based coverage and who has aggregate periods of creditable coverage<sup>140</sup> of three months or longer, does not have other specified coverage, and is not imprisoned. However, State-based coverage that satisfies any or all of the consumer-protection requirements for State-based coverage with respect to all eligible individuals is also qualified health insurance for purposes of HCTC.<sup>141</sup>

Qualified health insurance does not include coverage under a flexible spending or similar arrangement or any insurance if substantially all of the coverage is for excepted benefits.

#### Advance payment of HCTC

The credit is available on an advance payment basis by means of payments by the Department of the Treasury (“Treasury”) once a qualified health insurance costs credit eligibility certificate is in effect.<sup>142</sup> In some cases, Treasury may also make retroactive payments on behalf of a certified individual for qualified health insurance coverage for eligible coverage months occurring before the first month for which an advance payment is otherwise made on behalf of the individual. With respect to any taxable year, the amount which is allowed as HCTC for an eligible individual for a taxable year is reduced (but not below zero) by the aggregate amount of advance HCTC payments on behalf of the eligible individual for months beginning in the taxable year.

In the case of an eligible individual on whose behalf advance HCTC payment or advance premium assistance payment is made for months occurring during a taxable year and who subsequently elects HCTC for any eligible months,<sup>143</sup> the individual’s income tax liability is increased by the amount of the advance payment, but then offset by the amount of the HCTC allowed to the individual.<sup>144</sup> If the individual on whose behalf the advance HCTC payment is made does not elect HCTC but instead claims the premium assistance credit for any coverage months, the increase in tax liability equal to the advance payment is offset by the amount of the

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<sup>140</sup> Creditable coverage is determined under section 9801(c).

<sup>141</sup> See Q&A-10 of Notice 2005-50, 2005-2 C.B. 14.

<sup>142</sup> Sec. 7527.

<sup>143</sup> Receipt of advance HCTC payments during a year does not in itself constitute an election of the HCTC for the year.

<sup>144</sup> If a premium assistance credit is also allowed to the individual for months before the first month for which the HCTC is elected, the amount of the individual’s allowed premium assistance credit is also taken into account in applying the offset.

allowable premium assistance credit, and any remaining tax liability attributable to the advance payment (and advance premium assistance payment, if any) is limited in the same way as if the advance HCTC payment had instead been advance premium assistance payment.

Agency outreach

The Secretaries of the Treasury, HHS, and Labor and the Director of the PBGC are directed to carry out programs of public outreach, including on the Internet, to inform potential HCTC-eligible individuals of the extension of HCTC availability and the availability of the election to claim such credit retroactively for coverage months beginning after 2013.

## B. Additional Taxes

### 1. Requirement for individuals to maintain minimum essential coverage and reporting

#### Requirement to maintain minimum essential coverage

##### Requirement to maintain coverage

Under the ACA, individuals must be covered by a health plan that provides at least minimum essential coverage or be subject to a tax for failure to maintain the coverage (commonly referred to as the “individual mandate”).<sup>145</sup> If an individual is a dependent<sup>146</sup> of another taxpayer, the other taxpayer is liable for any tax for failure to maintain the required coverage with respect to the individual. The tax is imposed for any month that an individual does not have minimum essential coverage unless the individual qualifies for an exemption for the month as described below.

##### Minimum essential coverage

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. Certain individuals present or residing outside of the United States<sup>147</sup> and bona fide residents of territories of the United States<sup>148</sup> are deemed to maintain minimum essential coverage.

Minimum essential coverage does not include coverage that consists of only certain excepted benefits.<sup>149</sup> Excepted benefits include: (1) coverage only for accident, or disability income insurance; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers’ compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to

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<sup>145</sup> Sec. 5000A. Treas. Reg. secs. 1.5000A-1 through 1.5000A-5 provide guidance on this provision.

<sup>146</sup> Sec. 152.

<sup>147</sup> This rule applies to any month that occurs during a period described in section 911(d)(1)(A) or (B) which is applicable to an individual. Such periods include: (1) for a United States citizen, an uninterrupted period which includes an entire taxable year during which the individual is a bona fide resident of a foreign country or countries, and (2) for a United States citizen or resident, a period of 12 consecutive months during which the individual is present in a foreign country at least 330 full days.

<sup>148</sup> Bona fide residence in a territory is determined under section 937(a). For this purpose, the territories include Puerto Rico, Guam, the Northern Mariana Islands, American Samoa, and United States Virgin Islands.

<sup>149</sup> Sec. 2791(c)(1)-(4) of PHS (42 U.S.C. sec. 300gg-91(c)(1-4)). A parallel definition of excepted benefits is provided in section 9832(c)(1)-(4).

other insurance benefits. Other excepted benefits that do not constitute minimum essential coverage if offered under a separate policy, certificate or contract of insurance include long-term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance.

#### Tax on failure to maintain minimum essential coverage

The tax for failure to maintain minimum essential coverage for any calendar month is one-twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of the flat dollar amount or the excess income amount. The flat dollar amount is the lesser of the sum of the individual annual dollar amounts for the members of the taxpayer's family and 300 percent of the adult individual dollar amount. The excess income amount is a specified percentage of the excess of the taxpayer's household income for the taxable year over the threshold amount of income for required income tax return filing for that taxpayer.<sup>150</sup> The total annual household payment may not exceed the national average annual premium for bronze level health plans offered through Exchanges established under the ACA that year for the applicable family size. The individual adult annual dollar amount is phased in over the first three years as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016.<sup>151</sup> For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount. The specified percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015.

#### Exemptions

Exemptions from the requirement to maintain minimum essential coverage are provided for the following: (1) an individual for whom coverage is unaffordable because the required contribution exceeds eight percent of household income, (2) an individual with household income below the income tax return filing threshold, (3) a member of an Indian tribe, (4) a member of certain recognized religious sects or a health sharing ministry, (5) an individual with a coverage gap for a continuous period of less than three months, and (6) an individual who is determined by the Secretary of HHS to have suffered a hardship with respect to the capability to obtain coverage.

#### **Reporting of health insurance coverage**

The ACA requires every person that provides minimum essential coverage to any individual during a calendar year (including health insurance issuers, employers that self-insure, and an executive department or agency of a governmental unit that provides coverage under a government sponsored program) to file a return reporting certain health insurance coverage information to the IRS and furnish a statement to each covered individual.<sup>152</sup> However, this

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<sup>150</sup> Sec. 6012(a).

<sup>151</sup> For years after 2016, the \$695 amount is indexed to CPI-U, rounded to the next lowest multiple of \$50.

<sup>152</sup> Sec. 6055.

reporting is not required for coverage under a qualified health plan purchased in the individual market through an Exchange established under the ACA. In the case of coverage provided by a governmental unit, or any agency or instrumentality thereof, the reporting requirement applies to the person or employee appropriately designated for purposes of making the returns and statements required by the provision.<sup>153</sup>

A coverage provider who fails to comply with these reporting requirements is subject to the penalties for failure to file an information return and failure to furnish payee statements, respectively.

The information required to be reported on the return for the calendar year of coverage includes: (1) the name, address, and employer identification number (“EIN”) of the reporting entity required to file the return; (2) the name, address, and taxpayer identification number (“TIN”) of the responsible individual<sup>154</sup> (except that the TIN is not required for a responsible individual not enrolled in the coverage); (2) the name and TIN (or date of birth if TIN is not available) of each other individual obtaining coverage under the health plan; (3) for each covered individual, the months for which, for at least one day, the individual was enrolled in coverage and entitled to receive benefits during the calendar year; and (4) any other information specified in forms, instructions, or published guidance.<sup>155</sup>

To the extent health insurance coverage is provided through an employer-sponsored group health plan, the coverage provider’s return is also required to report (1) the name, address and employer identification number of the employer, whether the coverage is a qualified health plan enrolled in through the SHOP Exchange and the SHOP Exchange’s unique identifier, and any other information specified in forms, instructions, or published guidance.<sup>156</sup>

The coverage provider is required to file the return with the IRS by February 28 (March 31 if filed electronically), and furnish the statement to the covered individual by January 31, of the year following the calendar year in which it provided minimum essential coverage to the covered individual.<sup>157</sup> The forms for the return for an applicable large employer<sup>158</sup> providing

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<sup>153</sup> Sec. 6055(d). Treas. Reg. sec. 1.6055-1(c)(2)(ii) and (3) for special rules for governmental providers.

