

2013 PPACA Tax Overview Reference Guide

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Guide overview:

This reference guide highlights several key tax, funding, and coverage implications stemming from the Patient Protection and Affordable Care Act (PPACA). Topics include:

1. The tax implications of the Individual Mandate (Section I).
2. An overview of how premium subsidies will impact individuals and employees (Section II).
3. Several key tax implications impacting employers, including small employer tax credits, large employer tax penalties, W-2 reporting requirements, and employer deductions for retiree drug coverage (Section III).
4. Several new miscellaneous taxes, including an expanded Medicare tax, a “Cadillac” tax on high-cost insurance plans, and changes in how health savings accounts and similar financing arrangements operate (Section IV).
5. An overview of several key Medicaid and Medicare changes and how employers will be impacted.

Section 1.0

Individual Mandate and Tax Implications

After much speculation by legal experts, PPACA's Individual Mandate was upheld by the U.S. Supreme Court. This provision, which requires every individual obtain "essential minimum coverage" or pay a tax penalty beginning January 1, 2014, has tax implications for families and individuals. Section 1.0 of this reference guide highlights what you need to know.

1.1 To whom does the Individual Mandate provision apply?

The tax will be levied against any "applicable individual" who fails to maintain health insurance coverage for him/herself and his or her dependents. This Individual Mandate is an integral part of PPACA to ensure full participation by all U.S. citizens unless they are exempted. In theory, this will help spread the risk and make sure everyone is participating in the insurance system. Massachusetts used a similar approach when implementing a tax-enforced insurance mandate imposed on its residents several years ago. However, PPACA's mandate applies to anyone who is in the U.S. legally and who is not otherwise exempted from securing health insurance.

1.2 Who is exempted from the Individual Mandate?

The tax penalty will not be levied against individuals who:¹

- Already have qualified coverage through an employer-sponsored plan or through a state health benefit exchange.
- Are enrolled in a Medicaid or Medicare program.
- Are covered by a military plan.
- Are dependents of active military enrolled in a TriCare plan.
- Express a religious objection.
- Are incarcerated.
- Are members of an Indian tribe.
- Are undocumented aliens.

In addition, individuals (or families) will not be subject to the Individual Mandate requirements if they are without coverage for less than three months or if the Secretary of the U.S. Department of Health and Human Services (HHS) determines that obtaining coverage would constitute an extreme hardship for a particular individual. Further if an individual would be contributing more than 8% of their household income as a "required contribution," that person is likewise excused from the Individual Mandate requirement.

1.3 What is "Minimum Essential Coverage"?

The definition of minimum essential coverage is left to the HHS Secretary but can take on several forms through coverage obtained from:²

- An approved government program (for example, Medicaid, Medicare).
- An eligible employer-sponsored plan.

- A state's health insurance exchange.
- A grandfathered plan.

In addition, other coverage may meet the minimum essential coverage as deemed appropriate by the HHS Secretary after consulting with the Secretary of the U.S. Treasury. See also the response to question 5.12.

1.4 How much is someone taxed/penalized if he opts out of an approved health plan?

The annual tax (formerly known as a penalty) for not having minimum essential coverage will be the greater of a flat dollar tax amount per individual or a percentage of the individual's taxable income.

1.5 How much is the flat tax for individuals?

The applicable flat dollar amount for 2014 for a tax filer with no dependents will be \$95, and the amount for 2015 will increase to \$325.³ This amount will increase over the years, rising to \$695 in 2016, and will be further revised in 2017 according to the changes in cost of living.

1.6 Are dependents subject to a tax also?

Yes. Each tax filer is also responsible for the tax due on any dependents, including children younger than 18 who will be assessed one-half the adult amount.⁴ There is a household cap, as the total tax penalty cannot exceed three times the amount of the applicable flat dollar amount for an individual.

1.7 How are families subject to the tax?

Each adult will pay the rate of an individual and be responsible for each dependent at the 50% rate. For example, in 2016 a couple with one child under 18 would be assessed a flat dollar penalty of \$1,737.50 (two adults x \$695 plus one child at \$347.50—one half of adult penalty).

