Timeline of 2013–2018 tax changes in health care reform legislation-Feb. 25, 2013

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

Caution: These new requirements are a work in progress. For example, some of the rules in PPACA and HCERA have been repealed and the effective date of other rules has been modified (i.e., deferred, by IRS).

Tax Changes Taking Effect in 2013

Increased HI tax for high-earning workers and self-employed taxpayers. For tax years beginning after Dec. 31, 2012, an additional 0.9% hospital insurance (HI) tax applies under Code Sec. 3101(b)(2) to wages received with respect to employment in excess of: $250,000 for joint returns; $125,000 for married taxpayers filing a separate return; and $200,000 in all other cases. Under Code Sec. 1401(b)(2), the additional 0.9% HI tax also applies to self-employment income for the tax year in excess of the above figures. (Code Sec. 6051(a)(14))

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

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

Dollar cap on contributions to health FSAs. For tax years beginning after Dec. 31, 2012, for a health FSA (flexible spending account) to be a qualified benefit under a

cafeteria plan, the maximum amount available for reimbursement of incurred medical expenses of an employee (and dependents and other eligible beneficiaries) under the health FSA for a plan year (or other 12-month coverage period) can't exceed $2,500. (Code Sec. 125(i)) (Code Sec. 213(f))

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

Fee on health plans. For each policy year ending after Sept. 30, 2012, each specified health insurance policy and each applicable self-insured health plan will have to pay a fee equal to the product of $2 ($1 for policy years ending during 2013) multiplied by the average number of lives covered under the policy. The issuer of the health insurance policy or the self-insured health plan sponsor is liable for and must pay the fee. (Code Sec. 4375, Code Sec. 4376, and Code Sec. 4377)

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

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

Information reporting of health insurance coverage. Employers filing 250 or more Forms W-2 for 2011, were required to report the aggregate cost of the applicable

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

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

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

Tax Changes Taking Effect in 2014

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

1. Fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage (MEC) under an eligible employer-sponsored plan (Code Sec. 4980H(a) liability); or
2. Offers its full-time employees (and their dependents) the opportunity to enroll in MEC under an eligible employer-sponsored plan that, for a full-time employee who has been certified for the advance payment of an applicable premium tax credit or cost-sharing reduction, either is unaffordable or does not provide minimum value as these terms are defined in Code Sec. 36B(c)(2)(C) (Code Sec. 4980H(b) liability).

The payment under Code Sec. 4980H(a) is based on all (excluding the first 30) full-time employees, while the payment under Code Sec. 4980H(b) is based on the number of full-time employees who are certified to receive an advance payment of an applicable

premium tax credit or cost-sharing reduction. A full-time employee for any month is an employee who is employed on average at least 30 hours of service per week.

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

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

An individual is eligible for employer-sponsored MEC only if the employee's share of the premiums is “affordable” and the coverage provides “minimum value” (i.e., at least 60% of the plan's total allowed cost of benefits provided). In general, under Code Sec. 36B(c)(2)(C)(i), an employer-sponsored plan is not affordable if the employee's required contribution with respect to the plan exceeds 9.5% of his **household income** for the tax year. This percentage may be adjusted after 2014.

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

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

“Qualified health plans” may be offered through cafeteria plans by “qualified employers.” For tax years beginning after Dec. 31, 2013, a reimbursement (or direct payment) for the premiums for coverage under any “qualified health plan” through a

health insurance Exchange is a qualified benefit under a cafeteria plan if the employer is a qualified employer (generally, smaller businesses). (Code Sec. 125(f)(3)(B)) In very broad terms, a qualified health plan is one that meets certain certification requirements, provides “an essential health benefits package,” and is offered by an insurer meeting detailed requirements. And a health insurance “Exchange” is a federally supervised marketplace for health insurance policies meeting specific eligibility and benefit criteria, to be made available not later than Jan. 1, 2014, to qualifying individuals and employer groups of graduated sizes.

New information reporting of employer-provided health coverage. For periods beginning after Dec. 31, 2013, new information reporting and related statement obligations apply under Code Sec. 6056 for (1) certain applicable large employers required to offer their full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and (2) offering employers (those offering minimum essential coverage to employees and paying any portion of the such coverage, but only if the required employer contribution of any employee exceeds 8% of the employee's wages).

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

Tax Change Taking Effect in 2018

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