<sup>154</sup> Under Treas. Reg. sec. 1.6055-1(b)(11), the responsible individual includes a primary insured, employee, former employee, uniform services sponsor, parent, or other related person named on an application who enrolls one or more individuals including himself or herself, in minimum essential coverage.

<sup>155</sup> Treas. Reg. sec. 1.6055-1(e)(1).

<sup>156</sup> Treas. Reg. sec. 1.6055-1(e)(2).

<sup>157</sup> Treas. Reg. sec. 1.6055-1(f) provides guidance on the time and for filing the return. In Notice 2016-4, 2016-3 I.R.B. 279, the IRS extended the deadline for reporting to the IRS for 2015 coverage to May 31, 2016 (June 30, 2016 for electronic filing, and the deadline for providing the report to an individual to March 31, 2016. Further, the IRS has announced that there will be no penalties for incorrect or incomplete reporting of 2015 coverage as long as the reporting entity made a good faith effort to comply. See Q&A-3 in Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055) available at <https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055>.

coverage are Form 1094-C and Form 1095-C. The forms for the return for other coverage providers are Form 1094-5 and Form 1095-B. The statement furnished to the covered individual must also include the name, address and contact information of the reporting coverage provider. The return is required to be provided electronically to the IRS if the provider is required to provide at least 250 returns of any type. Rules are provided in the regulations for when a provider is permitted to provide the statement to a covered individual electronically, including affirmative consent.<sup>159</sup>

The IRS is required, not later than June 30 of each year, in consultation with the Secretary of HHS, to provide an annual notice to each individual who files an income tax return and who fails to enroll in minimum essential coverage. The notice is required to include information on the services available through the Exchange established under the ACA for the individual's State of residence.<sup>160</sup>

## **2. Medicare taxes**

### **Social Security and Medicare taxes - in general**

The Federal Insurance Contributions Act ("FICA") imposes tax on employers and employees based on the amount of wages (as defined for FICA purposes) paid to an employee during the year.<sup>161</sup> The tax imposed on the employer and on the employee is each composed of two parts: (1) the Social Security or old age, survivors, and disability insurance ("OASDI") tax equal to 6.2 percent of covered wages up to the taxable wage base (\$118,500 for 2016); and (2) the Medicare or hospital insurance ("HI") tax equal to 1.45 percent of all covered wages. The employee portion of the FICA tax generally must be withheld and remitted to the Federal government by the employer. If the employer fails to withhold the employee portion, the employer is generally liable for the amount that should have been withheld.

Instead of FICA taxes, railroad employers and employees are subject, under the Railroad Retirement Tax Act ("RRTA"), to taxes equivalent to the OASDI and Medicare taxes under FICA with respect to compensation as defined for RRTA purposes ("RRTA compensation").<sup>162</sup> The employee portion of RRTA taxes generally must be withheld from an employee's RRTA compensation and remitted to the Federal government by the employer.

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<sup>158</sup> Applicable large employer is defined in section 4980H(c)(2).

<sup>159</sup> Treas. Reg. sec.1.6055-2.

<sup>160</sup> Sec. 1501(c) of PPACA.

<sup>161</sup> Secs. 3101-3128.

<sup>162</sup> Secs. 3201-3233.

As a parallel to FICA and RRTA taxes, the Self-Employment Contributions Act (“SECA”) imposes tax on the self-employment income of self-employed individuals.<sup>163</sup> The rate of the OASDI portion of SECA tax is equal to the combined employee and employer OASDI FICA tax rates (12.4 percent) and applies to self-employment income up to the FICA taxable wage base (reduced by FICA wages, if any). Similarly, the rate of the Medicare portion of SECA tax is the same as the combined employer and employee Medicare rates (2.9 percent) and applies to all self-employment income.<sup>164</sup>

### **Additional Medicare tax under the ACA**

Under the ACA, an additional Medicare tax of 0.9 percent is imposed on employees and self-employed individuals with FICA wages, RRTA compensation or self-employment income exceeding a threshold amount.

Under FICA and RRTA, the employee portion of the Medicare tax (not the employer portion) is increased by an additional tax of 0.9 percent on wages received in excess of the threshold amount. The threshold amount is \$250,000 in the case of a joint return, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case. Thus, in the case of a joint return, the additional Medicare tax is based on the combined wages of an employee and the employee’s spouse.

The employer is required to withhold the additional Medicare tax from an employee’s wages and RRTA compensation only to the extent wages or compensation paid to the employee by the employer exceeds \$200,000. The employer’s withholding obligation does not depend on the amount of the employee’s ultimate liability for the additional Medicare tax, if any. That is, the amount required to be withheld may be more or less than the employee’s ultimate liability. If the employee’s liability is more than the amount withheld, the employee must pay the additional amount. If the employee’s liability is less than the amount withheld, the employee may claim a refund.

The additional Medicare tax applies also to self-employment income in excess of the threshold amount. As in the case of the additional Medicare tax for employees, the threshold amount for the additional SECA Medicare tax is \$250,000 in the case of a joint return, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case.<sup>165</sup>

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<sup>163</sup> Secs. 1401-1403.

<sup>164</sup> In computing self-employment income, taxpayers are permitted a deduction equal to the product of the taxpayer’s net earnings (determined without regard to this deduction) and one-half of the sum of the rates for OASDI (12.4 percent) and Medicare (2.9 percent), *i.e.*, 7.65 percent of net earnings. This deduction parallels FICA in that the FICA rates apply to an employee’s wages, which do not include FICA taxes paid by the employer, whereas the self-employed individual’s net earnings are economically equivalent to an employee’s wages plus the employer share of FICA taxes. In addition, under section 164(f), a self-employed individual may deduct for income tax purposes one-half of his or SECA taxes. This deduction parallels FICA in that an employee does not include in income FICA taxes paid by the employer.

<sup>165</sup> The additional Medicare tax is not taken into account for purposes of the deduction applicable in computing self-employment income or the income tax deduction for SECA taxes.

The threshold amount is reduced (but not below zero) by the amount of wages taken into account in determining the individual's additional FICA Medicare tax, if any. Thus, only a single threshold amount applies for an individual (or individual and spouse) with both FICA wages and self-employment income.<sup>166</sup>

### **3. Tax on net investment income for high-income taxpayers**

#### **In general**

Under the ACA, a tax is imposed with respect to unearned income on certain high-income individuals, estates and trusts.<sup>167</sup> In the case of an individual, the tax is 3.8 percent of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount.

The threshold amount is \$250,000 in the case of a joint return or surviving spouse, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case.

Modified adjusted gross income is adjusted gross income increased by the amount excluded from income as foreign earned income under section 911(a)(1) (net of the deductions and exclusions disallowed with respect to the foreign earned income).

In the case of an estate or trust, the tax is 3.8 percent of the lesser of undistributed net investment income or the excess of adjusted gross income (as defined in section 67(e)) over the dollar amount at which the highest income tax bracket applicable to an estate or trust begins.

The tax does not apply to a nonresident alien or to a trust all the unexpired interests in which are devoted to charitable purposes. The tax also does not apply to a trust that is exempt from tax under section 501 or a charitable remainder trust exempt from tax under section 664.

The tax is subject to the individual estimated tax provisions. The tax is not deductible in computing any tax imposed by subtitle A of the Code (relating to income taxes).

#### **Net investment income**

Net investment income is investment income reduced by the deductions properly allocable to such income.

Investment income is the sum of (i) gross income from interest, dividends, annuities, royalties, and rents (other than income derived from any trade or business to which the tax does not apply), (ii) other gross income derived from any business to which the tax applies, and (iii)

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<sup>166</sup> There is no similar provision to apply only a single threshold amount for an individual (or individual and spouse) with both RRTA compensation and self-employment income or both FICA wages and RRTA compensation.

<sup>167</sup> Sec. 1411.

net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business to which the tax does not apply.<sup>168</sup>

In the case of a trade or business, the tax applies if the trade or business is a passive activity with respect to the taxpayer or the trade or business consists of trading financial instruments or commodities (as defined in section 475(e)(2)). The tax does not apply to other trades or businesses conducted by a sole proprietor, partnership, or S corporation.

