

Items of interest on Checkpoint's "Newsstand" tab:

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Note: When the text-only articles appearing below are read online, they contain live links to referenced or cited information. For recipient reply options, see below.

In this issue:

New Act Complete Analysis now available on Checkpoint—

- **RIA's Complete Analysis of the Hiring Incentives to Restore Employment Act; the Worker, Homeownership, and Business Assistance Act of 2009; and Other Recent Tax Acts**

New Legislative Watch—

- **Senate passes Federal Aviation Administration Extension Act**

New developments at a glance—

- **State Officials File Lawsuits Challenging Health Care Reform Legislation; White House Responds**

Client Letters covering health reform legislation—

- **Tax changes affecting individuals in the 2010 health reform legislation**
- **Tax changes affecting small business in the 2010 health reform legislation**
- **Higher Medicare taxes on high-income taxpayers in the 2010 health reform legislation**
- **Penalties on individuals for remaining uninsured in the 2010 health reform legislation**
- **Employer requirement to offer coverage in the 2010 health reform legislation**
- **Premium assistance tax credits for purchasing health insurance in the 2010 health reform legislation**

Featured Articles—

- **RIA Special Study: Health-Related Revenue Raisers in New Health Reform Law**
- **Taxpayer needed IRS consent to change its book method for deferred advanced payments**

Accounting, SEC, SOX, etc. News—

- **AICPA's Auditing Standards Board issues four auditing interpretations**

New Act Complete Analysis now available on Checkpoint—

RIA's Complete Analysis of the Tax and Benefits Provisions of the 2010 Health Care Act as Amended by the 2010 Health Care Reconciliation Act—now available on Checkpoint

RIA's Complete Analysis of the Tax and Benefits Provisions of the 2010 Health Care Act as Amended by the 2010 Health Care Reconciliation Act is now available on Checkpoint. Subscribers can easily access the book in any of the following ways:

Home tab: Click the link notification link at the tops of the screen next to **NEW!**

Table of Contents location: Checkpoint contents/Federal Library/Tax Legislation/

Search screen (Research tab): Click "Legislation Search" on left side-bar

The Complete Analysis on Checkpoint covers:

- H.R. 3590, the Patient Protection and Affordable Care Act (Health Care Act, P.L. 111-148); and
- H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), as passed by Congress on March 25 and awaiting the President's signature.

The Health Care Act carries the bulk of the new law changes, but many of the Health Care Act's changes are modified by the Reconciliation Act, which adds new provisions as well.

Together, the Health Care Act and the Reconciliation Act establish a mandate for most U.S. residents to obtain health insurance and sets up insurance exchanges through which certain individuals and families can receive federal subsidies to substantially reduce the cost of buying that coverage. They also impose an excise tax on insurance plans with relatively high premiums, impose a surtax on unearned income, increase the HI tax rate for high income earners, and subject employers to new penalties if they don't provide health insurance (or if the insurance is deemed inadequate or unaffordable). Other tax changes include codification of the economic substance doctrine and imposition of penalties relating to the doctrine, and various revenue raisers and other tax changes targeting specific health related industries.

The Complete Analysis contains all the research aids that users need to understand the new law: Detailed editorial analysis, Code as amended, ERISA as amended, Act sections not amending the Code, Committee Reports, extensive cross-reference tables **with links** that help tie all the materials together, plus a topical index.

NOTE: Sample client letters covering the new law are provided below. These same client letters can also be accessed or exported by subscribers from within the Complete Analysis book on Checkpoint.

For more information about the new law, see RIA Special Study plus additional "Featured Articles" that appeared in last Friday's Newsstand e-mail. Checkpoint subscribers can read all the recent new law information on today's Newsstand tab with links to related information and cited authorities.

Legislative Watch—

Senate passes Federal Aviation Administration Extension Act

On March 25, during wrap-up of business, the Senate approved S. 3187, the "Federal Aviation Administration Extension Act of 2010" by unanimous consent. The House, before adjourning for the April recess, had previously approved by unanimous consent H.R. 4957, "Federal Aviation Administration Extension Act of 2010." It is a bill to amend the Internal Revenue Code of 1986 to extend the funding and expenditure authority of the Airport and Airway Trust Fund, to amend title 49, United States Code, to extend authorizations for the airport improvement program, and for other purposes.

New developments at a glance—

State Officials File Lawsuits Challenging Health Care Reform Legislation; White House Responds

Several state attorneys general have filed lawsuits challenging the constitutionality of H.R. 3590, the Patient Protection and Affordable Care Act (2010 Health Care Act, P.L. 111-148), which President Obama signed into law on March 23, 2010. The White House has expressed confidence that the states will not prevail. (*Florida v. U.S. Department of Health and Human Services*, (2010, N.D. FL) No. 3:10-cv-00091-RV-EMT; Briefing by White House Press Secretary Robert Gibbs, 3/2010)

In one lawsuit, 13 state attorneys general joined together to sue the Department of Health and Human Services (HHS), the Treasury Department, and DOL, seeking declaratory and injunctive relief against the 2010 Health Care Act's operation. Of those 13 attorneys general, 12 are Republican (i.e., the attorneys general from Florida, South Carolina, Nebraska, Texas, Utah, Alabama, Michigan, Colorado, Pennsylvania, Washington, Idaho, and South Dakota). Only one, the attorney general from Louisiana, is Democrat.

The Republican attorneys general from Missouri and Virginia have also filed separate lawsuits challenging the health care reform.

In the joint lawsuit, the states allege that the 2010 Health Care Act encroaches on the liberty of individuals by mandating that all citizens and legal residents of the U.S. have qualifying healthcare coverage or pay a tax penalty. Their suit states that Article I of the Constitution does not authorize the U.S. to so mandate. In addition, the states claim that the tax penalty, which the 2010 Health Care Act requires uninsured citizens and residents to pay, constitutes an unlawful capitation or direct tax, also in violation of Article I of the Constitution.

The lawsuit also asserts that the 2010 Health Care Act encroaches on the states' sovereignty, citing the 2010 Health Care Act's requirement that states expand their Medicaid programs and create Exchanges through which individuals can purchase healthcare

insurance coverage. The states further claim that the 2010 Health Care Act converts what had been a voluntary federal-state partnership into a compulsory top-down federal program in which the discretion of the states is removed, in derogation of the constitutional principle of federalism, and thus exceeds the powers of the Constitution's Tenth Amendment.

In addition, the states allege that the 2010 Health Care Act contains several unfunded mandates that will cost state governments significantly, and that by making federal funds potentially available at the discretion of federal agencies, the 2010 Health Care Act acknowledges the immediate burden on states to invest and implement the 2010 Health Care Act, but provides no guarantee that they will receive such funds or that the 2010 Health Care Act's implementation costs will be met.

White House response. In a press briefing, Robert Gibbs, White House Press Secretary, told reporters that the "law is not unconstitutional based on what these attorneys general are suing for," and "we'll win these lawsuits."

Noting that the states claim that the 2010 Health Care Act's requirement that individuals obtain health insurance coverage violates the Constitution's commerce clause, Gibbs said that there is established precedent on the constitutionality of regulation of interstate commerce. Gates further stated that "for many decades, the Supreme Court has recognized Congress's authority under the commerce clause to regulate activities relating to interstate commerce."

Client Letters covering health reform legislation—

Tax changes affecting individuals in the 2010 health reform legislation

Dear Client,

I'm writing to give you a brief overview of the key tax changes affecting individuals in the recently enacted health reform legislation. Please call our offices for details of how the new changes may affect your specific situation.

Individual mandate. The new law contains an "individual mandate"—a requirement that U.S. citizens and legal residents have qualifying health coverage or be subject to a tax penalty. Under the new law, those without qualifying health coverage will pay a tax penalty of the greater of: (a) \$695 per year, up to a maximum of three times that amount (\$2,085) per family, or (b) 2.5% of household income over the threshold amount of income required for income tax return filing. The penalty will be phased in according to the following schedule: \$95 in 2014, \$325 in 2015, and \$695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by a cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, aliens not lawfully present in the U.S., incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of household income, those with incomes below the tax filing threshold (in 2010 the threshold for taxpayers under age 65 is \$9,350 for singles and \$18,700 for couples), and those residing outside of the U.S.

Premium assistance tax credits for purchasing health insurance. The centerpiece of the health care legislation is its provision of tax credits to low and middle income individuals and families for the purchase of health insurance. For tax years ending after 2013, the new law creates a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an exchange. Under the provision, an eligible individual enrolls in a plan offered through an exchange and reports his or her income to the exchange. Based on the information provided to the exchange, the individual receives a premium assistance credit based on income and IRS pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium assistance credit amount and the total premium charged for the plan. For employed individuals who purchase health insurance through an exchange, the premium payments are made through payroll deductions.

The premium assistance credit will be available for individuals and families with incomes up to 400% of the federal poverty level (\$43,320 for an individual or \$88,200 for a family of four, using 2009 poverty level figures) that are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage. The credits will be available on a sliding scale basis. The amount of the credit will be based on the percentage of income the cost of premiums represents, rising from 2% of income for those at 100% of the federal poverty level for the family size involved to 9.5% of income for those at 400% of the federal poverty level for the family size involved.

Higher Medicare taxes on high-income taxpayers. High-income taxpayers will be hit with a double whammy: a tax increase on wages and a new levy on investments.

Higher Medicare payroll tax on wages. The Medicare payroll tax is the primary source of financing for Medicare's hospital insurance trust fund, which pays hospital bills for beneficiaries, who are 65 and older or disabled. Under current law, wages are subject to a 2.9% Medicare payroll tax. Workers and employers pay 1.45% each. Self-employed people pay both halves of the tax (but are allowed to deduct half of this amount for income tax purposes). Unlike the payroll tax for Social Security, which applies to earnings up to an annual ceiling (\$106,800 for 2010), the Medicare tax is levied on all of a worker's wages without limit.

Under the provisions of the new law, which take in 2013, most taxpayers will continue to pay the 1.45% Medicare hospital insurance tax, but single people earning more than \$200,000 and married couples earning more than \$250,000 will be taxed at an additional 0.9% (2.35% in total) on the excess over those base amounts. Employers will collect the extra 0.9% on wages exceeding \$200,000 just as they would withhold Medicare taxes and remit them to the IRS. Companies wouldn't be responsible for determining whether a worker's combined income with his or her spouse made them subject to the tax. Instead, some employees will have to remit additional Medicare taxes when they file income tax returns, and some will get a tax credit for amounts overpaid. Self-employed persons will pay 3.8% on earnings over the threshold. Married couples with combined incomes approaching \$250,000 will have to keep tabs on their spouses' pay to avoid an unexpected tax bill. It should also be noted that the \$200,000/\$250,000 thresholds are not indexed for inflation, so it is likely that more and more people will be subject to the higher taxes in coming years.