A family of four (one couple with two children over 18) would only be required to pay the 300% cap in 2016 (300% of the \$695 flat amount for 2016 is equal to \$2,085). This amount is less than the flat amount that could be charged if the cap were not in place (two adults + two children over 18 = \$695 x 4 = \$2,780).

1.8 How will income impact the tax rate?

There are many nuances on how to calculate the amount of tax owed if an individual has a high income and declines to purchase insurance.⁵ PPACA establishes a minimum amount of income that triggers the requirement of a tax payer to file a federal income tax return. As with the flat dollar calculations, there is also a maximum applied to the overall penalty. Under a sliding scale, the taxable income is an amount equal to a percentage of a household's income (as defined by PPACA) that is in excess of the tax filing threshold (phased in at 1% in 2014; 2% in 2015; 2.5% in 2016).

The tax penalty cannot exceed “the national average premium for qualified health plans which have a bronze level of coverage” for the taxpayer’s family size. While this national average premium has not yet been established, the Congressional Budget Office has estimated that the yearly individual premiums for a Bronze plan may average between \$4,500 and \$5,000. The estimated yearly family premium for 2015 may be between \$12,000 and \$12,500.

1.9 Can you clarify further how the Individual Mandate tax will work?

The National Federation of Independent Business (NFIB) has stated the following, which is helpful:

Penalties begin in 2014 and rise in years following. In each new year, the penalty consists of the higher of a dollar amount or a percentage of household income. For a given household, the penalty applies to each individual, up to a maximum of three.

Following is the schedule of penalties:

- 2014: The higher of \$95 or 1.0% of taxable income. Maximum \$285 (=3 x \$95) per household.
- 2015: The higher of \$325 or 2.0% of taxable income. Maximum \$975 (=3 x \$325) per household.
- 2016: The higher of \$695 or 2.5% of taxable income. Maximum \$2,085 (=3 x \$695) per household.

Here are some additional NFIB examples for families:

- 2014; family of two; taxable income=\$26,000; **penalty=\$260** ($\$260 = \$26,000 \times 1\% > \$190 = \95×2)
- 2014; family of three; taxable income=\$26,000; **penalty=\$285** ($\$260 = \$26,000 \times 1\% < \$285 = \95×3)
- 2016; family of three; taxable income=\$26,000; **penalty=\$2,085** ($\$650 = \$26,000 \times 2.5\% < \$2,085 = \695×3)
- 2016; family of three; taxable income=\$85,000; **penalty=\$2,125** ($\$2,125 = \$85,000 \times 2.5\% > \$2,085 = \695×3)
- 2016; family of eight; taxable income=\$85,000; **penalty=\$2,125** ($\$2,125 = \$85,000 \times 2.5\% > \$2,085 = \695×3)

1.10 How do individuals know that they are paying the right tax amount?

Over the coming year, the federal government will publish more details on how and when individuals might have to pay a tax. In addition, tax experts, brokers, and others will be able to provide additional details as the specific details are sorted out before 2014.

Section 2.0 Premium Subsidies

PPACA authorizes the payment of premium subsidies for qualified health coverage for certain individuals and families when their income is under 400% of the federal poverty level. Section 2.0 provides some background on the payment structure.

2.1 What types of premium subsidies will be available for individuals?

Beginning in 2014, PPACA will provide subsidies for individuals with incomes between 133% and 399% of the federal poverty level (FPL). Individuals eligible for government programs are not eligible for health insurance premium subsidies. Likewise, individuals who are offered employer health benefits coverage are not eligible for premium tax credits unless the employer plan does not comply with at least a 60% actuarial value, or unless the individual's share of the premium for employer-sponsored health insurance exceeds 9.5% of their income. The subsidy offered is tied to the second-lowest cost Silver level benefit plan offered by the exchange. This plan is estimated to cover 70% of the average person's health care expenditures for one year.