In the case of the disposition of a partnership interest or stock in an S corporation, gain or loss is taken into account only to the extent gain or loss would be taken into account by the partner or shareholder if the entity had sold all its properties for fair market value immediately before the disposition. Thus, only net gain or loss attributable to property held by the entity which is not property attributable to an active trade or business is taken into account.<sup>169</sup>

Income, gain, or loss on working capital is not treated as derived from a trade or business. Investment income does not include distributions from a qualified retirement plan or amounts subject to SECA tax.

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<sup>168</sup> Gross income does not include items, such as interest on tax-exempt bonds, veterans' benefits, and excluded gain from the sale of a principal residence, which are excluded from gross income under the income tax.

<sup>169</sup> For this purpose, a business of trading financial instruments or commodities is not treated as an active trade or business.

### III. BUSINESS-RELATED PROVISIONS

#### A. Tax Treatment of Certain Health Insurers

##### 1. General income tax treatment

###### **Taxation of stock and mutual companies providing health insurance**

Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Both mutual insurance companies and stock insurance companies are subject to Federal income tax under these rules. Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property and casualty insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.<sup>170</sup>

###### **Qualified nonprofit health insurance issuers under the ACA**<sup>171</sup>

The ACA authorizes \$6 billion in funding<sup>172</sup> for, and instructs the Secretary of HHS to establish, the Consumer Operated and Oriented Plan (the “CO-OP program”) to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans. Federal funds are to be distributed as loans to assist with start-up costs and grants to assist in meeting State solvency requirements.

Under section 501(c)(29), as enacted in the ACA, an organization receiving a grant or loan under the program qualifies for exemption from Federal income tax under section 501(a) of the Code with respect to periods during which the organization is in compliance with the above-described requirements of the CO-OP program and with the terms of any CO-OP program grant or loan agreement to which such organization is a party.<sup>173</sup>

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<sup>170</sup> Sec. 816(a).

<sup>171</sup> For a detailed discussion of the rules relating to qualified nonprofit health insurance issuers, see Joint Committee on Taxation, *Present Law Relating to Qualified Nonprofit Health Insurance Issuers Established Pursuant to Section 1322 of the Patient Protection and Affordable Care Act* (JCX-2-16), January 19, 2016.

<sup>172</sup> Funding for the CO-OP program subsequently was reduced to \$2.4 billion.

<sup>173</sup> Sec. 501(c)(29)(A).

## Other Tax-Exempt Insurers

### Health maintenance organizations exempt from tax under section 501(c)(3)

Certain health maintenance organizations (“HMOs”) have been held to qualify for tax exemption as charitable organizations described in section 501(c)(3). In *Sound Health Association v. Commissioner*,<sup>174</sup> the Tax Court held that a staff model HMO qualified as a charitable organization. A staff model HMO generally employs its own physicians and staff and serves its subscribers at its own facilities. In *Geisinger Health Plan v. Commissioner*,<sup>175</sup> the court applied the section 501(c)(3) community benefit standard to an individual practice association (“IPA”) model HMO. In the IPA model, health care generally is provided by physicians practicing independently in their own offices, with the IPA usually contracting on behalf of the physicians with the HMO.<sup>176</sup>

### Other insurers exempt from tax under section 501(c)

Although most organizations that engage principally in insurance activities are not exempt from Federal income tax, certain organizations that engage in insurance activities are described in section 501(c) and exempt from tax under section 501(a). Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than \$600,000 (\$150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals.

### Prohibition of tax exemption under section 501(c)(3) or (4) for certain organizations providing commercial-type insurance

Section 501(m) provides that an organization may not be exempt from tax under section 501(c)(3) (generally, charitable organizations) or section 501(c)(4) (social welfare organizations) unless no substantial part of its activities consists of providing commercial-type insurance. For this purpose, commercial-type insurance excludes, among other things: (1) insurance provided at

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<sup>174</sup> 71 T.C. 158 (1978), *acq.* 1981-2 C.B. 2.

<sup>175</sup> 985 F.2d 1210 (3<sup>rd</sup> Cir. 1993), *rev'g* T.C. Memo. 1991-649.

<sup>176</sup> See also *IHC Health Plans, Inc. v. Commissioner*, 325 F.3d 1188 (10<sup>th</sup> Cir. 2003), in which the court ruled that three affiliated HMOs did not operate primarily for the benefit of the community they served. The organizations in the case did not provide health care directly, but provided group insurance that could be used at both affiliated and non-affiliated providers. The court found that the organizations primarily performed a risk-bearing function and provided virtually no free or below-cost health care services. In denying charitable status, the court held that a health-care provider must make its services available to all in the community plus provide additional community or public benefits.

substantially below cost to a class of charitable recipients; and (2) incidental health insurance provided by an HMO of a kind customarily provided by such organizations.

## 2. Deductions

### Treatment of certain health organizations

#### In general

A property and casualty insurance company is subject to tax on its taxable income, generally defined as its gross income less allowable deductions.<sup>177</sup> For this purpose, gross income includes underwriting income and investment income, as well as other items. Underwriting income is the premiums earned on insurance contracts during the year, less losses incurred and expenses incurred. The amount of losses incurred is determined by taking into account the discounted unpaid losses. Premiums earned during the year is determined taking into account a 20-percent reduction in the otherwise allowable deduction, intended to represent the allocable portion of expenses incurred in generating the unearned premiums.<sup>178</sup>

As discussed above, present law provides that an organization described in sections 501(c)(3) or (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance.<sup>179</sup> When this rule was enacted in 1986,<sup>180</sup> special rules were provided under section 833 for Blue Cross and Blue Shield organizations providing health insurance that (1) were in existence on August 16, 1986; (2) were determined at any time to be tax-exempt under a determination that had not been revoked; and (3) were tax-exempt for the last taxable year beginning before January 1, 1987 (when the present-law rule became effective), provided that no material change occurred in the structure or operations of the organizations after August 16, 1986, and before the close of 1986 or any subsequent taxable year. Any other organization is eligible for section 833 treatment if it meets six requirements set forth in section 833(c): (1) substantially all of its activities involve providing health insurance; (2) at least 10 percent of its health insurance is provided to individuals and small groups (not taking into account Medicare supplemental coverage); (3) it provides continuous full-year open enrollment for individuals and small groups; (4) for individuals, it provides full coverage of pre-existing conditions of high-risk individuals and coverage without regard to age, income, or employment

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<sup>177</sup> Sec. 832.

<sup>178</sup> Sec. 832(b)(4)(B).

<sup>179</sup> Sec. 501(m).

<sup>180</sup> See H. Rep. 99-426, Tax Reform Act of 1985, (December 7, 1985), p. 664. The Committee stated, “[T]he availability of tax-exempt status under [then-] present law has allowed some large insurance entities to compete directly with commercial insurance companies. For example, the Blue Cross/Blue Shield organizations historically have been treated as tax-exempt organizations described in sections 501(c)(3) or (4). This group of organizations is now among the largest health care insurers in the United States.” See also Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986*, JCS-10-87 (May 4, 1987), pp. 583-592.

of individuals under age 65; (5) at least 35 percent of its premiums are community rated; and (6) no part of its net earnings inures to the benefit of any private shareholder or individual.

Section 833 provides a deduction with respect to health business of such organizations. The deduction is equal to 25 percent of the sum of (1) claims incurred, and liabilities incurred under cost-plus contracts, for the taxable year, and (2) expenses incurred in connection with administration, adjustment, or settlement of claims or in connection with administration of cost-plus contracts during the taxable year, to the extent this sum exceeds the adjusted surplus at the beginning of the taxable year. Only health-related items are taken into account.

Section 833 provides an exception for such an organization from the application of the 20-percent reduction in the deduction for increases in unearned premiums that applies generally to property and casualty companies.

Section 833 provides that such an organization is taxable as a stock property and casualty insurer under the Federal income tax rules applicable to property and casualty insurers.

#### ACA change

As modified by the ACA, Code section 833 applies a medical loss ratio threshold. The consequences for not meeting the medical loss ratio threshold are that the 25-percent deduction for claims and expenses and the exception from the 20-percent reduction in the deduction for unearned premium reserves are not allowed. In calculating the medical loss ratio, the organization includes both the cost of reimbursement for clinical services provided to the individuals they insure and the cost of activities that improve health care quality. This determination is made on an annual basis and affects the application of the 25-percent deduction for that year.