Medicare payroll tax extended to investments. Under current law, the Medicare payroll tax only applies to wages. Beginning in 2013, a Medicare tax will, for the first time, be applied to investment income. A new 3.8% tax will be imposed on net investment income of single taxpayers with AGI above \$200,000 and joint filers over \$250,000 (unindexed). Net investment income is interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income is reduced by properly allocable deductions to such income. However, the new tax won't apply to income in tax-deferred retirement accounts such as 401(k) plans. Also, the new tax will apply only to income in excess of the \$200,000/\$250,000 thresholds. So if a couple earns \$200,000 in wages and \$100,000 in capital gains, \$50,000 will be subject to the new tax. Because the new tax on investment income won't take effect for three years, that leaves more time for Congress and the IRS to tinker with it. So we can expect lots of refinements and "clarifications" between now and when the tax is actually rolled out in 2013.

Floor on medical expenses deduction raised from 7.5% of adjusted gross income (AGI) to 10%. Under current law, taxpayers can take an itemized deduction for unreimbursed medical expenses for regular income tax purposes only to the extent that those expenses exceed 7.5% of the taxpayer's AGI. The new law raises the floor beneath itemized medical expense deductions from 7.5% of AGI to 10%, effective for tax years beginning after Dec. 31, 2012. The AGI floor for individuals age 65 and older (and their spouses) will remain unchanged at 7.5% through 2016.

Limit reimbursement of over-the-counter medications from HSAs, FSAs, and MSAs. The new law excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account (HRA) or health flexible savings accounts (FSAs) and from being reimbursed on a tax-free basis through a health savings account (HSA) or Archer Medical Savings Account (MSA), effective for tax years beginning after Dec. 31, 2010.

Increased penalties on nonqualified distributions from HSAs and Archer MSAs. The new law increases the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% (from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount, effective for distributions made after Dec. 31, 2010.

Limit health flexible spending arrangements (FSAs) to \$2,500. An FSA is one of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan of an employer. An FSA allows an employee to set aside a portion of his or her earnings to pay for qualified expenses as established in the cafeteria plan, most commonly for medical expenses but often for dependent care or other expenses. Under current law, there is no limit on the amount of contributions to an FSA. Under the new law, however, allowable contributions to health FSAs will be capped at \$2,500 per year, effective for tax years beginning after Dec. 31, 2012. The dollar amount will be indexed for inflation after 2013.

Dependent coverage in employer health plans. Effective on the enactment date, the new law extends the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan to any child of an employee who has not attained age 27 as of the end of the tax year. This change is also intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child. A parallel change is made for VEBA's and 401(h) accounts. Also,

self-employed individuals are permitted to take a deduction for the health insurance costs of any child of the taxpayer who has not attained age 27 as of the end of the tax year.

Excise tax on indoor tanning services. The new law imposes a 10% excise tax on indoor tanning services. The tax, which will be paid by the individual on whom the tanning services are performed but collected and remitted by the person receiving payment for the tanning services, will take effect July 1, 2010.

Liberalized adoption credit and adoption assistance rules. For tax years beginning after Dec. 31, 2009, the adoption tax credit is increased by \$1,000, made refundable, and extended through 2011. The adoption assistance exclusion is also increased by \$1,000.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

Tax changes affecting small business in the 2010 health reform legislation

Dear Client,

For owners of small businesses and their workers, the recently enacted health reform legislation has some key provisions to pay attention to. The major ones include: tax credits; excise taxes; and penalties. But whether a business will be affected by them depends on a variety of factors, such as the number of employees the business has. I'm writing to give you an overview of the provisions in the new law with the biggest impact on small business. Please call our offices for details of how the new changes may affect your specific business.

Tax credits to certain small employers that provide insurance. The new law provides small employers with a tax credit (i.e., a dollar-for-dollar reduction in tax) for nonelective contributions to purchase health insurance for their employees. The credit can offset an employer's regular tax or its alternative minimum tax (AMT) liability.

Small business employers eligible for the credit. To qualify, a business must offer health insurance to its employees as part of their compensation and contribute at least half the total premium cost. The business must have no more than 25 full-time equivalent employees ("FTEs"), and the employees must have annual full-time equivalent wages that average no more than \$50,000. However, the full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than \$25,000.

Years the credit is available. The credit is initially available for any tax year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage purchased from an insurance company licensed under state law. For tax years beginning after 2013, the credit is only available to an eligible small employer that purchases health insurance coverage for its employees through a state exchange and is only available for two years. The maximum two-year coverage period does not take into account any tax years beginning in years before 2014.

Thus, an eligible small employer could potentially qualify for this credit for six tax years, four years under the first phase and two years under the second phase.

Calculating the amount of the credit. For tax years beginning in 2010, 2011, 2012, or 2013, the credit is generally 35% (50% for tax years beginning after 2013) of the employer's nonelective contributions toward the employees' health insurance premiums. The credit phases out as firm-size and average wages increase. Tax-exempt small businesses meeting these requirements are eligible for payroll tax credits of up to 25% for tax years beginning in 2010, 2011, 2012, or 2013 (35% in tax years beginning after 2013) of the employer's nonelective contributions toward the employees' health insurance premiums.

Special rules. The employer is entitled to an ordinary and necessary business expense deduction equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if an eligible small employer pays 100% of the cost of its employees' health insurance coverage and the amount of the tax credit is 50% of that cost (i.e., in tax years beginning after 2013), the employer can claim a deduction for the other 50% of the premium cost.

Self-employed individuals, including partners and sole proprietors, two percent shareholders of an S corporation, and five percent owners of the employer are not treated as employees for purposes of this credit. Any employee with respect to a self-employed individual is not an employee of the employer for purposes of this credit if the employee is not performing services in the trade or business of the employer. Thus, the credit is not available for a domestic employee of a sole proprietor of a business. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for any contribution to the purchase of health insurance for these individuals and the individual is not taken into account in determining the number of full-time equivalent employees or average full-time equivalent wages.

Most small businesses exempted from penalties for not offering coverage to their employees. Although the new law imposes penalties on certain businesses for not providing coverage to their employees (so-called "pay or play"), most small businesses won't have to worry about this provision because employers with fewer than 50 employees aren't subject to the "pay or play" penalty. For businesses with at least 50 employees, the possible penalties vary depending on whether or not the employer offers health insurance to its employees. If it does not offer coverage and it has at least one full-time employee who receives a premium tax credit, the business will be assessed a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. So, for example, an employer with 51 employees who doesn't offer health insurance to his employees will be subject to a penalty of \$42,000 (\$2,000 multiplied by 21). Employers with at least 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit will pay \$3,000 for each employee receiving a premium credit (capped at the amount of the penalty that the employer would have been assessed for a failure to provide coverage, or \$2,000 multiplied by the number of its full-time employees in excess of 30). These provisions take effect Jan. 1, 2014.

The "Cadillac tax" on high-cost health plans. The new law places an excise tax on high-cost employer-sponsored health coverage (often referred to as "Cadillac" health plans). This is a 40% excise tax on insurance companies, based on premiums that exceed certain amounts. The tax is not on employers themselves unless they are self-funded (this typically occurs at larger firms). However, it is expected that employers and workers will ultimately bear this tax in the form of higher premiums passed on by insurers.

Here are the specifics: The new tax, which applies for tax years beginning after Dec. 31, 2017, places a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan to the extent that the annual premium exceeds \$10,200 for single coverage and \$27,500 for family coverage. An additional threshold amount of \$1,650 for single coverage and \$3,450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. The tax will apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). Stand-alone dental and vision plans will be disregarded in applying the tax. The dollar amount thresholds will be automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office (CBO) estimates in 2010. Employers with age and gender demographics that result in higher premiums could value the coverage provided to employees using the rates that would apply using a national risk pool. The excise tax will be levied at the insurer level. Employers will be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

Higher Medicare taxes on high-income taxpayers in the 2010 health reform legislation

Dear Client,

High-income taxpayers will be hit with two big tax hikes under the recently enacted health overhaul legislation: a tax increase on wages and a new levy on investments.

To help offset the cost of providing health insurance to millions of Americans, the new law imposes an additional 0.9% Medicare tax on wages above \$200,000 for individuals and \$250,000 for married couples filing jointly. In addition, for higher-income households, the new law adds a 3.8% tax on unearned income, including interest, dividends, capital gains and other investment income.

I'm writing to give you an overview of these two tax increases. Please call our offices for details of how the new changes may affect you or your business.

Higher Medicare tax on wages and self-employment income. The Medicare tax is the primary source of financing for Medicare's hospital insurance trust fund, which pays hospital bills for beneficiaries who are 65 and older or disabled.

Under current law, wages are subject to a 2.9% Medicare tax. Workers and employers pay 1.45% each. Self-employed people pay both halves of the tax (but are allowed to deduct half of this amount for income tax purposes).

Unlike the payroll tax for Social Security, which applies to earnings up to an annual ceiling (\$106,800 for 2010), the Medicare tax is levied on all of a worker's wages without limit.

Under the provisions of the new law, which take effect in 2013, most taxpayers will continue to pay the 1.45% Medicare tax, but single people earning more than \$200,000 and married couples earning more than \$250,000 will be taxed at an additional 0.9% (2.35% in total) on the excess over those base amounts. Self-employed persons will pay 3.8% on earnings over those thresholds.

It should be noted that the \$200,000/\$250,000 thresholds aren't indexed for inflation, so it is likely that more and more people will be subject to the higher tax in coming years.

Employers will collect the extra 0.9% on wages exceeding \$200,000 just as they would withhold Medicare taxes and remit them to the IRS. However, companies won't be responsible for determining whether a worker's combined income with his or her spouse made them subject to the tax.

Instead, some employees will have to remit additional Medicare taxes when they file income tax returns, and some will get a tax credit for amounts overpaid. Married couples with combined incomes approaching \$250,000 will have to keep tabs on both spouses' pay to avoid an unexpected tax bill.