Individuals who have coverage that fails to meet the thresholds are eligible for the followings subsidies:

Premiums and Cost Sharing Subsidies Under the Patient Protection & Affordable Care Act

Reported Income (% poverty level)	Premium Subsidies (% of income cap)	Actuarial Value	Out-of-Pocket Maximum
<133	0%	100%	–
133–149	3%–4%	94%	\$1,983
150–199	4%–6.3%	87%	\$1,983
200–249	6.3%–8.05%	73%	\$2,975
250–299	8.05%–9.5%	70%	\$2,975
300–399	9.5%	70%	\$3,967
≥400	–	60%	\$5,950

Although the premium subsidies will greatly assist individuals with lower incomes, these subsidies will likely prove extraordinarily complex for these individuals to understand and to use to their advantage. Likewise, the process of enforcing the subsidies and tax credits will consume a great deal of time and resources for the IRS.

2.2 How do premium subsidies impact employees?

Employees who are offered employer-sponsored health benefits **are not eligible** for the premium tax credits if:

- The employer sponsored health benefits comply with the 60% actuarial value threshold.
- The employee's share of the premium for the health insurance benefit does not exceed 9.5% of his income.

Employees who are offered employer-sponsored health benefits **are eligible** for the premium tax credits if:

- The employer sponsored health benefits do not comply with at least a 60% actuarial value.
- The employee's share of the premium for employer-sponsored health insurance exceeds 9.5% of his income.
- The employee seeks health care coverage through a state health insurance exchange and receives a subsidy.

Section 3.0 Employer Requirements and Tax Implications

PPACA also contains many tax implications for small and large employers. Specifically, Section 3.0 covers how PPACA:

- Provides premium subsidy via tax credits for small employers.
- Assesses the potential monetary penalties to large employers who do not offer coverage or the right level of coverage.
- Creates new W-2 reporting requirements for most employers.
- Limits employer deductions for retirees' drug coverage.

Part A: Small Employer Tax Credits

3.1 Can a small employer receive federal funding assistance under the PPACA?

Yes. Under PPACA, small employers offering health insurance coverage to employees enjoy several benefits, including a new income tax credit. However, certain criteria must be met as described below.

3.2 How does PPACA define a small employer for purposes of qualifying for a tax credit?

Eligible small employers are defined as those employing fewer than 25 full-time-equivalent employees with average annual wages of less than \$50,000 and contributing to employees' qualified health care coverage a uniform percentage, no less than 50 percent, of the premium cost. These employers are eligible for a partial tax credit. Employers who pay annual wages greater than \$50,000 are not eligible for the tax credit, as the purpose of the tax credit is to incentivize small employers to provide insurance to employees who earn low wages. Employers can receive the full amount of the tax credit percentage if they employ ten or fewer full-time employees and pay an average of \$25,000 or less in annual wages. If an employer chooses to purchase insurance outside of a state health insurance exchange, that employer will not be eligible for the tax credit.

3.3 When does a small employer get a tax credit to help subsidize the premiums?

In keeping with PPACA's stated goal of providing health care to all Americans, the Government Accountability Office (GAO) closely examined the small business tax credit. The GAO report states that while "about 17 percent of employers with less than 10 employees who earn low wages offered health insurance to their employees in 2011, about 90 percent of employers with 100 to 999 employees who earn low wages did." To remedy this problem, PPACA offers a tax credit to eligible small employers, as described above. If an eligible employer meets the specified criteria, the employer can then "claim the credit as part of the general business tax credit and use it to offset actual tax liability. If they do not have a federal tax liability, they cannot receive the credit as a refund but may carry the credit forward or back to offset tax liabilities for other years." Employers that claim the credit also are permitted to deduct health insurance expenses on any tax returns minus the amount of the credit. The credit may be claimed for up to six years; initially, the tax can be claimed from 2010 through 2013, and if insurance is purchased through an Exchange, an employer may claim the credit for an additional two years.