### **Limit under the ACA on deduction for compensation paid by health insurance providers**

#### Limit on deduction for compensation of certain executives of public companies

An employer generally may deduct reasonable compensation for personal services as an ordinary and necessary business expense.<sup>181</sup> However, in the case of a publicly held corporation, a deduction limit of \$1 million generally applies to compensation of a covered employee.<sup>182</sup> For this purpose, covered employees include any employee who is (1) as of the close of the employer's taxable year, the principal executive officer (or an individual acting in such capacity) defined by reference to the Securities Exchange Act of 1934 ("Exchange Act"), or (2) among the three most highly compensated officers for the taxable year (other than the principal executive officer), again defined by reference to the Exchange Act.<sup>183</sup>

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<sup>181</sup> Sec. 162.

<sup>182</sup> Sec. 162(m)(1)-(4).

<sup>183</sup> Notice 2007-49, 2007-25 I.R.B. 1429.

The following types of compensation are not taken into account in applying the limit: (1) remuneration payable on a commission basis (“commission compensation”); (2) remuneration payable solely on account of the attainment of one or more performance goals if certain outside director and shareholder approval requirements are met (“performance-based compensation”); (3) payments to a tax-qualified retirement plan (including salary reduction contributions); and (4) benefits that are excludable from the employee’s gross income.

The deduction limit applies with respect to compensation of an employee who is a covered employee for the employer’s taxable year that would otherwise be deductible for that taxable year, regardless of the employee’s status when the compensation was earned. Thus, for example, compensation earned as a covered employee, but paid (and otherwise deductible) in a later year for which the employee is not a covered employee is not subject to the limit.

#### Limit on compensation deduction of health insurance providers

Under the ACA, the deduction allowable for compensation attributable to services performed by an applicable individual for a covered health insurance provider during a taxable year is limited to \$500,000.<sup>184</sup> Applicable individuals include all officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of a covered health insurance provider. In general, an insurance provider is a covered health insurance provider if at least 25 percent of the insurance provider’s gross premium income from health business is derived from health insurance plans that provide minimum essential coverage.<sup>185</sup>

For purposes of this limit, performance-based and commission-based compensation (as described above) are taken into account. In addition, the deduction limit applies without regard to whether compensation is otherwise deductible for the taxable year during which services are performed or a subsequent taxable year. In the case of remuneration that relates to services that an applicable individual performs during a taxable 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.

### **3. Other taxes and fees**

#### **Annual fee on health insurance providers**

Under the ACA, an annual fee applies to any covered entity engaged in the business of providing health insurance with respect to United States (“U.S.”) health risks.<sup>186</sup> The aggregate

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<sup>184</sup> Sec. 162(m)(6). All members of any controlled group of corporations (within the meaning of section 414(b)), other businesses under common control (within the meaning of section 414(c)), or affiliated service group (within the meaning of sections 414(m) and (o)) are generally treated as a single employer for purposes of the deduction limitation.

<sup>185</sup> Minimum essential coverage is defined in section 5000A(f).

<sup>186</sup> Sec. 9010 of PPACA.

annual fee for all covered entities is the applicable amount. The applicable amount is \$8 billion for calendar year 2014, \$11.3 billion for calendar years 2015 and 2016, and \$14.3 billion for calendar year 2018. A one-year moratorium on the annual fee on health insurance providers applies for calendar year 2017.<sup>187</sup> For calendar years after 2018, the applicable amount is indexed to the rate of premium growth.

The aggregate annual fee is apportioned among the providers based on a ratio designed to reflect relative market share of U.S. health insurance business. For each covered entity, the fee for a calendar year is an amount that bears the same ratio to the applicable amount as (1) the covered entity's net premiums written during the preceding calendar year with respect to health insurance for any U.S. health risk bears to (2) the aggregate net written premiums of all covered entities during such preceding calendar year with respect to such health insurance.

### **Qualified long-term care insurance contracts**

Tax-favored treatment applies to premiums and benefits under a qualified long-term care insurance contract.<sup>188</sup> The contract is treated as an accident and health insurance contract; thus, amounts received under the contract generally are excludable from income as amounts received for personal injuries or sickness.<sup>189</sup> An employer-sponsored health plan that provides employees with coverage under a qualified long-term care insurance contract generally is treated in the same manner as employer-provided health benefits. As a result, the employer's premium payments are generally excluded from income and wages,<sup>190</sup> and benefits payable under the contract generally are excludable from the recipient's income. Long-term care insurance expenses of a self-employed individual are deductible under the self-employed health insurance deduction. In addition, premiums paid for a qualified long-term care insurance contract and unreimbursed expenses for qualified long-term care services are treated as medical expenses for purposes of the itemized deduction for medical care.<sup>191</sup>

A qualified long-term care insurance contract is defined as any insurance contract that provides only coverage for qualified long-term care services and that meets additional

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<sup>187</sup> Pub. L. No. 114-113, Div. P, sec. 201.

<sup>188</sup> Sec. 7702B(a).

<sup>189</sup> In the case of per diem contracts, the excludable amount is subject to a per-day dollar cap. If payments under such contracts exceed the dollar cap, then the excess is excludable only to the extent of actual costs in excess of the dollar cap that are incurred for long-term care services.

<sup>190</sup> However, section 106(c) provides that gross income of an employee includes employer-provided coverage of qualified long-term care services to the extent such coverage is provided through a flexible spending or similar arrangement. Thus, the exclusion does not apply to qualified long-term care insurance provided under a cafeteria plan.

<sup>191</sup> Under section 213(d)(10), premiums paid for long-term care coverage are deductible only to the extent that the premiums do not exceed a dollar cap measured by the insured's age at the end of the taxable year.

requirements.<sup>192</sup> Per diem-type and reimbursement-type contracts are permitted. Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.<sup>193</sup>

The definition of qualified long-term care insurance contract includes a requirement that long-term care contract terms, and issuers of such contracts, satisfy certain consumer protection provisions of the long-term care insurance model act and model regulation promulgated by the National Association of Insurance Commissioners (“NAIC”) (as adopted as of January 1993).<sup>194</sup> In the case of a failure to meet these requirements, an excise tax may be imposed on the issuer of the long-term care insurance contract equal to \$100 per insured per day.<sup>195</sup>

Specifically, issuers of long-term care insurance contracts must meet the consumer protection requirements under the model regulation relating to application forms and replacement coverage, reporting requirements, marketing, appropriateness of recommended purchase, standard format outline of the coverage, delivering a shopper's guide, right to return, outline of coverage, certificates under group plans, policy summary, monthly reports on accelerated death benefits, and incontestability period. Further, under the consumer protection requirements for issuers, if an application for a qualified long-term contract (or certificate under such contract) is approved, the issuer must deliver the applicant (or policyholder or certificate holder) the contract (or certificate) of the insurance not later than 30 days after the date of approval. If a claim under a qualified long-term care contract is denied, the issuer must, within 60 days of a written request by the policy holder or certificate holder, provide a written explanation of the reasons for the denial and make available all information relating to the denial. Also, the issuer must disclose in the policy and outline of coverage that the policy is intended to be a qualified long-term care insurance contract.

For purposes of both the requirements as to contract terms and the requirements relating to issuers of contracts, the determination of whether any requirement of a model regulation or model act has been met is made by the Secretary.<sup>196</sup>

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<sup>192</sup> Sec. 7702B(b). For example, the contract is not permitted to provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed (and any premium refunds must be applied as a reduction in future premiums or to increase future benefits).

<sup>193</sup> Sec. 7702B(c)(1). A chronically ill individual is generally one who has been certified within the previous 12 months by a licensed health care practitioner as being unable to perform (without substantial assistance) at least two activities of daily living (“ADLs”) for at least 90 days due to a loss of functional capacity (or meeting other definitional requirements). Sec. 7702B(c)(2).

<sup>194</sup> Sec. 7702B(b)(1)(F) and (g).

<sup>195</sup> Sec. 4980C. In the case of a failure that is due to reasonable cause (and not to willful neglect), the Secretary may waive all or part of the tax to the extent that payment of the tax would be excessive relative to the failure involved.