Medicare tax extended to investments. Under current law, the Medicare tax only applies to wages and self-employment income. Beginning in 2013, a Medicare tax will, for the first time, be applied to investment income. A new 3.8% tax will be imposed on net investment income of single taxpayers with AGI above \$200,000 and joint filers over \$250,000 (unindexed).

Net investment income is interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income is reduced by the deductions that are allocable to that income. However, the new tax won't apply to income in tax-deferred retirement accounts such as 401(k) plans.

Because the new tax on investment income won't take effect for three years, that leaves more time for Congress and the IRS to tinker with it. So we can expect lots of refinements and "clarifications" between now and when the tax actually takes hold in 2013.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please don't hesitate to call.

Very truly yours,

Penalties on individuals for remaining uninsured in the 2010 health reform legislation

Dear Client,

The recently enacted health care overhaul legislation contains an "individual mandate"—a requirement that U.S. citizens and legal residents have qualifying health coverage or be subject to a tax penalty. I'm writing to give you an overview of the penalty provisions enforcing the individual mandate.

Under the new law, effective for tax years beginning after Dec. 31, 2013, non-exempt U.S. citizens and legal residents will be required to maintain minimum essential coverage or pay a penalty. Those failing to maintain minimum essential coverage in 2016 will be subject to a penalty equal to the greater of: (1) 2.5% of household income over the threshold amount of income required for income tax return filing (generally, in 2010, the filing threshold is \$9,350 for a single person or a married person filing separately and \$18,700 for married filing jointly); or (2) \$695 per uninsured adult in the household. The fee for an uninsured individual under age 18 will be one-half of the adult fee for an adult. The total household penalty can't exceed 300% of the per adult penalty (\$2,085), nor exceed the national average annual premium for the "bronze level" health plan offered through the Insurance Exchange that year for the household size.

The per adult annual penalty is phased in as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016. For years after 2016, the \$695 amount will be increased annually by the cost-of-living adjustment. The percentage of income will be phased in as follows: 1% for 2014; 2% in 2015; and 2.5% beginning after 2015. If a taxpayer files a joint return, the individual and spouse would be jointly liable for any penalty payment. The penalty, which will apply to any period the individual does not maintain minimum essential coverage (determined monthly), will be assessed through the Internal Revenue Code.

Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, aliens not lawfully present in the U.S., incarcerated individuals, those for whom the lowest cost "bronze plan" option exceeds 8% of household income, those with incomes below the tax filing threshold, and those residing outside of the U.S.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

Employer requirement to offer coverage in the 2010 health reform legislation

Dear Client,

The recently enacted health overhaul legislation requires certain employers to offer and contribute to their workers' health insurance or pay a penalty. Under the new law, effective for months beginning after Dec. 31, 2013, a large employer that does not offer coverage for all its full-time employees, offers minimum essential coverage that is unaffordable, or offers minimum essential coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%, is required to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee. Here are the details:

Who is subject to the employer mandate? Only an "applicable large employer," defined as someone who employed an average of at least 50 full-time employees during the preceding calendar year, is subject to the requirement to offer coverage. Most small businesses, since they have fewer than 50 employees, are thus exempt from the employer requirement. In counting the number of employees for purposes of determining whether an

employer is an applicable large employer, a full-time employee (meaning, for any month, an employee working an average of at least 30 hours or more each week) is counted as one employee and all other employees are counted on a pro-rated basis. However, even an employer with 50 or more employees isn't subject to the penalty for not offering coverage if the employer doesn't have any full-time employees who are certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee. In other words, if an employer doesn't have any full-time employees who have a lower income that might qualify him or her to receive a subsidy when purchasing a health plan in the proposed health insurance exchange, the employer will not pay a "pay or play" penalty.

Penalty for employers not offering coverage. An applicable large employer who fails to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month is subject to a penalty if at least one of its full-time employees is certified to the employer as having enrolled in health insurance coverage purchased through a state exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to the employee. The penalty for any month is an excise tax equal to the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of \$2,000. For example, if an employer fails to offer minimum essential coverage and has 60 full-time employees, ten of whom receive a tax credit for the year for enrolling in a state exchange-offered plan, the employer will owe \$2,000 for each employee over the 30-employee threshold, for a total penalty of \$60,000 (\$2,000 multiplied by 30 (60 minus 30)). This penalty is assessed on a monthly basis.

Penalty for employers that offer coverage but have at least one employee receiving a premium tax credit. An applicable large employer who offers coverage but has at least one full-time employee receiving a premium tax credit or cost-sharing reduction is subject to a penalty. The penalty is an excise tax that is imposed for each employee who receives a premium tax credit or cost-sharing reduction for health insurance purchased through a state exchange. For each full-time employee receiving a premium tax credit or cost-sharing subsidy through a state exchange for any month, the employer is required to pay an amount equal to one-twelfth of \$3,000. The penalty for each employer for any month is capped at an amount equal to the number of full-time employees during the month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of \$2,000. For example, if an employer offers health coverage and has 60 full-time employees, 15 of whom receive a tax credit for the year for enrolling in a state exchange-offered plan, the employer will owe a penalty of \$3,000 for each employee receiving a tax credit, for a total penalty of \$45,000. The maximum penalty for this employer is capped at the amount of the penalty that it would have been assessed for a failure to provide coverage, or \$60,000 (\$2,000 multiplied by 30 (60 minus 30)). Since the calculated penalty of \$45,000 is less than the maximum amount, the employer pays the \$45,000 calculated penalty. This penalty is assessed on a monthly basis.

Requirement to offer "free choice vouchers." After 2013, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage will have to provide qualified employees with a voucher whose value could be applied to purchase of a health plan through the Insurance Exchange. Qualified employees would be those employees: who do not participate in the employer's health plan; whose required contribution for employer sponsored minimum essential coverage exceeds 8%, but

does not exceed 9.8% of household income; and whose total household income does not exceed 400% of the poverty line for the family. The value of the voucher would be equal to the dollar value of the employer contribution to the employer offered health plan. Employers providing free choice vouchers will not be subject to penalties for employees that receive a voucher.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

Premium assistance tax credits for purchasing health insurance in the 2010 health reform legislation

Dear Client,

The centerpiece of the recently enacted health care overhaul legislation is its provision of tax credits to low and middle income individuals and families for the purchase of health insurance. I'm writing to give you an overview of how the new tax credits will work.

For tax years ending after 2013, the new law creates a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an exchange. Under the provision, an eligible individual enrolls in a plan offered through an exchange and reports his or her income to the exchange. Based on the information provided to the exchange, the individual receives a premium assistance credit based on income, and IRS pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium assistance credit amount and the total premium charged for the plan. For employed individuals who purchase health insurance through an exchange, the premium payments are made through payroll deductions.

The premium assistance credit will be available for individuals and families with incomes up to 400% of the federal poverty level (\$43,320 for an individual or \$88,200 for a family of four, using 2009 poverty level figures) that are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage. The credits will be available on a sliding scale basis. The amount of the credit will be based on the percentage of income the cost of premiums represents, rising from 2% of income for those at 100% of the federal poverty level for the family size involved to 9.5% of income for those at 400% of the federal poverty level for the family size involved.

I hope this information is helpful. If you would like more details about these provisions or any other aspect of the new law, please do not hesitate to call.

Very truly yours,

Featured Articles—

RIA Special Study: Health-Related Revenue Raisers in New Health Reform Law

The sweeping health reform law that Congress has passed—consisting of H.R. 3590, the Patient Protection and Affordable Care Act (Health Care Act, P.L. 111-148), and H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act)—pays for its cost in a number of ways, including taxes, penalties and tougher rules for health care related exclusions and deductions. These include a surtax on “Cadillac” employer health plans, higher HI taxes on wages, an “unearned income Medicare contribution” surtax, tougher limits on medical expense deductions, and a new limit on health FSA contributions under cafeteria plans. The new health reform law also imposes a number of industry specific revenue raisers and toughened rules, such as a new executive compensation deduction limit for insurance providers, and annual fees for pharmaceutical companies, manufacturers and importers of medical devices, and health insurance providers.

This Special Study features highlights of the health-related revenue raisers in the new health reform law. It includes citations to the Health Care Act and Reconciliation Act, and the applicable Code Sections they amend. Note that some changes may be affected by more than one Health Care Act Section, or by both the Health Care Act and the Reconciliation Act.

[Note: For a Special Study on tax changes in the new health reform law relating to the mandate for universal health coverage and for an overall summary of key provisions in the new health reform legislation, see the “Featured Articles” provide in last Friday’s Newsstand e-mail. Checkpoint subscribers can read all these articles in the online version of today’s Newsstand tab with complete links to related information and cite authorities.]

Excise Tax on High Cost Employer Sponsored Health Coverage

For tax years beginning after Dec. 31, 2017, insurers will be subject to a nondeductible excise tax if the aggregate value of employer sponsored health insurance coverage for an employee (plus any former employee, surviving spouse and any other primary insured individual) exceeds a threshold amount. (Code Sec. 4980I , as added by Health Care Act Sec. 9001 as amended by Health Care Act Sec. 10901, and as amended by Reconciliation Act Sec. 1401) The tax is equal to 40% of the aggregate value of the health insurance coverage that exceeds the threshold amount, calculated by way of a complex formula, explained later.

The principal components of this complex new excise tax are:

- The amount that's subject to the excise tax.
- How the excise tax is computed.
- Who pays the excise tax and how it is allocated.

The amount that's subject to the excise tax. In determining the amount by which the value of employer-sponsored health insurance coverage exceeds the threshold amount, the aggregate value of all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a Health flexible spending account (FSA) or a health reimbursement account (HRA), contributions to a health savings account

(HSA) or Archer medical savings account (MSA), and, except as provided below, other supplementary health insurance coverage. (Code Sec. 4980I(d))

For purposes of the excise tax on employer-sponsored health insurance, coverage is health coverage under any group health plan offered by an employer to an employee without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee's income) or the employee pays for the coverage with after-tax dollars. Employer-sponsored health insurance coverage includes coverage under any group health plan established and maintained primarily for the civilian employees of the Federal government or any of its agencies or instrumentalities and, generally, of any State government or political subdivision or by any state agencies or instrumentalities.

Employer-sponsored health insurance coverage includes both fully-insured and self-insured health coverage excludable from the employee's gross income, including, in the self insured context, on-site medical clinics that offer more than a de minimis amount of medical care to employees and executive physical programs. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for any portion of which a deduction is allowable to the self-employed individual under Code Sec. 162(l).