The tax credit for small business employers, or "for-profit" companies that meet the requirements, equals 35% of the employee's annual premiums the employer pays for the years before 2014, and will increase to 50% after 2014. The tax credit for "not-for-profit" organizations is substantially lower, with those employers only eligible for a 25% tax credit computed in the same manner as described above.⁶

The income tax credit is subject to several limitations. Employers are only eligible for up to 50 percent of an average premium costs for the surrounding area.⁷ Also, the credit is effectively phased out as additional employees are hired, beginning with the eleventh employee.⁸ Finally, the amount of the credit decreases as the average wage paid by the employer raises above \$25,000 annually.

Part B: Large Employer Tax Penalties

3.4 How does PPACA define a large employer?

A large employer is defined as employing at least 50 full-time equivalent employees in the previous calendar year, for at least 120 days.⁹ A full-time employee is defined as one who works at least 30 hours of service per week.¹⁰ Part-time employees are also added into this calculation by adding together the total hours worked by all part-time employees and dividing that total by 120.¹¹

3.5 Do large employers get help funding employer-sponsored coverage?

No. Under PPACA, a premium subsidy program is not established for a large employer. In fact, a tax penalty may be assessed against a large employer as described below.

3.6 What is the tax penalty that may be assessed against a large employer?

Perhaps the most important requirement that PPACA imposes on large employers is the requirement that large employers must offer medical coverage to substantially all of its full-time employees and their dependents beginning in 2015.¹² If a large employer fails to offer appropriate coverage, that employer may be liable for a tax penalty.

3.7 What triggers the tax penalty for large employers?

The tax penalty can be triggered in one of two ways:

1. If the employer does not offer coverage, and at least one of its full-time employees claims the premium assistance tax credit.
2. The employer does offer coverage, but the coverage fails to meet the minimum essential coverage threshold (as defined in section 1.3) and one full-time employee is certified to claim the premium tax credit.¹³

3.8 What is the minimum essential coverage threshold?

The type of coverage an individual, employer, or health plan must meet to satisfy the requirements under PPACA, avoid paying tax penalties, and qualify for premium subsidies are outlined in section 1.3 of this reference guide. Minimum essential coverage can include individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. For example, a bare bones or catastrophic only policy would not qualify.

Minimum essential coverage can be obtained through a government sponsored plan, an employer-sponsored plan, plans obtained in the individual market, grandfathered health plans, and any other health benefits coverage recognized by the Secretaries of HHS and the Treasury. The IRS defines “minimum essential coverage” as a term “to include health insurance coverage offered in the individual market (such as a qualified health plan enrolled in through an Affordable Insurance Exchange (Exchange)), an eligible employer-sponsored plan, or government-sponsored coverage such as Medicare, Medicaid, the Children’s Health Insurance Program, TRICARE, or veterans’ health care under chapter 17 or 18 of Title 38 U.S.C.”¹⁴

3.9 How much will the tax penalty cost?

The monthly penalty a large employer is obligated to pay for **not offering any coverage** is equal to \$2,000 divided by 12, times the number of full-time employees employed during the applicable month, minus the first 30 full-time employees. Only full-time employees (not full-time equivalents) are counted for purposes of determining the penalty.

A large employer that **offers coverage which does not satisfy the minimum value or minimum affordability threshold** is assessed a penalty of \$3,000 divided by 12, times the number of employees that qualify for the tax credit. The purpose of the tax penalty in this case is to reimburse the federal government the cost of the premium assistance tax credit afforded to the employee.¹⁵

Part C: Employer W-2 Reporting Requirements

3.10 What is the W-2 reporting requirement that the PPACA establishes?

An additional requirement imposed on employers by PPACA concerns reporting the cost of employer-sponsored healthcare coverage on employees' W-2 forms for all tax years starting on or after January 1, 2011.¹⁶ This deadline was revised through IRS Notice 2010-69. Additional guidance on this subject was issued in March 2011 by the IRS.

3.11 Who must report the cost of employer-provided health insurance?

The reporting requirement is applicable to all employers that provide group health plans, including federal, state, and local governments and religious organizations. The Notice provides two exemptions.