<sup>196</sup> Sec. 7702B(g)(2)(B)(iii).

## **B. Section 501(c)(3) Hospitals**

### **Tax exemption for certain hospitals**

The Code does not provide a per se exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and otherwise meets the requirements of section 501(c)(3).<sup>197</sup> The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.<sup>198</sup> It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care. Since 1969, the IRS has applied a “community benefit” standard for determining whether a hospital is charitable.<sup>199</sup> According to Revenue Ruling 69-545, community benefit can include, for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees composed of representatives of the community; operating with an open medical staff policy, with privileges available to all qualifying physicians; providing charity care; and utilizing surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education and research.

### **Additional requirements for section 501(c)(3) hospitals under the ACA**

The ACA establishes additional requirements applicable to section 501(c)(3) hospitals, which are set forth in new section 501(r) of the Code. Section 501(r) provides that each hospital facility: (1) must conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment; (2) must adopt, implement, and widely publicize a written financial assistance policy; (3) is permitted to bill for emergency or other medically necessary care provided to individuals who qualify for financial assistance under the facility’s financial assistance policy no more than the amounts generally billed to individuals who have insurance covering such care; and (4) may not undertake extraordinary collection actions (even if otherwise permitted by law) against an individual without first making reasonable efforts to determine whether the individual is eligible for assistance under the hospital’s financial assistance policy. The section 501(r) requirements are in addition to, and not in lieu of, other requirements applicable to an organization described in section 501(c)(3).

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<sup>197</sup> Section 501(c)(3) hospitals are classified as public charities rather than private foundations. See secs. 509(a)(1) and 170(b)(1)(A)(iii).

<sup>198</sup> Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 7.6 (11th ed. 2016) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

<sup>199</sup> Rev. Rul. 69-545, 1969-2 C.B. 117. From 1956 until 1969, the IRS applied a “financial ability” standard, requiring that a charitable hospital be “operated to the extent of its financial ability for those not able to pay for the services rendered and not exclusively for those who are able and expected to pay.” Rev. Rul. 56-185, 1956-1 C.B. 202.

## C. Other Health-Related Business Provisions

### 1. Credit for clinical testing expenses for certain drugs for rare diseases or conditions

The Code provides a 50-percent business tax credit for qualified clinical testing expenses incurred in testing of certain drugs for rare diseases or conditions, generally referred to as “orphan drugs.”<sup>200</sup> Qualified clinical testing expenses are costs incurred to test an orphan drug after the drug has been approved for human testing by the Food and Drug Administration (“FDA”) but before the drug has been approved for sale by the FDA.<sup>201</sup> A rare disease or condition is defined as one that (1) affects less than 200,000 persons in the United States, or (2) affects more than 200,000 persons, but for which there is no reasonable expectation that businesses could recoup the costs of developing a drug for such disease or condition from sales in the United States of the drug.<sup>202</sup>

Amounts included in computing the credit under this section are excluded from the computation of the research credit under section 41.<sup>203</sup>

### 2. Annual fee on branded prescription pharmaceutical manufacturers and importers

The ACA imposed an annual fee on covered entities engaged in the business of manufacturing or importing branded prescription drugs for sale to any specified government program or pursuant to coverage under any such program.<sup>204</sup> Fees collected are credited to the Medicare Part B trust fund.

The aggregate annual fee imposed on all covered entities is \$3 billion for calendar years 2014 through 2016, \$4 billion for calendar year 2017, \$4.1 billion for calendar year 2018, and \$2.8 billion for calendar year 2019 and thereafter. The aggregate fee is apportioned among the covered entities each year based on their relative share of branded prescription drug sales taken into account during the previous calendar year.

A covered entity’s relative market share for a calendar year is the entity’s branded prescription drug sales taken into account during the preceding calendar year as a percentage of the aggregate branded prescription drug sales of all covered entities taken into account during the preceding calendar year. Sales taken into account during any calendar year with respect to a covered entity is: (1) zero percent of sales not more than \$5 million; (2) 10 percent of sales over \$5 million but not more than \$125 million; (3) 40 percent of sales over \$125 million but not

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<sup>200</sup> Sec. 45C.

<sup>201</sup> Sec. 45C(b).

<sup>202</sup> Sec. 45C(d).

<sup>203</sup> Sec. 45C(c).

<sup>204</sup> Sec. 9008 of PPACA as amended by sec. 1404 of the HCERA.

more than \$225 million; (4) 75 percent of sales over \$225 million but not more than \$400 million; and (5) 100 percent of sales over \$400 million.

A covered entity is any manufacture or importer with gross receipts from branded prescription drug sales. All persons treated as a single employer under section 52(a) or (b) or under section 414(m) or 414(o) are treated as a single covered entity. In applying the single employer rules under 52(a) and (b), foreign corporations are not excluded. If more than one person is liable for payment of the fee, all such persons are jointly and severally liable for payment of such fee.

Branded prescription drug sales are sales of branded prescription drugs made to any specified government program, or pursuant to coverage under any such program. The term branded prescription drugs includes any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act and for which an application was submitted under section 351(a) of such Act. Branded prescription drug sales do not include sales of any drug or biological product with respect to which an orphan drug tax credit was allowed for any taxable year under section 45C. The exception for orphan drug sales does not apply to any drug or biological product after such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the rare disease or condition with respect to which the section 45C credit was allowed.

Specified government programs include: (1) the Medicare Part D program under part D of title XVIII of the Social Security Act; (2) the Medicare Part B program under part B of title XVIII of the Social Security Act; (3) the Medicaid program under title XIX of the Social Security Act; (4) any program under which branded prescription drugs are procured by the Department of Veterans Affairs; (5) any program under which branded prescription drugs are procured by the Department of Defense; or (6) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

For purposes of procedure and administration, the fees are treated in the same manner as those excise taxes identified in subtitle F, "Procedure and Administration" for which the only avenue for judicial review is a civil action for refund. Thus, the fees may be assessed and collected using the procedures in subtitle F without regard to the restrictions on assessment in section 6213.

The fee is required to be paid no later than an annual payment date determined by the Secretary of the Treasury, but in no event later than September 30th each calendar year.

For purposes of section 275, relating to the nondeductibility of specified taxes, the fee is considered to be a nondeductible tax described in section 275(a)(6).

### **3. Excise tax on certain medical devices**

The ACA provided for a new excise tax on certain medical devices.<sup>205</sup> Under that provision, a tax equal to 2.3 percent of the sale price is imposed on the sale of any taxable

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<sup>205</sup> Sec. 4191.

medical device by the manufacturer, producer, or importer of such device. A taxable medical device is any device, as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act,<sup>206</sup> intended for humans. Regulations further define a medical device as one that is listed by the Food and Drug Administration (“FDA”) under section 510(j) of the Federal Food, Drug, and Cosmetic Act and 21 C.F.R. Part 807, pursuant to FDA requirements.<sup>207</sup>

The excise tax does not apply to eyeglasses, contact lenses, hearing aids, or any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use (“retail exemption”). Regulations provide guidance on the types of devices that are exempt under the retail exemption. A device is exempt under these provisions if: (1) it is regularly available for purchase and use by individual consumers who are not medical professionals; and (2) the design of the device demonstrates that it is not primarily intended for use in a medical institution or office or by a medical professional.<sup>208</sup> Additionally, the regulations provide certain safe harbors for devices eligible for the retail exemption.<sup>209</sup>

The medical device excise tax is generally subject to the rules applicable to other manufacturers excise taxes. These rules include certain general manufacturers excise tax exemptions including the exemption for sales for use by the purchaser for further manufacture (or for resale to a second purchaser in further manufacture) or for export (or for resale to a second purchaser for export).<sup>210</sup> If a medical device is sold free of tax for resale to a second purchaser for further manufacture or for export, the exemption does not apply unless, within the six-month period beginning on the date of sale by the manufacturer, the manufacturer receives proof that the medical device has been exported or resold for use in further manufacturing.<sup>211</sup> In general, the exemption does not apply unless the manufacturer, the first purchaser, and the

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<sup>206</sup> 21 U.S.C. sec. 321. Section 201(h) defines device as “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.”