What's not taken into account in determining whether the value of health coverage exceeds the threshold amount:

- The value of employer sponsored coverage for long term care and the following benefits described in Code Sec. 9832(c)(1) that are excepted from the portability, access and renewability requirements of the Health Insurance Portability and Accountability Act (HIPAA): (1) coverage only for accident or disability income insurance, or any combination of these coverages; (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; and (7) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- The value of independent, noncoordinated coverage described in Code Sec. 9832(c)(3) as excepted from the portability, access and renewability requirements of HIPAA if that coverage is purchased exclusively by the employee with after-tax dollars (or, in the case of a self-employed individual, for which a deduction under Code Sec. 162(l) is not allowable). The value of employer-sponsored health insurance coverage does include the value of such coverage if any portion of the coverage is employer-provided (or, in the case of a self-employed individual, if a deduction is allowable for any portion of the payment for the coverage). Coverage described in Code Sec. 9832(c)(3) is coverage only for a specified disease or illness or for hospital or other fixed indemnity health coverage. Fixed indemnity health coverage pays fixed dollar amounts based on the occurrence of qualifying events, including but not limited to the diagnosis of a specific disease, an accidental injury or a hospitalization, provided that the coverage is not coordinated with other health coverage.
- Any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye. (Code Sec. 4980I(d)(1))

The amount subject to the excise tax on high cost employer-sponsored health insurance coverage for each employee is the sum of the aggregate premiums for health insurance

coverage, the amount of any salary reduction contributions to a health FSA for the tax year, and the dollar amount of employer contributions to an HSA or an Archer MSA, minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer sponsored health insurance coverage including coverage for any supplementary health insurance coverage. The applicable premium for health coverage provided through an HRA is also included in this aggregate amount. (Code Sec. 4980I(d)(2))

How the excise tax is computed. The tax is equal to 40% of the aggregate value of the health insurance coverage that exceeds:

- (1) the threshold dollar amount, which is
- (2) multiplied by the health cost adjustment percentage, and finally
- (3) increased by the age and gender adjusted excess premium amount. (Code Sec. 4980I(b)(3))

Threshold dollar amount. In general, for 2018, the threshold dollar amount is \$10,200 for individual coverage and \$27,500 for family coverage. (Code Sec. 4980I(b)(3)) However, increased thresholds apply for certain classes of taxpayers as explained below.

The threshold amounts are increased for an individual who has attained age of 55 who is non-Medicare eligible and receiving employer-sponsored retiree health coverage, or is covered by a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high risk profession or employed to repair or install electrical and telecommunications lines. For these individuals, the threshold amount in 2018 is increased by (1) \$1,650 for individual coverage or \$3,450 for family coverage and (2) the age and gender adjusted excess premium amount (as defined below). In 2019, the additional \$1,650 and \$3,450 amounts are indexed to the CPI-U, plus one percentage point, rounded to the nearest \$50. In 2020 and thereafter, the additional threshold amounts are indexed to the CPI-U, rounded to the nearest \$50. (Code Sec. 4980I(b)(3)(C))

For purposes of the higher threshold, employees treated as engaged in a high risk profession are: law enforcement officers; those engaged in fire protection activities; providers of out-of-hospital emergency medical care (e.g., emergency medical technicians); those whose primary work is longshore work; and those engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. A retiree with at least 20 years of employment in a high risk profession is also eligible for the increased threshold. (Code Sec. 4980I(f))

Under the relaxed rule for these special classes of individuals, a person's threshold can't be increased by more than \$1,650 for individual coverage or \$3,450 for family coverage (indexed as described above) and the age and gender adjusted excess premium amount, even if he would qualify for an increased threshold both on account of his status as a retiree over age 55 and as a participant in a plan that covers employees in a high risk profession.

Health cost adjustment percentage. The health cost adjustment percentage is designed to increase the thresholds if growth in the cost of U.S. health care between 2010 and 2018 exceeds the projected growth for that period. The health cost adjustment percentage is equal to 100% plus the excess, if any, of (1) the percentage by which the per employee

cost of coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (standard FEHBP coverage) for plan year 2018 (as determined using the benefit package for standard FEHBP coverage for plan year 2010) exceeds the per employee cost of standard FEHBP coverage for plan year 2010; over (2) 55%. (Code Sec. 4980I(b)(3)(C))

Age and gender adjusted excess premium amount. In 2019, the threshold amounts, after application of the health cost adjustment percentage in 2018, if any, are indexed to the CPI-U, as determined by the Department of Labor, plus one percentage point, rounded to the nearest \$50. In 2020 and thereafter, the threshold amounts are indexed to the CPI-U as determined by the Department of Labor, rounded to the nearest \$50. For each employee (other than for certain retirees and employees in high risk professions, whose thresholds are adjusted under rules described below), the age and gender adjusted excess premium amount is equal to the excess, if any, of:

- (1) the premium cost of standard FEHBP coverage for the type of coverage provided to the individual if priced for the age and gender characteristics of all employees of the individual's employer, over
- (2) the premium cost, determined under procedures proscribed by IRS, for that coverage if priced for the age and gender characteristics of the national workforce. (Code Sec. 4980I(b)(3)(C))

Illustration: If the growth in the cost of health care during the period between 2010 and 2018, calculated by reference to the growth in the per employee cost of standard FEHBP coverage during that period (holding benefits under the standard FEHBP plan constant during the period) is 57%, the threshold amounts for 2013 will be \$10,200 for individual coverage and \$27,500 for family coverage, multiplied by 102% (100% plus the excess of 57% over 55%), or \$10,404 for individual coverage and \$28,050 for family coverage. In 2019, the new threshold amounts of \$10,404 for individual coverage and \$28,050 for family coverage are indexed for CPI-U, plus one percentage point, rounded to the nearest \$50.

Beginning in 2020, the threshold amounts are indexed to the CPI-U, rounded to the nearest \$50.

The new threshold amounts (as indexed) are then increased for any employee by the age and gender adjusted excess premium amount, if any. For an employee with individual coverage in 2019, if standard FEHBP coverage priced for the age and gender characteristics of the workforce of the employee's employer is \$11,400 and IRS estimates that the premium cost for individual standard FEHBP coverage priced for the age and gender characteristics of the national workforce is \$10,500, the threshold for that employee is increased by \$900 (\$11,400 less \$10,500) to \$11,304 (\$10,404 plus \$900). (Committee Report)

Who pays the excise tax and how it is allocated. The excise tax is imposed pro rata on the issuers of the insurance. For a self insured group health plan, a health FSA or an HRA, the excise tax is paid by the entity that administers benefits under the plan or arrangement (the "plan administrator"). The excise tax is paid by the employer if it acts as plan administrator to a self-insured group health plan, a health FSA or an HRA. Where an

employer contributes to an HSA or an Archer MSA, the employer is responsible for payment of the excise tax, as the insurer. (Code Sec. 4980I(c))

The excise tax is allocated pro rata among the insurers, with each insurer responsible for payment of the excise tax on an amount equal to the amount subject to the total excise tax multiplied by a fraction, having as the numerator the amount of employer sponsored health insurance coverage provided by that insurer to the employee and having as the denominator the aggregate value of all employer-sponsored health insurance coverage provided to the employee. (Code Sec. 4980I(c))

For a self-insured group health plan, a health FSA or an HRA, the excise tax is allocated to the plan administrator. If an employer contributes to an HSA or an Archer MSA, it is responsible for payment of the excise tax, as the insurer. The employer is responsible for calculating the amount subject to the excise tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer, plan administrator and IRS, in the form and at the time that IRS may prescribe.

Each insurer and plan administrator is then responsible for calculating, reporting and paying the excise tax to IRS on such forms and at such time as IRS may prescribe.

Illustration: In 2018, an employee elects family coverage under a fully-insured health care policy covering major medical and dental with a value of \$31,000. The health cost adjustment percentage for that year is 100%, and the age and gender adjusted excess premium amount for the employee is \$600. On these facts, the amount subject to the excise tax is \$2,900 (\$31,000 less the threshold of \$28,100 (\$27,500 multiplied by 100% and increased by \$600)).

The employer reports \$2,900 as taxable to the insurer, which calculates and remits the excise tax to IRS. (Committee Report)

Illustration: In 2018, an employee elects family coverage under a fully-insured major medical policy with a value of \$28,500 and contributes \$2,500 to a health FSA, and thus has an aggregate health insurance coverage value of \$31,000 (\$28,500 plus \$2,500). The health cost adjustment percentage for that year is 100% and the age and gender adjusted excess premium amount for the employee is \$600. On these facts, the amount subject to the excise tax is \$2,900 (\$31,000 less the threshold of \$28,100 (\$27,500 multiplied by 100% and increased by \$600)).

The employer reports \$2,666 ($\$2,900 \times \$28,500/\$31,000$) as taxable to the major medical insurer which then calculates and remits the excise tax to IRS. If the employer uses a third-party administrator for the health FSA, the employer reports \$234 ($\$2,900 \times \$2,500/\$31,000$) to the administrator and the administrator calculates and remits the excise tax to IRS. If the employer is acting as the plan administrator of the health FSA, the employer is responsible for calculating and remitting the excise tax on the \$234 to IRS. (Committee Report)

Penalty for underreporting liability for tax to insurers. A penalty applies to an employer that reports to insurers, plan administrators and IRS a lower amount of insurance cost subject to the excise tax than required. The penalty is equal to the sum of any additional excise tax that each such insurer and administrator would have owed if the

employer had reported correctly and interest attributable to that additional excise tax as determined under Code Sec. 6621 from the date that the tax was otherwise due to the date paid by the employer. (Code Sec. 4980I(e)) This may occur, for example, if the employer undervalues the aggregate premium and thereby lowers the amount subject to the excise tax for all insurers and plan administrators (including the employer, when acting as plan administrator of a self-insured plan). (Committee Report)

The penalty won't apply if it is established to IRS's satisfaction that the employer neither knew, nor exercising reasonable diligence would have known, that the failure existed. In addition, no penalty will be imposed on any failure corrected within the 30-day period beginning on the first date that the employer knew, or exercising reasonable diligence, would have known, that the failure existed, so long as the failure is due to reasonable cause and not to willful neglect. All or part of the penalty may be waived by IRS in the case of any failure due to reasonable cause and not to willful neglect, to the extent that the payment of the penalty would be excessive or otherwise inequitable relative to the failure involved. (Code Sec. 4980I(e))

Cost of Employer-Sponsored Health Coverage Included on W-2

Every employer must furnish each employee and IRS with a statement of compensation information on Form W-2, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. Under pre-Act law, there is no requirement that the employer report the total value of employer sponsored health insurance coverage on the Form W-2, although some employers voluntarily report the amount of salary reduction under a cafeteria plan resulting in tax-free employee benefits in box 14.