An employer need not report if:

1. The employer was required to file fewer than 250 W-2 Forms for the preceding calendar year.
2. The employer is a federally recognized Indian tribal government.

3.12 What exactly must an employer report?

Guidance issued by the IRS clarifies that employers must report the aggregate cost of applicable employer-sponsored coverage.¹⁷ Key terms include the following:

Applicable employer-sponsored coverage is defined as "the total cost of coverage under any group health plan made available to the employee by an employer that is excludable from the employee's gross income, or would be so excludable if it were employer-provided coverage."¹⁸

A group health plan is defined as “a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.”¹⁹

3.13 What costs are excluded from the aggregate reportable cost?

Several costs are not included in the aggregate reportable cost of the applicable employer-sponsored coverage. The following is a list of those costs:

- The amount contributed to any Health Savings Account (HSA) or Archer Medical Savings Account (MSA)
- The amount of Health Flexible Spending Arrangement funded solely by salary reduction amounts
- An employer’s contributions to a multiemployer plan (this item is optional)
- Costs of coverage under a stand-alone dental plan or a vision plan (this item is optional)
- Costs of coverage provided by the federal government, the government of any state or political subdivision thereof, or any agency or instrumentality of any such government, under a plan maintained primarily for members of the military or for members of the military and their families.²⁰

3.14 When should an employer report the cost of the health benefit on the employee’s W-2?

The reporting requirement is effective for January 1, 2013, for W-2 forms referencing tax year 2012 and thereafter. For an employee who terminates before the end of the calendar year and requests a W-2 in writing, the employer may report the cost of health benefit plan coverage. Otherwise, employers must include the cost of an employee’s health benefit on the W-2 that must be postmarked no later than January 31, 2013, and for each succeeding year thereafter.

As previously stated, this is interim guidance. The federal government will issue final rules at some time in the future.

Part D: Employer Deductions for Retiree Drug Coverage

3.15 How does PPACA limit employer deductions for retiree drug coverage?

Prior to January 1, 2013, employers are authorized by the Medicare Modernization Act of 2003 to a tax-free subsidy of 28 percent of the costs they incur to provide a prescription drug benefit program to their retirees. Employers are also permitted to deduct any outlays made with these subsidies to provide retiree drug coverage for income tax purposes. This legislation was intended to provide relief by reducing the coverage gap, known as the Donut Hole, for individuals in the Medicare Part D program.

Under PPACA, employers will still receive the tax-free subsidy after 2012, but they will no longer be able to deduct on their federal tax returns the cost of the prescription drugs to the extent reimbursed by the federal subsidy.²¹

3.16 What type of economic impact will this have on businesses?

The economic impact of this provision should not be underestimated. Even though this provision did not become effective until 2013, its impact on a company's bottom line could be significant. A Towers Watson study estimates that the total cost would be \$14 billion if companies do not shift their retired employees out of drug subsidy plans. An American Benefits Council study concluded that between 1.5 million and 2 million retirees would have their drug coverage terminated because employers would be forced to shift them into Medicare Part D coverage.

This provision may have an unanticipated impact of losing the federal government a substantial amount of money. James A. Klein, president of the American Benefits Council, explains, "The \$4.5 billion figure only looks at the revenue from the tax; it does not take into account the increased government outlays as retirees are moved to the Medicare Part D program. As more retirees are moved, the revenue collected will go down, and the government expense in Medicare will go up."

Section 4.0 Additional PPACA Tax Provisions Impacting Employers and Employees

PPACA also includes a number of other tax provisions that both directly and indirectly impact employers and their employees. Section 4.0 covers an expanded Medicare tax, a "Cadillac" tax on high-cost insurance plans, and changes in how health savings accounts and similar financing arrangements operate.

Part A: The Unearned Income Medicare Contribution Tax

4.1 What is the PPACA Medicare tax increase?

PPACA includes a provision that will create a new tax for certain Americans. Specifically, section 1411 of PPACA imposes an additional tax of 3.8% if certain conditions are met. Currently, individuals pay a Medicare tax of 2.9% of their wages. The new tax is in addition to the current Medicare taxes and expands the definition of income subject to Medicare taxes. The tax also applies to trusts and estates.