<sup>207</sup> Treas. Reg. sec. 48.4191-2(a). The regulations also include as devices items that should have been listed as a device with the FDA as of the date the FDA notifies the manufacturer or importer that corrective action with respect to listing is required.

<sup>208</sup> Treas. Reg. sec. 48.4191-2(b)(2).

<sup>209</sup> Treas. Reg. sec. 48.4191-2(b)(2)(iii). The safe harbors include devices that are described as over-the-counter devices in relevant FDA classification headings as well as certain FDA device classifications listed in the regulations.

<sup>210</sup> Sec. 4221(a). Other general manufacturers excise tax exemptions (*i.e.*, the exemption for sales to purchasers for use as supplies for vessels or aircraft, to a State or local government, to a nonprofit educational organization, or to a qualified blood collector organization) do not apply to the medical device excise tax.

<sup>211</sup> Sec. 4221(b).

second purchaser are registered with the Secretary of the Treasury. Foreign purchasers of articles sold or resold for export are exempt from the registration requirement.

The lease of a medical device is generally considered to be a sale of such device.<sup>212</sup> Special rules apply for the imposition of tax to each lease payment. The use of a medical device subject to tax by manufacturers, producers, or importers of such device, is treated as a sale for the purpose of imposition of excise taxes.<sup>213</sup>

There are also rules for determining the price of a medical device on which the excise tax is imposed.<sup>214</sup> These rules provide for (1) the inclusion of containers, packaging, and certain transportation charges in the price, (2) determining a constructive sales price if a medical device is sold for less than the fair market price, and (3) determining the tax due in the case of partial payments or installment sales.

The PATH Act<sup>215</sup> contained a provision that suspended the medical device excise tax for a period of two years, for sales on or after January 1, 2016 and before January 1, 2018.

#### **4. Excise tax on indoor tanning services**

A retail excise tax is imposed on indoor tanning services (including services paid for by insurance).<sup>216</sup> The tax rate is ten percent of the amount paid for such services. Consumers are liable for the tax, with service providers being responsible for collecting and remitting the tax to the Federal Government.<sup>217</sup>

Indoor tanning services are services employing any electronic product designed to induce skin tanning and which incorporate one or more ultraviolet lamps with wavelengths in air between 200 and 400 nanometers. Taxable services do not include phototherapy service performed by a licensed medical professional.

#### **5. Patient-Centered Outcomes Research Trust Fund excise taxes**

The ACA established the Patient-Centered Outcomes Research Institute, a nonprofit corporation (not part of the Federal Government) to support research, evidence synthesis, and dissemination of research findings with respect to “the manner in which diseases, disorders, and

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<sup>212</sup> Sec. 4217(a).

<sup>213</sup> Sec. 4218.

<sup>214</sup> Sec. 4216.

<sup>215</sup> Pub. L. No. 114-113, Div. Q, sec. 174.

<sup>216</sup> Sec. 5000B.

<sup>217</sup> This structure is like that of other excise taxes, such as the communications excise tax on local telephone service and the domestic air passenger excise tax.

other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored and managed.”<sup>218</sup>

The Patient-Centered Outcomes Research Institute is funded through the Patient-Centered Outcomes Research Trust Fund (the “PCORI Fund”).<sup>219</sup> The PCORI Fund receives net revenues from excise taxes (referred to statutorily as “fees”) generally imposed on health insurance policies and self-insured health plans.<sup>220</sup> These excise taxes are effective for policy years ending after September 30, 2012, and before October 1, 2019.

For fiscal year 2016, the tax rate for “specified health insurance policies” is \$2.17. For “applicable self-insured plans,” the tax rate for fiscal year 2016 is \$2.17. In both cases, the tax is determined by applying the applicable rate to the average number of lives covered under the policy or plan. Both tax rates are indexed to reflect annual increases in the per capita amount of national health expenditures.

The taxes are imposed on the issuers of specified health insurance policies or plan sponsors of applicable self-insured health plans, including governmental entities (other than Medicare, Medicaid, the State Children’s Health Insurance Program (“SCHIP”), and Federal programs for providing medical care (other than through insurance policies) to members of the Armed Forces, veterans, or members of Indian tribes). The taxes further are imposed both within the 50 States and the District of Columbia and in all U.S. possessions.

## **6. Vaccine Injury Compensation Trust Fund excise taxes**

### **In general**

A 75-cents-per-dose<sup>221</sup> excise tax<sup>222</sup> is imposed on the sale or use by a manufacturer or importer of listed vaccines to finance the Vaccine Injury Compensation Trust Fund program. The tax is imposed on sale or use by private parties and governmental entities, including the Federal, State, and local governments. The tax further is imposed within the 50 States, the District of Columbia, and all U.S. possessions.

The following table lists the currently taxable vaccines.

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<sup>218</sup> Sec. 6301(b) of PPACA.

<sup>219</sup> Sec. 9511.

<sup>220</sup> Secs. 4375-4377.

<sup>221</sup> Vaccines comprised of more than one taxable component vaccine are taxed as if the components were separate doses.

<sup>222</sup> Sec. 4131.

<b>Taxable Vaccines:</b>
Any vaccine containing diphtheria toxoid
Any vaccine containing tetanus toxoid
Any vaccine containing pertussis bacteria, extracted or partial cell bacteria, or specific pertussis antigens
Any vaccine against measles, mumps, or rubella
Any vaccine containing polio virus
Any vaccine against hepatitis A, hepatitis B, chicken pox, or rotavirus gastroenteritis
Any conjugate vaccine against streptococcus pneumoniae
Any trivalent vaccine against influenza or any other vaccine against seasonal influenza
Any meningococcal vaccine
Any vaccine against the human papillomavirus
Any HIB vaccine

### **Overview of Vaccine Injury Compensation Trust Fund provisions**

Operation of the Vaccine Injury Compensation Trust Fund is governed by parallel provisions of the Code and authorizing statutes.<sup>223</sup> The Code provisions govern deposit of net revenues into the Trust Fund and approve general expenditure programs. The authorizing statutes specify expenditure purposes.

Amounts in the Vaccine Injury Compensation Trust Fund are available, as provided in appropriations Acts, for the following:

1. Payment of compensation under subtitle 2 of Title XXI of the Public Health Service Act (as in effect on October 18, 2000) for vaccine-related injury or death with respect to any vaccine which is (a) administered after September 30, 1988, and (b) a taxable vaccine (defined in sec. 4132(a)(1)) at the time compensation is paid; and
2. Payment of expenses of administration (not to exceed \$9.5 million for any fiscal year) incurred by the Federal Government in administering subtitle 2.

Liability of the United States relating to vaccine injury compensation is limited to the amount in the Vaccine Injury Compensation Trust Fund, and any claim filed against the Trust Fund may be paid only out of the Fund.

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<sup>223</sup> Sec. 9510 and 42 U.S.C. sec. 300aa.

## 7. Black Lung Disability Trust Fund excise taxes

### Coal excise tax

To finance the Black Lung Disability Trust Fund, an excise tax is imposed on producers of coal mined in the United States.<sup>224</sup> The tax rate is \$1.10 per ton for coal from underground mines and 55 cents per ton for coal from surface mines. Both rates are limited to a maximum of 4.4 percent of the coal's selling price. The coal excise tax rates are scheduled to decline to 50 cents per ton for underground mines and 25 cents per ton for surface mines (both limited to two percent of the coal's selling price) on the earlier of January 1, 2019 or the first January 1 after which there is no balance of repayable advances from the General Fund that have been made to the Trust Fund and no unpaid interest on previous such advances.<sup>225</sup>

The tax does not apply to lignite<sup>226</sup> or to coal mined in the United States that is to be exported.<sup>227</sup>

### Black lung benefit trusts and penalty excise taxes

Present law allows coal mine operators that are liable for paying black lung benefits to miners or their survivors to fund that liability through deductible contributions to a qualified tax-exempt trust.<sup>228</sup> To qualify, the trust must be established for the sole purpose of satisfying the operator's liability under Black Lung Acts, paying premiums for insurance exclusively covering such liability, and paying administrative expenses of the trust.

The Code imposes three "penalty excise taxes" to regulate potential misuse of monies in these trusts. Revenues from the penalty excise taxes are dedicated to the Black Lung Disability Trust Fund. The following table summarizes these penalty excise taxes.

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<sup>224</sup> Sec. 4121.