New law. For tax years beginning after Dec. 31, 2010, an employer must disclose on each employee's annual Form W-2 the value of the employee's health insurance coverage sponsored by the employer. (Code Sec. 6051(a)(14) , as amended by Health Care Act Sec. 9002) If an employee enrolls in employer-sponsored health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement (FSA)). (Committee Report)

For example, if an employee enrolls in employer sponsored health insurance coverage under a major medical plan, a dental plan, and a vision plan, the employer must report the total value of the combination of all of these health related insurance policies. For this purpose, employers generally use the same value for all similarly situated employees receiving the same category of coverage (such as single or family health insurance coverage). (Committee Report)

The value of employer-sponsored health insurance coverage is found by calculating the applicable premiums for the tax year for the employee under the rules for COBRA continuation coverage under Code Sec. 4980B(f)(4) (and accompanying regs), including the special rule for self-insured plans. The value reported on Form W-2 is the portion of the aggregate premium. (Committee Report)

If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan must calculate separate individual and family premiums for this purpose. (Committee Report)

The reporting requirement for the cost of employer-sponsored coverage doesn't apply to coverage for amounts contributed by an employer to: (1) any Archer medical savings account of an employee or the employee's spouse; or (3) to a health savings account of an employee or the employee's spouse. (Code Sec. 6051(a)(14)(A))

RIA observation: Under pre-Health Care Act law, employer contributions to Archer medical savings accounts and health savings accounts were already required to be reported on Form W-2.

In addition, reporting isn't required for the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of Code Sec. 125). (Code Sec. 6051(a)(14)(B))

Other New Employer Responsibilities for Health Coverage

There is no provision requiring employer reporting of health insurance coverage.

New law. For periods beginning after Dec. 31, 2013, there are new information reporting and related statement obligations 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. Specifically, every applicable large employer required to meet the requirements of new Code Sec. 4980H with respect to its full-time employees during a calendar year and every offering employer will be required, at the time IRS prescribes, to make a return reporting certain information. (Code Sec. 6056(a), as amended by Health Care Act Sec. 1514(a), as amended by Health Care Act Sec. 10108(j)(1))

The information required to be reported includes: (1) the name, address and employer identification number of the employer; (2) 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; (3) the number of full-time employees of the employer for each month during the calendar year; (4) 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 a plan sponsored by the employer during the calendar year; and (5) such other information as IRS may require. (Code Sec. 6056(b))

An applicable large employer is an employer who employed an average of at least 50 "full-time employees" on business days during the preceding calendar year. An offering employer is any employer who offers minimum essential coverage to its employees under an eligible employer-sponsored plan and who pays any portion of the costs of such plan, but only if the required employer contribution of any employee exceeds 8% of the wages paid by the employer to the employee. (Code Sec. 6056(f)(1)(A))

Additional Hospital Insurance Tax for High Wage Workers

The Federal Insurance Contributions Act (FICA) imposes two taxes on employees on wages received with respect to employment. Similar taxes are imposed on wages paid by employers.

The Old Age, Survivors and Disability Insurance (OASDI) tax is imposed at a 6.2% rate, on wages up to an annually-adjusted "wage base" (\$106,800 for 2010). The Medicare Hospital Insurance (HI) tax is imposed at a 1.45% rate on all wages, regardless of amount.

The Self-Employment Contributions Act (SECA) imposes two taxes on self-employed individuals, the OASDI tax and the HI tax. There is also an annually-adjusted "ceiling" limitation on the OASDI tax (\$106,800 for 2010), but no limit on the HI tax. The OASDI rate is 12.4%. The HI rate is 2.9%.

An above-the-line income tax deduction is allowed for one-half of the SECA taxes. In computing net earnings from self-employment, in lieu of the deduction of one-half of the SECA taxes, a taxpayer is allowed a deduction under Code Sec. 1402(a)(12) equal to the taxpayer's net earnings from self-employment, as determined before taking the Code Sec. 1402(a)(12) deduction into account, multiplied by one-half of the sum of the OASDI tax rate and the HI tax rate.

New law. For tax years beginning after 2012, an additional 0.9% HI tax will be imposed on taxpayers (other than corporations, estates, or trusts) on wages received with respect to employment in excess of:

- \$250,000 for joint returns,
- \$125,000 for married taxpayers filing a separate return, and
- \$200,000 in all other cases. (Code Sec. 3101(b)(2), as amended by Health Care Act Sec. 9015(a)(1)(D), as amended by Health Care Act Sec. 10906(a))

RIA observation: These threshold amounts, and the ones below for the additional SECA tax, aren't indexed for inflation.

RIA observation: Thus, the HI tax rate will be 1.45% on the first \$200,000 of wages (\$250,000 of combined wages on a joint return); and 2.35% (1.45% + 0.9%) on wages in excess of \$200,000 (\$250,000 of combined wages on a joint return).

RIA observation: This change doesn't affect the HI tax imposed on employers.

The employer must withhold the additional 0.9% HI tax on wages that the employee receives from the employer. The employer may disregard the amount of wages received by the employee's spouse. (Code Sec. 3102(f)(1), as amended by Health Care Act Sec. 9015(a)(2))

The employer will not be liable for any additional 0.9% HI tax that it fails to withhold and that the employee later pays, but will be liable for any penalties resulting from its failure to withhold. (Code Sec. 3102(f)(3)) The employee will be liable for the additional 0.9% HI tax to the extent it isn't deducted by the employer. (Code Sec. 3102(f)(2))

The additional 0.9% HI tax, to the extent not withheld, is treated as SECA tax for purposes of determining the taxpayer's estimated tax liability. (Code Sec. 6654(m), as amended by Reconciliation Act Sec. 1402(b)(2))

For tax years beginning after Dec. 31, 2012, an additional 0.9% HI tax will be imposed on taxpayers (other than corporations, estates, or trusts) on self-employment income for the tax year in excess of:

- \$250,000 for joint returns,
- \$125,000 for married taxpayers filing a separate return, and
- \$200,000 in all other cases. (Code Sec. 1401(b)(2), as amended by Health Care Act Sec. 9015(b)(1)(B), as amended by Health Care Act Sec. 10906(b))

RIA observation: Thus, the tax rate for the HI portion of the SECA taxes will be 2.9% on the first \$200,000 of self-employment income (\$250,000 of combined self-employment income on a joint return); and 3.8% (2.9% + 0.9%) on self-employment income in excess of \$200,000 (\$250,000 of combined self-employment income on a joint return).

The above thresholds will be reduced (but not below zero) by the amount of wages taken into account in determining the additional 0.9% HI tax on employees under Code Sec. 3101(b)(2) (above). (Code Sec. 1401(b)(2)(B), as amended by Reconciliation Act Sec. 1402(b)(1)(B)(ii))

The income tax deduction for one-half of SECA taxes will be computed without regard to the additional 0.9% SECA tax. (Code Sec. 164(f), as amended by Health Care Act Sec. 9015(b)(2)(A))

RIA observation: Thus, although taxpayers will pay the HI portion of SECA tax at a 3.8% rate on the excess over the \$200,000 or \$250,000 threshold, the income tax deduction for one-half of SECA taxes will be computed based on a 2.9% rate. The additional 0.9% tax won't generate an income tax deduction.

The Code Sec. 1402(a)(12) deduction from net earnings from self-employment will be computed using half the sum of the OASDI tax rate and the regular HI tax rate (i.e., 7.65%), without regard to the additional 0.9% SECA tax. (Code Sec. 1402(a)(12)(B), as amended by Health Care Act Sec. 9015(b)(2)(B))

New Unearned Income Medicare Contribution Tax Imposed After 2012

Two taxes are imposed under the Federal Insurance Contributions Act (FICA) on employers and employees: (1) the Old Age, Survivors and Disability Insurance (OASDI) tax equal to 6.2% of covered wages up to the taxable wage base (\$106,800 in 2010); and (2) the Medicare Hospital Insurance (HI) tax equal to 1.45% of covered wages (with no maximum limit). The employee level tax generally must be withheld and remitted to the Federal government by the employer. As a parallel to FICA taxes, under the Self-Employment Contributions Act of '54 (SECA), a self-employment tax is imposed on self-employed people at a rate of 15.30%: a combination of a 12.40% OASDI tax, and a 2.90% HI tax. The self-employment income subject to the OASDI tax is limited to an annually-adjusted ceiling (\$106,800 for 2010) minus the wages that the individual receives in the tax year.

New law. For tax years beginning after Dec. 31, 2012, an unearned income Medicare contribution tax is imposed on individuals, estates, and trusts. (Code Sec. 1411, as added by Reconciliation Act Sec. 1402(a)) For an individual, the tax is 3.8% of the lesser of either (1) net investment income or (2) the excess of modified adjusted gross income (MAGI) over the threshold amount. (Code Sec. 1411(a)(1)) MAGI is adjusted gross income (AGI) increased by the amount excluded from income as foreign earned income under Code Sec. 911(a)(1) (net of the deductions and exclusions disallowed for the foreign earned income). (Code Sec. 1411(d)) The threshold amount is \$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. (Code Sec. 1411(b)) For this purpose, 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. (Committee Report)

RIA observation: The tax is generally levied on income from interest, dividends, annuities, royalties, rents, and capital gains. The Medicare contribution tax is in addition to the 0.9% HI tax on employee's wages and on self-employment income in excess of threshold amounts, as discussed above. Taxpayers who have both high wages or self-employment income and high investment income may be hit with both taxes.

RIA illustration 1: For 2013, a single taxpayer has net investment income of \$100,000 and MAGI of \$220,000. The taxpayer would pay a Medicare contribution tax only on the \$20,000 amount by which his MAGI exceeds his threshold amount of \$200,000, because that is less than his net investment income of \$100,000. Thus, the taxpayer's Medicare contribution tax would be \$760 ($\$20,000 \times 3.8\%$).

RIA illustration 2: Assume that the taxpayer in Illustration (1) had MAGI of \$300,000. Because the taxpayer's MAGI exceeds his threshold amount by \$100,000, he would pay a Medicare contribution tax on his full \$100,000 of net investment income. Thus, the taxpayer's Medicare contribution tax would be \$3,800 ($\$100,000 \times 3.8\%$).