4.2 When does the tax become effective?

The tax applies to taxable years beginning after December 31, 2012.

4.3 Who will be impacted by this tax increase?

The tax applies to single taxpayers with a modified adjusted gross income of \$200,000 or higher and married taxpayers with a modified adjusted gross income of \$250,000 or over. The tax also applies to a married person filing separately whose modified gross adjusted income exceeds \$125,000. Anyone with a modified adjusted gross income below these amounts is be subject to the tax.

4.4 How is the tax calculated?

The tax is calculated by multiplying the 3.8% tax rate by the lower of either the “net investment income” for the year or the “modified adjusted gross income” over the threshold amount.

4.5 What is “net investment income” for the purpose of the new tax?

In calculating net investment income for purposes of the new tax, items such as interest, dividends, capital gains, annuities, royalties, rents, and pass-through income from a passive business (for example, S-corporations and partnerships) are included. Items such as tax-exempt municipal bond interest, nontaxable veteran’s benefits, capital gains excluded from the sale of a principal residence, distributions from IRAs, 403(b) plans, 401(k) plans, 457 plans, pensions, profit-sharing plans, stock bonus plans, or qualified annuity plans are not included in net investment income calculations.

4.6 What is “modified adjusted gross income” for the purpose of the tax?

For the purpose of the new tax calculation, the modified adjusted gross income includes wages, salaries, tips, other compensation, dividend and interest income, business and form income, realized capital gains, and income from other passive activities and the foreign earned income exclusion or foreign housing exclusion included.

4.7 What income is excluded from the new tax hike?

Income not subject to the modified adjusted gross income calculations includes income derived from: tax-exempt municipal bond interest, capital gains excluded from the sale of a principal residence, nontaxable veteran’s benefits, and IRA, 403(b) plan, 401(k) plan, 457 plan, or pension distributions. Proceeds from stock bonus plans, profit-sharing plans, or qualified annuity plans are also exempt.

Part B: Excise Tax on Comprehensive, High-Cost Health Insurance Plans

4.8 What is the new excise tax on comprehensive, high-cost insurance plans?

In an effort to penalize employers who offer excessively rich health benefit plans, PPACA includes an excise tax on high-cost health plans, called “Cadillac” health arrangements. This is a new, nondeductible 40% excise tax that some experts have estimated will affect more than half of large employers’ active health plans by 2018.

The Congressional Budget Office estimates that 19 percent of workers with employment-based coverage would be affected by the excise tax in 2016 and hypothesize that “most people would avoid the cost of the excise tax by enrolling in plans that had lower premiums.” The study then states that this is only a guess, as how enrollees, insurers, employers, and other key actors will respond to the tax is extremely uncertain.

Currently, employees are able to exclude from gross income calculations both employer contributions for health care coverage and the value of medical services that the employee receives under the coverage. Edward A. Zelinsky writes, “This favorable tax treatment effectively immunizes the employee from confronting the cost of his medical coverage and services. This, in turn, leads to elevated levels of medical service consumption and the large costs attendant to such consumption.” Thus, the excise tax was included in PPACA to generate additional revenue to help pay for the uninsured and to motivate employers to use utilization reducing measures that would not reward overutilization of health care services.

4.9 When does the excise tax become effective?

The tax becomes effective January 1, 2018.

4.10 How is the excise tax calculated?

The 40% nondeductible tax will be levied on employers and assessed against the annual value of any excess benefit provided under applicable employer-sponsored coverage.²² Excess benefit is defined as exceeding the aggregate of \$10,200 for single coverage or \$27,500 for family coverage in 2018. Those in high-risk professions and retirees are subject to higher thresholds.

4.11 What is excluded from the excise tax calculation?

Stand-alone vision and dental benefit expenses are excluded from the calculation. Employers with a workforce of older or female workers who have higher-than-average health costs will be held to higher thresholds.