<sup>225</sup> Sec. 4121(e).

<sup>226</sup> Sec. 4121(c).

<sup>227</sup> See *Ranger Fuel Corp. v. U.S.*, 33 F.Supp.2d 466 (E.D. Va., 1998).

<sup>228</sup> Sec. 501(c)(21).

Tax (and Code Section)	Tax Rates
<b>Self-dealing (sec. 4951)<sup>229</sup></b>	<p><i>Initial tax.</i>—Ten percent of the amount of self-dealing on the self-dealer; 2.5 percent of such amount on the trustee</p> <p><i>Additional tax.</i>—If not corrected, additional tax of 100 percent of amount involved on the self-dealer; 50 percent of such amount on the trustee</p>
<b>Taxable expenditures (sec. 4952)<sup>230</sup></b>	<p><i>Initial tax.</i>—Ten percent of taxable expenditure on the fund; 2.5 percent of such amount on the trustee</p> <p><i>Additional tax.</i>—If not corrected, additional tax of 100 percent of amount of expenditure on the fund; 50 percent of such amount on the trustee</p>
<b>Excess contributions to benefit trust (sec. 4953)<sup>231</sup></b>	Five percent of excess contribution on the contributor

### **Overview of Black Lung Disability Trust Fund expenditure provisions**

In general.—Operation of the Black Lung Disability Trust Fund is governed by parallel provisions of the Code and authorizing statutes.<sup>232</sup> The Code provisions govern deposit of revenues into the Trust Fund and approve general expenditure programs. The authorizing statutes specify expenditure programs.

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<sup>229</sup> Self-dealing is defined as sale, leasing, etc. of real or personal property, lending of money or other extension of credit, furnishing of goods, services or facilities, and payment of compensation between a benefit trust and a disqualified person. A disqualified person is a contributor to the benefit trust, a trustee, or an owner of more than ten percent of the combined voting power of a corporation, the profits interest of a partnership, or the beneficial interest of a trust or unincorporated entity that is a contributor to the benefit trust. Officers, directors, and employees of contributors to the benefit trust and spouses, family members, and certain related corporations and trusts also are disqualified persons.

<sup>230</sup> A taxable expenditure is any expenditure other than for a purpose described in section 501(c)(21).

<sup>231</sup> An “excess contribution” is any amount greater than the amount deductible under sec. 192, defined as (1) amounts necessary to fund (with level funding) the remaining unfunded liability of the taxpayer for black lung claims of the employer’s past and present employees or (2) amounts necessary to provide a trust balance equal to the amounts payable for the taxable year.

<sup>232</sup> Sec. 9501 and 30 U.S.C. sec. 901 et. seq.

Black Lung Disability Trust Fund expenditure purposes.—Amounts in the Trust Fund are available, as provided in appropriation Acts, for the following purposes:

1. Payment of benefits under section 422 of the Black Lung Benefits Act in cases where the Secretary of Labor determines that (a) the coal mine operator liable for the payment of such benefits has not commenced payment of benefits within 30 days after the date of an initial determination of eligibility or has not made a payment within 30 days after the payment is due, or (b) there is no operator who is liable for payment of such benefits;
2. Payment of obligations incurred by the Secretary of Labor for claims of miners or their survivors where the miner's last coal mine employment was before January 1, 1970;
3. Repayment to the General Fund of amounts paid by the Secretary of Labor for claims under part C of the Black Lung Benefits Act that were attributable to eligibility between January 1, 1974 and March 31, 1978;
4. Repayment of advances (and interest on advances) to the General Fund;
5. Payment of administrative expenses incurred on or after March 1, 1978, by the Department of Labor or Department of Health and Human Services under Part C of the Black Lung Benefits Act (other than sections 427(a) or 433), or by the Treasury Department in administering the excise tax and the Trust Fund;
6. Reimbursement of operators for amounts paid (other than for penalties or interest) before April 1, 1978, in satisfaction of claims of miners whose last employment in coal mines was terminated before January 1, 1970; and
7. Reimbursement of operators and insurers for amounts paid (other than for penalties, interest, or attorney's fees) for any claim denied before March 1, 1978, and which is or has been approved under section 435 of the Black Lung Benefits Act.

## **8. Coal industry retiree health benefits**

Two multiemployer plans providing retiree health benefits for employees in the coal industry (and their beneficiaries) are established under the Code: the United Mine Workers of America ("UMWA") Combined Benefit Fund ("Combined Fund") and the UMWA 1992 Benefit Plan ("1992 Benefit Plan").<sup>233</sup> Retiree health benefits are provided also by the UMWA 1993 Benefit Plan ("1993 Benefit Plan"), established under the National Bituminous Coal Wage Agreement of 1993, and by plans maintained by particular employers ("individual employer plans").

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<sup>233</sup> Section 9702 provides for the establishment of the Combined Fund, and section 9712 provides for the establishment of the 1992 Plan. These are part of Chapter 99 of the Code (secs. 9701-9722), enacted by the Coal Industry Retiree Health Act of 1992 (the "Coal Act"), Pub. L. No. 102-486.

The Code provides for the retirees to be covered by the Combined Fund and the 1992 Benefit Plan and the benefits to be provided by each plan.<sup>234</sup> The Code also requires coverage under individual employer plans to be provided to certain participants (and related beneficiaries).<sup>235</sup>

The Combined Fund and the 1992 Benefit Plan are funded in part by premiums required under the Code to be paid by coal mining operators and by transfers from the Abandoned Mine Lands Reclamation Fund.<sup>236</sup> Failure to pay required premiums with respect to an individual may result in the imposition of a penalty of \$100 per day for the period from when the premium was due until the premium is paid.<sup>237</sup> In addition, a civil action may be brought by a plan fiduciary, employer, or plan participant or beneficiary with respect to an obligation to pay the required premiums, in the same manner as a claim arising from an employer's obligation to pay withdrawal liability under ERISA with respect to a multiemployer pension plan.<sup>238</sup>

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<sup>234</sup> Secs. 9703 and 9712.

<sup>235</sup> Sec. 9711.

<sup>236</sup> Secs. 9704 and 9712(d). Under the Surface Mining Control and Reclamation Act of 1977 ("SMCRA"), Pub. L. No. 95 -87, coal mining operators are required to pay certain fees to the Secretary of the Interior, which are deposited in the Abandoned Mine Lands Reclamation Fund (commonly referred to as the "AML Fund"). In addition to uses relating to mining reclamation, the Secretary of the Treasury is authorized to transfer certain amounts from the AML Fund to the Combined Fund, the 1992 Benefit Plan, and the 1993 Benefit Plan (which is referred to in SMCRA as the "Multiemployer Health Benefit Plan") if needed to provide the benefits due under the plans.

<sup>237</sup> Sec. 9707. The penalty may apply also with respect to contributions required to be made to the 1993 Benefit Plan.

<sup>238</sup> Sec. 9721 and ESRISA sec. 4301.

## **PART TWO: ESTIMATES OF TAX SUBSIDIES AND RECEIPTS RELATING TO SELECTED FEATURES OF PRESENT LAW**

### **In general**

This section provides estimates of tax subsidies and receipts for certain provisions related to health care. These estimates are similar, but not identical to, tax expenditure estimates. Tax expenditures are defined under the Congressional Budget and Impoundment Control Act of 1974 (the “Budget Act”) as “revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax or a deferral of tax liability.” Thus, tax expenditures include any reduction in income tax liabilities that result from special tax provisions or regulations that provide tax benefits to particular taxpayers. Conceptually, a tax expenditure is measured by the difference between tax liability under present law and the tax liability that would result from a recomputation of tax without benefit of the tax expenditure provision.<sup>239</sup>

Note that the estimate of a tax expenditure is not equivalent to a Joint Committee revenue estimate of a proposal to repeal the tax benefit in question. A Joint Committee revenue estimate of a repeal compares *predicted* Federal revenues under repeal with *predicted* revenues under present law. Because the revenue estimate involves predictions of revenues both under the proposal and under present law, it requires consideration and modeling of factors that may change revenues in the future, such as relevant taxpayer behavior. As a result, revenue estimates include economic and behavioral effects of taxpayer behavior, such as shifts in timing and type of consumption; and tax planning and tax avoidance (or evasion) strategies. These models also take into account certain projected economic, demographic, and social trends that may influence the size and composition of the taxpayer population for each future year.