RIA illustration 3: Assume that for 2013 a single taxpayer has net investment income of \$100,000, wages of \$300,000, and MAGI of \$375,000. In addition to paying a Medicare contribution tax of \$3,800, as explained in Illustration (2), the taxpayer would also pay an additional HI (Medicare) tax of \$900 ($\$100,000 \times 0.9\%$) on his wages in excess of \$200,000.

For an estate or trust, the Medicare contribution tax is 3.8% of the lesser of either: (1) undistributed net investment income or (2) the excess of AGI (as defined in Code Sec. 67(e)) over the dollar amount at which the highest income tax bracket applicable to an estate or trust begins. (Code Sec. 1411(a)(2))

RIA observation: The Medicare contribution tax probably won't apply to simple trusts and grantor trusts. Simple trusts require all income to be distributed currently and don't provide for charitable contributions. They generally won't have any undistributed net investment income. To the extent that the grantor trust rules apply (under which the owner is taxed directly on the trust), the regular rules for taxing trusts and their beneficiaries don't apply.

The tax doesn't apply to a non-resident alien, a trust all the unexpired interests in which are devoted to charitable purposes, a trust that's tax-exempt under Code Sec. 501 or a charitable remainder trust tax-exempt under Code Sec. 664 . (Code Sec. 1411(e))

Net investment income defined. Net investment income is investment income reduced by the deductions properly allocable to such income. Investment income is the sum of: (1) 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); (2) other gross income derived from any trade or business to which the tax applies; and (3) 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. (Code Sec. 1411(c)(1)) In the case of a trade or business, the tax applies if the trade or business is either a passive activity with respect to the taxpayer or the trade or business consists of trading financial instruments or commodities (as defined in Code Sec. 475(e)(2)). (Code Sec. 1411(c)(2)) The tax does not apply to other trades or businesses conducted by a sole proprietor, partnership, or S corporation. (Committee Report)

RIA observation: Thus, for a taxpayer that doesn't engage in a passive activity or a financial instrument or commodities trading business, "net investment income" will include non-business income from interest, dividends, annuities, royalties, rents, and capital gains, minus the allocable deductions. Business income won't be included. For a taxpayer that does engage in a passive activity or a financial instrument or commodities trading business, "net investment income" will include the above items, plus the gross income (minus allocable deductions) from the passive activity or trading business

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. (Code Sec. 1411(c)(4))

Income, gain, or loss on working capital is not treated as derived from a trade or business. (Code Sec. 1411(c)(3))

Investment income does not include distributions from a qualified retirement plan (i.e., a plan or arrangement described in Code Sec. 401(a), Code Sec. 403(a), Code Sec. 403(b), Code Sec. 408, Code Sec. 408A, Code Sec. 457(b)) or amounts subject to SECA tax. (Code Sec. 1411(c)(5))

The tax is subject to the individual estimated tax provisions. (Code Sec. 6654, as amended by Reconciliation Act Sec. 1402(a)(2)) The tax isn't deductible in computing any tax imposed by subtitle A of the Code (relating to income taxes). (Committee Report)

Medicine for Purposes of Employer Health Plan Payouts Limited to Prescribed Drugs or Insulin

Expenses for medical care, not compensated for by insurance or otherwise, may be claimed as an itemized deduction to the extent they exceed, under pre-Act law, 7.5% of adjusted

gross income (AGI). Medical care generally is defined broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body. However, any amount paid during a tax year for medicine or drugs is explicitly deductible as a medical expense only if it is a prescribed drug or is insulin. Thus, any amount paid for non-prescription medicine is not deductible as a medical expense, including any medicine recommended by a physician.

Reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income. An employer may agree to reimburse expenses for medical care of its employees (and their spouses and dependents), not covered by a health insurance plan, through a flexible spending arrangement (FSA) which allows reimbursement not in excess of a specified dollar amount. The dollar amount is either elected by an employee under a cafeteria plan (health FSA) or otherwise specified by the employer under a health reimbursement account (HRA). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage. The general definition of medical care without the explicit limitation on medicine applies for the exclusion for employer-provided health coverage and medical care. Thus, under an HRA or under a health FSA, amounts paid for prescription and over-the-counter medicine are treated as medical expenses, and reimbursements for these amounts are excludible from gross income.

Individuals with a high deductible health plan (and generally no other health plan) purchased either through the individual market or through an employer may, with certain limitations, establish and make tax-deductible contributions to a health savings account (HSA). Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. The general definition of medical care without the explicit limitation on medicine also applies for purposes of the HSA. Similar rules apply for an Archer medical savings account (MSA). Thus, a distribution from a HSA or an Archer MSA used to buy over-the-counter medicine also is excludible as an amount used for qualified medical expenses.

New law. The definition of medical expense for purposes of employer-provided health coverage (including HRAs and health FSAs), HSAs, and Archer MSAs, is conformed to the definition for purposes of the itemized deduction for medical expenses, except that a prescribed drug is determined without regard to whether it is available without a prescription. The changed definition for HSAs and Archer MSAs applies for amounts paid with respect to tax years beginning after Dec. 31, 2010. The changed definition for health FSAs and HRAs applies for expenses incurred with respect to tax years beginning after Dec. 31, 2010. (Code Sec. 106(f), Code Sec. 220(d)(2)(A), and Code Sec. 223(d)(2)(A), as amended by Health Care Act Sec. 9003)

Thus, under the provision, the cost of over-the-counter medicines can't be reimbursed with excludible income through a health FSA, HRA, HSA, or Archer MSA, unless the medicine is prescribed by a doctor.

RIA observation: Many formerly prescription only drugs, such as anti-reflux medicines, are now available over the counter. Under the new law, these currently over the counter medicines will continued to eligible to be reimbursed with excludible income if formally prescribed by a doctor.

10%-of-AGI Medical Expense Deduction Floor After 2012 (Later for Seniors)

Under pre-Act law, an individual who itemized could deduct certain unreimbursed medical expenses paid during the year for himself, his spouse, and his dependents, to the extent that those expenses exceeded 7.5% (the 7.5% floor) of the individual's adjusted gross income (AGI) for the tax year. For alternative minimum tax (AMT) purposes, medical expenses are deductible to the extent they exceed 10% (rather than 7.5%) of the taxpayer's AGI.

New law. For tax years beginning after Dec. 31, 2012, the floor beneath the itemized deduction for medical expenses is increased from 7.5% of AGI to 10% of AGI. Thus, an individual's unreimbursed medical expenses will be deductible to the extent they exceed 10% of the individual's AGI for the tax year. (Code Sec. 213(a) , as amended by Health Care Act Sec. 9013(a))

RIA illustration 1: For 2013, Individual A, age 42, has \$25,000 of medical expenses and AGI of \$100,000. A may deduct, as a medical expense, the excess of \$25,000 over \$10,000 ($\$100,000 \times 10\%$), or \$15,000. The other \$10,000 of Y's medical expenses will be permanently lost.

Increase postponed for seniors. For tax years beginning after Dec. 31, 2012 and ending before Jan. 1, 2017—i.e., for 2013, 2014, 2015, and 2016—the 7.5% floor will apply if the taxpayer or his or her spouse has reached age 65 before the close of the tax year. (Code Sec. 213(f)) Thus, the 10% floor will take effect for such “seniors” for tax years ending after Dec. 31, 2016.

RIA observation: The 7.5% floor will apply to a married taxpayer for 2013 through 2016 if either the taxpayer or the taxpayer's spouse is 65, whether they file a joint return or separate returns.

AMT treatment. For AMT purposes, the 10% floor continues to apply, and there is no special rule for seniors. (Code Sec. 56(b)(1)(B), as amended by Health Care Act Sec. 9013(c))

RIA observation: From 2013 through 2016, because they are subject to a 7.5% floor for regular tax purposes, but a 10% floor for AMT purposes, seniors must make an AMT adjustment equal to the lesser of: (1) 2.5% of AGI or (2) the entire regular-tax medical deduction.

RIA illustration 2: For 2013, Individual Z, age 68, has AGI of \$100,000 and incurred \$11,000 of medical expenses. For regular-tax purposes, Z's medical deduction is \$3,500—\$11,000 minus \$7,500 (7.5% of AGI). However, for AMT purposes, Z's medical deduction is only \$1,000—\$11,000 minus \$10,000 (10% of AGI). Thus, \$2,500, the amount by which the medical deduction is reduced for AMT purposes, is added back to taxable income in determining alternative minimum taxable income (AMTI).

Penalty Tax on HSA Distributions Not Used for Medical Expenses Boosted to 20%

Individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (HSA). An HSA

is a tax-exempt account held by a trustee or custodian for the benefit of the individual, and is subject to a number of eligibility and contribution limitations.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income, but distributions that are not so used are includible in gross income. An additional 10% tax applies for all HSA disbursements not made for qualified medical expenses. The additional 10% tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently, age 65).

An Archer medical savings account (MSA) provides tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. One difference is that the additional tax on distributions not used for medical expenses is 15% rather than 10%. After 2007, no new 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.

New law. For disbursements made during tax years starting after Dec. 31, 2010, the additional tax on distributions from an HSA that are not used for qualified medical expenses is increased from 10% to 20% of the disbursed amount, and the additional tax on distributions from an Archer MSA that are not used for qualified medical expenses is increased from 15% to 20% of the disbursed amount. (Code Sec. 220(f)(4)(A) and Code Sec. 223(f)(4)(A), as amended by Health Care Act Sec. 9004)

Dollar Limitation on Health FSAs under Cafeteria Plans

Under pre-Act law, there is no dollar limit on the amount that an employer may allow an employee to contribute each plan year to a health flexible spending account (health FSA) maintained through a cafeteria plan by means of a salary reduction agreement.

New law. For tax years beginning after Dec. 31, 2012, in order for a health FSA to be a qualified benefit under a cafeteria plan, the maximum amount available for reimbursement of incurred medical expenses of an employee, the employee's dependents, and any other eligible beneficiaries with respect to the employee, under the health FSA for a plan year (or other 12-month coverage period) cannot exceed \$2,500. (Code Sec. 125(i), as amended by Health Care Act Secs. 9005 and 10902, and by Health Care Act Sec. 1403) The \$2,500 limit is indexed to the CPI-U, with any increase that is not a multiple of \$50 rounded to the next lowest multiple of \$50 for years beginning after Dec. 31, 2013.