4.12 How would this tax impact insurance premiums?

Employers subject to this tax in 2018 will either have premiums increased by the insurer on an insured health benefit plan or be subject to a surcharge levied by the administrator of a self-funded health benefit plan. Thus, employers will be forced to either absorb the additional cost of the tax or pass some, or all, of the cost increase on to employees in the form of higher premiums or higher deductibles. Ultimately, the cost of this tax will likely be passed on to the employees covered by the plan.

4.13 What are the long-term implications of this tax?

While the thresholds for this tax may appear to be avoidable for now, the longer-term implications are daunting. A study conducted by Tower Watson found that the average 2010 cost of medical coverage for nonretiree single coverage was \$5,184, and a nonretiree family plan was \$14,988. Using past levels of premium increases projected forward, the study estimates that many employer benefit plans will exceed the excise tax threshold.

Dave Ostendorf, a consulting actuary with Towers Watson explains, "All it takes to drive costs above the excise tax cap for six in ten employers is an 8% average annual cost increase. And, without making plan design changes, that's what many employers are projecting."

Part C: Assessing the Impact of PPACA on HSAs, MSAs, FSAs, and HRAs

4.14 How will PPACA change the way health savings accounts and similar financing arrangements operate?

Section 9003 of PPACA establishes a new uniform standard for the preferred tax treatment of medicine and drug expenses for Health Savings Accounts (HSAs), Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs). Effective January 1, 2011, only prescribed medicines or drugs including over-the-counter medicines and drugs that are prescribed will be considered qualifying medical expenses. Over-the-counter drugs purchased without a prescription will no longer qualify for preferred tax treatment, and these accounts will no longer pay for or reimburse the cost of these items. Additionally, PPACA increases the penalty tax for using HSA and MSA funds for nonmedical purposes to 20% beginning in 2011.²³ Finally, PPACA also limits annual FSA contributions for health care to \$2,500.²⁴

4.15 What, if any, medical supplies are exempt from this provision?

Insulin purchased with or without a prescription still qualifies for the preferred tax treatment. In addition, durable medical equipment or other nondrug medical items acquired over the counter such as bandages, tape, and crutches and diagnostic items such as glucose monitors are exempted.

4.16 What verification is required to preserve the preferred tax treatment?

Individuals seeking reimbursement from an employer-sponsored HSA, MSA, FSA, or HRA should submit a copy of the prescription along with the receipt showing the date and amount of the purchase with the request for reimbursement.

For further information, including guidance on purchases of over-the-counter medicines and drugs from health care providers other than pharmacies and mail order and web-based vendors (such as physicians or hospitals), please see IRS Notice 2011-5.

Section 5.0 Medicaid and Medicare Changes and the Impact on Employers

Section 5.0 highlights several key changes to the Medicaid and Medicare Programs that will impact employers, including the Medicaid expansion, emphasis on prevention and related services, and changes to Medicare Part D Program.

Part A: The Expanding Medicaid Program

5.1 How did PPACA initially attempt to expand the Medicaid program?

In keeping with its stated goal of providing health care coverage to all Americans, PPACA contains several provisions designed to significantly expand the number of persons covered under state Medicaid programs.²⁵ The federal government initially attempted to expand the number of individuals with health care coverage by establishing one national standard for Medicaid participation.

Beginning in 2014, states that choose to expand their eligibility criteria will allow individuals with modified adjusted gross incomes below 133% of the federal poverty level (FPL) to participate in a state Medicaid program. Also, children currently covered by state Children's Health Insurance Programs (CHIP) in households with modified adjusted gross incomes (MAGI) between 100% and 133% of the FPL would be transitioned to Medicaid coverage. Under the expanded eligibility requirements, there would be no assets test or resource test. It was originally estimated that this expansion, on a nationwide basis, would cover 21 million or one half of the targeted uninsured that would have been covered by PPACA.

5.2 How did the U.S. Supreme Court ruling impact this expansion goal?

The Medicaid expansion requirements were challenged by the Attorneys General of 26 states who argued the provisions were overly coercive and effectively threatened states with the loss of all Medicaid federal funding if a state refused to implement the expanded eligibility criteria. The U.S. Supreme Court agreed with this argument and ordered the provisions be narrowed.