In contrast, conventional Joint Committee estimates of tax expenditures generally do not include any of these economic and behavioral assumptions, an approach meant to simplify the calculation and conform to the presentation of government outlays. An exception to this absence of behavior in conventional Joint Committee tax expenditure calculations is that a taxpayer is assumed to make simple additions or deletions in filing tax forms, what the Joint Committee staff refers to as “tax form behavior.” Generally, when a particular tax benefit is repealed, taxpayers are assumed to claim the next best tax treatment. For example, a taxpayer that is eligible for one of two alternative credits is assumed to file for the second credit if the first credit is eliminated.

### **Tax subsidies for health**

Table 3 below shows estimates of certain tax subsidies for the health care sector in calendar year 2016. These estimates differ from conventional Joint Committee estimates of tax expenditures in three respects. First, they do not include effects of “tax form behavior.” For example, conventional Joint Committee tax expenditure estimates assume that when taxpayers are denied an exclusion for employer sponsored insurance, they may deduct premiums under

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<sup>239</sup> See Joint Committee on Taxation, *Background Information on Tax Expenditure Analysis and Historical Survey of Tax Expenditure Estimates* (JCX-18-15), February 2015.

section 213 to the extent that their expenses exceed 10 percent of adjusted gross income (7.5 percent of adjusted gross income for taxpayers aged 65 or older). However, the estimates in Table 3 reflect the full value of the tax exclusion to taxpayers. They do not assume that, if the exclusion for employer sponsored health insurance were repealed, employees would take into account the insurance premiums towards the section 213 medical expense deduction.

Second, Table 3 includes payroll tax (FICA) effects, whereas conventional tax expenditures are calculated only with respect to their effect on income taxes. The estimate for the FICA effect of the employer exclusion in Table 1 does not reflect the effect of changes in current FICA liability on the present value of taxpayers' future social security benefits.

Third, Table 3 shows tax subsidies in a single calendar year. Conventional Joint Committee tax expenditure estimates measure expenditures over several fiscal years.

According to Table 3, the largest tax subsidy is the exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums. The premium tax credit for purchase of insurance through exchange marketplaces is the next largest tax subsidy, but at a total of \$35.9 billion, is only a fraction of the size of the expenditure for employer-provided health care benefits. The relative scale of these estimates is consistent with Congressional Budget Office projections that in 2016, 155 million people under age 65 will receive employer-based health insurance coverage; 10 million people will receive health insurance coverage purchased through exchanges and subsidized through a tax credit; and two million people will receive coverage through the exchange but without the benefit of a tax credit.<sup>240</sup>

The remaining tax subsidies, such as the deduction for medical expenses and long-term care expenses; the deduction for health insurance premiums and long-term care insurance by the self-employed; and the deduction for contributions to health savings accounts are all smaller still.

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<sup>240</sup> See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016-2026*, March 2016, p. 30.

**Table 3.—Estimated Value of Certain Tax Subsidies for Health Care,  
Calendar Year 2016**

	<b>Billions of Dollars</b>
Exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums .....	323.3
Income .....	198.3
FICA.....	124.5
HI surtax <sup>1</sup> .....	0.5
Memorandum: amount attributable to Flexible Spending Arrangements.....	5.4
Premium tax credit for purchase of insurance through exchange marketplaces..	35.9
Deduction for medical expenses and long-term care expenses .....	10.3
Deduction for health insurance premiums and long-term care insurance by the self-employed.....	6.3
Deductible contributions to health savings accounts.....	2.2
Small business tax credit.....	1.2
Health coverage tax credit.....	[2]

<sup>[1]</sup> Additional Medicare tax of 0.9 percent on earned income in excess of \$200,000 in the case of a joint return, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case (unindexed).

<sup>[2]</sup> Loss of less than \$50 million.

**Tax receipts related to financing the Affordable Care Act**

Table 4 provides estimates of baseline receipts from certain taxes enacted in the Affordable Care Act for calendar year 2016. Conceptually, these estimates measure the difference between tax liability under present law and the tax liability that would result from a recomputation of tax without the relevant provision. As with Table 3, the estimates in Table 4 include FICA effects and include only assumptions of “tax form behavior” but not any other economic and behavioral responses by taxpayers.

According to Table 4, receipts from the 3.8 percent surtax on investment income for high AGI taxpayers are estimated to be \$28.7 billion in calendar year 2016. Receipts from the annual fee on health insurance providers (net of offset),<sup>241</sup> the additional health insurance tax of 0.9

<sup>241</sup> In estimating the revenue effects of changes in excise taxes, the Joint Committee staff generally assumes that the net effect on total Federal tax receipts from an increase in Federal excise taxes is less than the increase in gross excise tax receipts. The difference arises because an increase in excise taxes results in a decrease in income subject to Federal income and payroll taxation. Conversely, a decrease in excise taxes results in an increase in Federal income and payroll tax. This interaction between excise tax receipts and total Federal tax receipts is referred to as the “income and payroll tax offset.” See Joint Committee on Taxation, *The Income and Payroll Tax Offset to Changes in Excise Tax Revenues* (JCX-59-11), December 2011.

percent, and the annual fee on manufacturers and importers of branded drugs are estimated to be \$9.9 billion, \$9.0 billion, and \$3.0 billion, respectively.<sup>242</sup>

**Table 4.—Estimated Receipts from Certain Taxes Enacted in the Affordable Care Act , Calendar Year 2016**

	<b>Billions of Dollars</b>
Unearned Income Medicare Contribution of 3.8% on investment income for taxpayers with AGI in excess of \$200,000/\$250,000 (unindexed).....	28.7
Additional HI tax of 0.9% on earned income in excess of \$200,000/\$250,000 (unindexed).....	9.0
Annual Fee on health insurance providers (net of offset).....	9.9
Annual Fee on manufacturers and importers of branded drugs (net of offset)....	3.0
2.3% excise tax on manufacturers and importers of certain medical devices.....	[1]
40% excise tax on health coverage in excess of certain thresholds.....	[2]

<sup>[1]</sup> This tax is suspended for calendar years 2016 and 2017.

<sup>[2]</sup> This tax is effective beginning in 2020.

**Excise taxes on medical devices and high cost coverage**

With passage of the PATH Act in 2015, Congress suspended the excise tax on medical devices for a period of two years, for sales on or after January 1, 2016 and before January 1, 2018. As a result, there are no estimated receipts for this provision in calendar year 2016. Similarly, Congress passed a two-year postponement of the excise tax on high cost employer-sponsored health coverage. The excise tax is now effective for years beginning after December 31, 2019, and therefore has no estimated receipts for calendar year 2016.

In the absence of estimated receipts for calendar year 2016, Tables 5 and 6 present estimates of the loss in revenue due to repeal of each provision, as they were provided during consideration of their repeal in December, 2015.<sup>243</sup> Note that these estimates are not comparable to those in Table 4. In contrast to the estimates of receipts shown above, the estimates in Tables 5 and 6 measure the predicted revenues under repeal of each of the provisions in question relative to the predicted revenues under present law, incorporating economic and behavioral effects of taxpayer behavior as well as certain projected changes in taxpayer populations.

<sup>242</sup> The amounts provided here would not be the same as the absolute value of a revenue estimate for repeal of these provisions, as revenue estimates would reflect behavioral responses.

<sup>243</sup> See JCX-142-15 and JCX-143-15.

**Table 5.—Estimated Revenue Effects of a Proposal to Delay High Cost Employer-Sponsored Health Coverage Excise Tax until 2020**

<i>Fiscal Years</i> <i>[Billions of Dollars]</i>											
<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2016-21</u>	<u>2016-25</u>
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NOTE: Details do not add to totals due to rounding.

**Table 6.—Estimated Revenue Effects of a Proposal for a Two-Year Moratorium of the ACA Medical Device Excise Tax (Sales in Calendar Years 2016 and 2017)**

<i>Fiscal Years</i> <i>[Billions of Dollars]</i>											
<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2016-21</u>	<u>2016-25</u>
-1.4	-2.0	-0.6	---	---	---	---	---	---	---	-3.9	-3.9

NOTE: Details do not add to totals due to rounding.