Deduction for Subsidized Retiree Drug Costs Eliminated

Sponsors of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of Health and Human Services 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.

The Code generally doesn't permit a deduction for any expense that would otherwise be allowable as a deduction if the expense is allocable to a class of exempt income. However, the exclusion of the qualified retiree prescription drug plan subsidy from income isn't taken into account in determining whether any deduction is allowable with respect to covered

retiree prescription drug expenses that are taken into account in determining the subsidy payment. Thus, a taxpayer may claim a business deduction for covered retiree prescription drug expenses incurred, notwithstanding that it excluded qualified retiree prescription drug plan subsidies allocable to those expenses.

New law. For tax years beginning after Dec. 31, 2012, the amount otherwise allowable as a deduction for retiree prescription drug expenses will be reduced by the amount of the excludable subsidy payments received. (Code Sec. 139A, as amended by Health Care Act Sec. 9012, as amended by Reconciliation Act Sec. 1407)

RIA illustration: A company receives a \$28 subsidy for \$100 of eligible drug expenses. The \$28 is excludable from income under Code Sec. 139A, and the amount otherwise allowable as a deduction will be reduced by the \$28. If the company otherwise meets the Code Sec. 162 requirements for its eligible drug expenses, it is entitled to a \$72 ordinary business expense deduction.

New 10% Excise Tax on Indoor Tanning Services

There is no federal tax imposed on amounts paid for tanning services.

New law. For indoor tanning services performed on or after July 1, 2010, a new tax is imposed on any indoor tanning service, whether paid for by insurance or otherwise. The tax, imposed on tanning service recipients in the first instance (see below), is equal to 10% of the amount paid for the services, whether or not the amount will be paid by insurance. (Code Sec. 5000B(a), as added by Health Care Act Sec. 10907(b)) "Indoor tanning service" is a service that uses any electronic product that's designed to incorporate one or more ultraviolet lamps, and that's intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers, to induce skin tanning. (Code Sec. 5000B(b)(1)) The term "indoor tanning service" excludes any phototherapy service performed by a licensed medical professional. (Code Sec. 5000B(b)(2))

The tax imposed is paid by the individual on whom the service is performed, although the service provider is secondarily liable (see below). (Code Sec. 5000B(c)(1))

The tax is computed without regard to Code Sec. 5000B itself (i.e., without being "grossed up"). (Code Sec. 5000B(a))

If the tax is not paid at the time payments for the tanning services are made, then to the extent that it is not collected, it has to be paid by the person performing the service. (Code Sec. 5000B(c)(1))

Tax Breaks Eliminated for Health Organizations with Medical Loss Ratios below 85%

An organization described in Code Sec. 501(c)(3) or Code Sec. 501(c)(4) is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance. However, special rules apply to certain eligible health insurance organizations. They are (1) Blue Cross and Blue Shield organizations existing on Aug. 16, '86, which have not experienced a material change in structure or operations since that date, and (2) other organizations that meet certain community-service-related requirements and substantially

all of whose activities involve the providing of health insurance. These eligible organizations are generally treated as "stock" property and casualty insurance companies.

They are taxed, at regular corporate rates, on their taxable income. Taxable income is gross income reduced by deductions. Gross income is investment income, underwriting income, gains from sales or other dispositions of property, and all other items constituting gross income for corporations. Gross income is then reduced by losses and expenses incurred, plus certain other deductions.

There is a special deduction for eligible organizations, equal to the excess (if any) of: (1) 25% of the sum of: (i) the claims incurred during the tax year, and liabilities incurred during the year under cost-plus contracts, and (ii) expenses incurred during the tax year for the adjustment, administration, and settlement of claims, or in connection with the administration of cost-plus contracts, over (2) the "adjusted surplus" at the beginning of the tax year.

For tax years ending before '97, this special deduction was limited to large health insurance providers, and Blue Cross/Blue Shield organizations described above. For tax years ending after '96, it was extended to any other organization that met the requirements that applied to existing Blue Cross/Blue Shield organizations, if the organization was organized under and governed by state laws specifically and exclusively applicable to not-for-profit health insurance or health service type organizations, and was not a health maintenance organization, or a Blue Cross or Blue Shield organization.

Further, an insurer's opening and closing balances for the tax year in reserves for certain unearned premiums and premiums received in advance take into account only 80% of the amount otherwise required without regard to this rule. This means that the company's deduction for reserve increases is reduced by 20%.

New law. For tax years beginning after Dec. 31, 2009, health organizations whose medical loss ratio is below 85% cannot take advantage of the favorable tax provisions of Code Sec. 833 including treatment as a stock insurance company, and the special deduction discussed above. (Code Sec. 833(c)(5), as amended by Health Care Act Sec. 9016(a))

Other Industry Specific Revenue Raisers and Tax Changes

The following revenue raisers and other changes apply to various health related industries and constituencies:

\$500,000 compensation deduction limit for health insurance providers after 2012.

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" in excess of \$500,000. (Code Sec. 162(m)(6)(A), as amended by Health Care Act Sec. 9014) 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. (Code Sec. 162(m)(6)(F) The exceptions to Code Sec. 162(m)(1) (the \$1 million compensation deduction limit for publicly held corporations) for commissions, performance-based compensation, or remuneration under written binding contracts doesn't apply. (Committee Report)

In addition, under a rule limiting the deduction on deferred compensation, for tax years beginning after Dec. 31, 2012, for compensation that is attributable to services performed in a tax year beginning after Dec. 31, 2009 in a "disqualified year" (one in which the employer is a covered insurance provider for any portion of the tax year), a covered health insurance provider isn't allowed a deduction for an applicable individual to the extent that the amount of that remuneration exceeds \$500,000, reduced (but not below zero) by the sum of: (a) the aggregate amount allowable as an income tax deduction for that disqualified tax year, determined without regard to Code Sec. 162(m) for remuneration for services performed by that individual, whether or not during the tax year (i.e., the "applicable individual remuneration"), plus (b) the portion of the "deferred deduction remuneration" for those services that either was taken into account as deferred deduction remuneration in an earlier tax year, or would have been taken into account if the limitation on deferred deduction remuneration had applied to tax years beginning after Dec. 31, 2009, and before Jan. 1, 2013. (Code Sec. 162(m)(6)(A)(ii)) Deferred deduction remuneration means remuneration that would be applicable individual remuneration for services performed in a disqualified tax year but for the fact that the income tax deduction for that remuneration (determined without regard to the new \$500,000 limit) is allowable in a later tax year. (Code Sec. 162(m)(6)(E)) Thus, for remuneration that relates to services that an applicable individual performs during a tax year but that isn't 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. (Committee Report)

For tax years beginning after Dec. 31, 2009, and before Jan. 1, 2013, a covered health insurance provider is any employer that is a health insurance issuer (as defined in Code Sec. 9832(b)(2)) and receives premiums from providing health insurance coverage (as defined in Code Sec. 9832(b)(1)). For tax years beginning after Dec. 31, 2012, a covered health insurance provider is any employer that is a health insurance issuer, and for which not less than 25% of the gross premiums received from providing health insurance coverage is from minimum essential coverage (as defined in new Code Sec. 5000A(f)). (Code Sec. 162(m)(6)(C)(i))

New qualification requirements for Code Sec. 501(c)(3) hospitals. Generally for tax years beginning after Mar. 23, 2010, new qualification requirements apply to any Code Sec. 501(c)(3) organization that operates at least one hospital facility. (Code Sec. 501(r) and Code Sec. 6033(b) as amended by Health Care Act Secs. 9007 and 10903)

In brief, these requirements are as follows: (1) For tax years beginning after Mar. 2012, each hospital facility must conduct a community health needs assessment at least once every three tax years and adopt an implementation strategy to meet the community needs identified through such assessment. For failures occurring after Mar. 23, 2010, an excise tax of \$50,000 applies if a tax-exempt charitable hospital organization fails to complete a community health needs assessment in any applicable three-year period. (Code Sec. 4959, as added Health Care Act Sec. 9007) (2) Each hospital facility must adopt, implement, and widely publicize a written financial assistance policy. The financial assistance policy must indicate the eligibility criteria for financial assistance and whether such assistance includes free or discounted care. (3) Each hospital facility must adopt and implement a policy to provide emergency medical treatment to individuals. The policy must prevent discrimination in the provision of emergency medical treatment, including denial of service, against those eligible for financial assistance under the facility's financial assistance policy or those eligible for government assistance. (4) Each hospital facility may 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. (5) A hospital facility (or its affiliates) can't 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. (6) The organization must file with its annual information return (i.e., Form 990) a copy of its audited financial statements (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statements. (Code Sec. 501(r))

Annual fee on branded prescription pharmaceutical manufacturers and importers.

For calendar years beginning after Dec. 31, 2010 each covered entity 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 must pay an annual nondeductible fee, which will be credited to the Medicare Part B trust fund. A covered entity is any manufacturer or importer with gross receipts from branded prescription drug sales. (Health Care Act Sec. 9008, as amended by Reconciliation Act Sec. 1404)

The annual flat fee beginning in 2011 is allocated across the industry according to market share. The schedule for the flat fee is: 2011, \$2.5 billion; 2012 to 2013, \$2.8 billion; 2014 to 2016, \$3 billion; 2017, \$4 billion; 2018, \$4.1 billion; 2019 and later, \$2.8 billion.

The aggregate fee will be apportioned among the covered entities each year based on each entity's relative share of branded prescription drug sales taken into account during the previous calendar year. IRS will calculate the amount of each covered entity's fee for each calendar year by determining the relative market share for each covered entity. A covered entity's relative market share for a calendar year is its 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. The branded prescription drug sales taken into account during any calendar year with respect to any covered entity will be (1) zero percent of sales not more than \$5 million, (2) 10% of sales over \$5 million but not more than \$125 million, (3) 40% of sales over \$125 million but not more than \$225 million, (4) 75% of sales over \$225 million but not more than \$400 million, and (5) 100% of sales over \$400 million.

The fees are treated as excise taxes with respect to which only civil actions for refunds under the provisions of subtitle F will apply. Thus, the fees may be assessed and collected using the procedures in subtitle F without regard to the Code Sec. 6213 restrictions on assessment.

Excise tax imposed on medical device manufacturers. For sales after Dec. 31, 2012, a tax equal to 2.3% of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of such device. (Code Sec. 4191(a), as added by Reconciliation Act Sec. 1405, which repeals Health Care Act Sec. 9009) A taxable medical device is any device defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act, that's intended for humans. However, the excise tax 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. (Code Sec. 4191(b))

IRS may determine that a specific medical device is exempt if the device is generally sold at retail establishments (including over the internet) to individuals for their personal use. The exemption for such items isn't limited by device class as defined in Section 513 of the

Federal Food, Drug, and Cosmetic Act. For example, it can include certain bandages and tipped applicators, pregnancy test kits, diabetes testing supplies, denture adhesives and snake bite kits if they are generally designed and sold for individual use. It is anticipated that IRS will publish a list of medical device classifications that are of a type generally purchased by the general public at retail for individual use. (Committee Report)

The Code Sec. 4221(a) manufacturers excise tax exemptions for further manufacture and for export apply to the excise tax imposed under Code Sec. 4191 . But the exemptions for use as supplies for vessels or aircraft, and for sales to State or local governments, nonprofit educational organizations, and qualified blood collector organizations aren't applicable. (Code Sec. 4221(a), as amended by Reconciliation Act Sec. 1405(b))

For purposes of the excise tax imposed under Code Sec. 4191, of the specified sales and uses listed under Code Sec. 6416(b)(2), only tax paid on a sale described in Code Sec. 6416(b)(2)(A) (i.e., a sale for export) will be deemed to be an overpayment of tax for which a credit or refund under Code Sec. 6416 may be claimed. (Code Sec. 6416(b)(2), as amended by Reconciliation Act Sec. 1405(b)(2))

Annual fee on health insurance providers. Covered entities engaged in the business of providing health insurance with respect to U.S. health risk will face an annual flat fee, effective for calendar years beginning after Dec. 31, 2013. The fee will be determined with respect to net premiums written after Dec. 31, 2012, with respect to health insurance for any U.S. health risk. The aggregate annual flat fee will be: \$8 billion for 2014; \$11.3 billion for 2015 and 2016; \$13.9 billion for 2017; and \$14.3 billion for 2018. The fee will be indexed to the rate of premium growth for later years. (Health Care Act Sec. 9010, as amended by Health Care Act Sec. 10905, and as further amended by Reconciliation Act Sec. 1406)

“Covered entities” generally are entities providing health insurance with respect to United States health risks during the calendar year in which the fee is due. However, “covered entities” does not include governmental entities, certain nonprofits, or organizations that qualify as a VEBA under Code Sec. 501(c)(9) that are established by an entity other than the employer (i.e., a union) for the purpose of providing health care benefits (but the latter exclusion does not apply to multi-employer welfare arrangements).

Each covered entity's share of the aggregate annual fee is determined by the ratio of its net premiums written during the preceding calendar year with respect to health insurance for any U.S. health risk, to the aggregate net written premiums of all covered entities during such preceding year with respect to such insurance. Net premiums written during the calendar year that are not more \$25 million are not taken into account for this purpose; for a covered entity's net premiums written during the calendar year that are more than \$25 million but not more than \$50 million, 50% are taken into account; and 100% of net premiums written in excess of \$50 million are taken into account.

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.

The fee is treated as an excise tax with respect to which only civil actions for refund under Subtitle F apply, and IRS may redetermine the amount of a covered entity's fee under the provision for any calendar year for which the statute of limitations remains open. For Code Sec. 275 purpose (nondeductibility of specified taxes), the fee is a nondeductible tax.

A covered entity must report to IRS the amount of its net premiums written during any calendar year with respect to health insurance for any U.S. health risk. A penalty for noncompliance applies unless it is shown that the failure is due to reasonable cause.

Source: Federal Tax Updates on Checkpoint Newsstand tab 3/29/2010

Taxpayer needed IRS consent to change its book method for deferred advanced payments

Chief Counsel Advice 201011009

In Chief Counsel Advice (CCA), IRS has concluded that an accrual method taxpayer that had used the deferral accounting method in Rev Proc 2004-34, 2004-1 CB 991, to defer advance payments, had to obtain IRS's consent under Code Sec. 446(e) to change its applicable financial statements (book method) for deferred advance payments.

Background on accounting method change. Under Code Sec. 446(e), a taxpayer that changes the accounting method on which it regularly keeps its books must generally secure IRS's consent before computing taxable income under a new method. Under Reg. § 1.446-1(e)(2)(ii)(a), a change in accounting methods includes a change in the overall plan of accounting for gross income or deductions or a change in the treatment of any material item used in such overall plan. A material item is any item that involves the proper time for the inclusion of an item in income or the taking of a deduction. Under Code Sec. 481, taxpayers must make an adjustment to prevent any duplication or omission of amounts attributable to previous years that would otherwise result from any change in an accounting method.

Background on accruing income. Reg. § 1.451-1(a) provides that under an accrual accounting method, income is includible in gross income when all the events have occurred that fix the right to receive the income and the amount can be determined with reasonable accuracy. All the events that fix the right to receive income generally occur when (1) the required performance occurs; (2) payment is due to the taxpayer; or (3) payment is received by the taxpayer, whichever happens earliest. (Rev Rul 84-31, 1984-1 CB 127)

Under Rev Proc 2004-34, 2004-1 CB 991, a taxpayer is generally allowed to defer the inclusion in gross income of advance payments to the next succeeding tax year. A payment is an advance payment if: (1) including the payment in gross income for the tax year of receipt is a permissible method of accounting for federal income tax purposes; (2) the payment is recognized by the taxpayer (in whole or in part) in revenues in its applicable financial statement for a later tax year; and (3) the payment is for certain specified activities, including the performance of services.

Facts. Accrual method Taxpayer is in the business of providing services to clients. The clients generally make advance payments to Taxpayer for services that it provides to them over a period of 15 months. Taxpayer performs most of these services in the first 10 months of the 15-month period.

For Year 1, Taxpayer properly filed a Form 3115, Application for Change in Accounting Method, and requested permission to change its method of accounting for advance payments to the deferral method in Rev Proc 2004-34. IRS granted permission. Under this deferral method, for Years 1 and 2, Taxpayer deferred to the next succeeding tax year the

inclusion in gross income of advance payments for tax purposes to the extent the advance payments were not recognized in revenues in its applicable financial statement for the year of receipt. Taxpayer included the payments in income on a pro rata basis over the first 10 months of the 15-month period during which it performed services.

In Year 3, Taxpayer's financial auditors determined that its book method of accounting for advance payments improperly overstated revenues. Taxpayer changed its book method for advance payments in order to recognize the advance payments in income in its applicable financial statements on a pro rata basis over the entire 15-month period during which it performs the services. Taxpayer began using this new book method for advance payments in its applicable financial statement for Year 3 and restated its applicable financial statements for Years 1 and 2.

Beginning in Year 3, Taxpayer reported income from advance payments on its return in the same manner as in its Year 3 applicable financial statement, i.e., consistent with the taxpayer's new book method. Taxpayer didn't file a Form 3115 to request IRS's consent to change its accounting method.

IRS's consent required. The CCA concluded that Taxpayer, which previously elected to defer advance payments under Rev Proc 2004-34, was required to obtain IRS's consent under Code Sec. 446(e) to change its book method for the deferred advance payments.

Taxpayer asserted that a change in its underlying book method for advance payments was not a change in method of accounting under Code Sec. 446(e) because the taxpayer had already received advance consent to change its method of accounting for advance payments to the deferral method, using its applicable financial statement, under Rev Proc 2004-34. The CCA disagreed. It reasoned that Taxpayer adopted a method of accounting for the inclusion of advance payments for Year 1 and 2 under which it included the payments in income on a pro rata basis over the first 10 months of the 15-month period during which it performed services. In conjunction with changing its method of recognizing revenues for financial purposes, Taxpayer changed in Year 3 to including advance payments in income for tax purposes on a pro rata basis over 15 months. Thus, it changed the timing of including an item in income from the timing of including that item in income in the previous two years.

Taxpayer's treatment of advance payments was a material item under Code Sec. 446 because both methods determined in which tax year the income was included and neither method created a permanent change in Taxpayer's lifetime taxable income. Accordingly, the change in timing of inclusion of the advance payments was a change in an accounting method under Reg. § 1.446-1(e)(2)(ii)(a). As a result, Taxpayer was required to file a Form 3115 to obtain IRS's consent to make this change.

The CCA was also not persuaded by Taxpayer's argument that the use of its new book method for purposes of Rev Proc 2004-34 shouldn't be treated as a change in accounting methods because any omission or duplication could be avoided by making an adjustment on a cut-off basis. Under the cut-off method, only the items arising on or after the beginning of the year of change are accounted for under the new accounting method; any items arising before the year of change continue to be accounted for under the taxpayer's former accounting method. The CCA noted that use of the cut-off basis was premised on the existence of a Code Sec. 446(e) change in accounting methods and, further, that it could find no authority allowing a taxpayer in Taxpayer's situation to make such a change on a cut-off basis.

RIA Research References: For advance payments received by accrual basis taxpayers, see FTC 2d/FIN ¶ G-2540 et seq.; United States Tax Reporter ¶ 4514.166 ; TaxDesk ¶ 441,708 et seq.

Source: Federal Tax Updates on Checkpoint Newsstand tab 3/26/2010

Accounting, SEC, SOX, etc. News—

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AICPA's Auditing Standards Board issues four auditing interpretations

Summary: *The auditing interpretations address questions from auditors about AU Section 325, which provides guidance on communicating matters related to an entity's internal control over financial reporting identified in an audit of financial statements.*

The Auditing Standards Board, the senior technical committee of the AICPA designated for issuing auditing, attestation, and quality control standards and guidance, issued four auditing interpretations of AU Section 325, *Communicating Internal Control Related Matters Identified in an Audit*, on March 24, 2010:

- Interpretation No. 1, "Communicating Deficiencies in Internal Control Over Compliance in an Office of Management and Budget Circular A-133 Audit";
- Interpretation No. 2, "Communication of Significant Deficiencies and Material Weaknesses Prior to the Completion of the Compliance Audit for Participants in Office of Management and Budget Single Audit Pilot Project";
- Interpretation No. 3, "Communication of Significant Deficiencies and Material Weaknesses Prior to the Completion of the Compliance Audit for Auditors That Are Not Participants in Office of Management and Budget Pilot Project"; and
- Interpretation No. 4, "Appropriateness of Identifying No Significant Deficiencies or No Material Weaknesses in an Interim Communication.

Source: WG&L Accounting & Compliance Alert Checkpoint 3/29/2010

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