5.3 What practical impact will the Court's decision have?

Due to the Supreme Court decision, the number of persons who will be covered by state Medicaid programs will be less than originally anticipated. Large numbers of currently uninsured individuals reside in states such as Florida and Texas that have decided not to expand their Medicaid eligibility requirements due to budget constraints. In 2014, many residents of states that refuse to adopt the expanded criteria and who would have been covered will now be moving into the state health insurance exchanges,

becoming eligible for federal subsidies. This will significantly increase the number of people covered by federal subsidized health insurance and effectively shift some of the coverage costs away from states and back to the federal government.

5.4 How will the Medicaid expansion post the U.S. Supreme Court ruling impact employers?

Employers may experience different cost obligations depending on how each state adopts PPACA's new requirements for covering the underinsured or uninsured individuals. Milliman provides some insights to this question when it wrote:

The change to Medicaid expansion could also complicate matters for employers. Under PPACA, employers with over 50 employees may be subject to additional plan affordability penalties for employees under 133% FPL—unless these individuals are Medicaid eligible. If a state does not expand Medicaid, employers above 50 lives may be subject to more plan affordability penalties than they would be were their state to pursue Medicaid expansion. In this sense, a state's decision to expand Medicaid may have cost implications for employers.

More specifics will become available as each state decides how to move forward with PPACA's Medicaid provisions.

Part B: Emphasis on Prevention and Related Services

5.5 Will preventive services be offered to Medicaid and Medicare enrollees?

One of the more popular provisions of PPACA concerns the preventive care services benefit. This provision provides coverage for preventive services and applies to those covered by private health benefit plans as well as government health insurance programs. Both Medicaid and Medicare programs must now provide beneficiaries with preventive services with no cost sharing, deductibles, or copays. Services such as an annual wellness visit, screenings for various illnesses, and flu shots are covered under the benefit.

5.6 What are some of the additional benefits that Medicare will be offering?

Here are some examples of prevention and wellness benefits that will be offered to Medicare enrollees:

- Initial preventive physical examination
- Annual wellness visit
- Cancer screenings
- Cardiovascular disease screening
- Diabetes screening and self-management training
- Glaucoma screening
- Human immunodeficiency virus (HIV) screening
- Immunizations
- Medical nutrition therapy (for beneficiaries with diabetes or renal disease)

- Tobacco-use cessation counseling
- Screening for depression in adults
- Intensive behavioral therapy for obesity

5.7 What are some of the additional benefits that Medicaid will offer?

Medicaid also now provides the following services:

- Benchmark Benefit Plans, including mental health services and prescription drugs
- Family Planning—States have the option to begin providing medical assistance for family planning services and supplies
- Hospice Care for Children—Children enrolled in Medicaid or the Children’s Health Insurance Program (CHIP) are now assured hospice care
- Preventive and Obesity-Related Services—States can choose to cover specified obesity-related services at no cost to adult Medicaid enrollees
- Tobacco Cessation, including counseling and pharmacotherapy

Other services will be offered as well. Some customization will be likely at the state level since Medicaid is a state/federal program.

5.8 How will employers be impacted by the general expansion of preventive health care services?

Generally speaking, premium increases will be experienced both in the private and public sectors as these new services are covered with little or no cost-sharing requirements. Some actuaries say this will reduce the overall costs to the health care system. Others disagree. In the short term, employers will pay more into the health care system through premium increases and/or through increased taxes/penalties.

Part C: Medicare Part D Updates

5.9 What are some of the Medicare Part D improvements?

PPACA also includes a provision that addresses the gap in drug coverage in Medicare Part D. This gap, called the “Donut Hole,” has left many Medicare enrollees without sufficient prescription drug coverage. Many Medicare Advantage Prescription Drug Plans often do not have a Donut Hole, but the coverage is more expensive. Beginning in 2011, PPACA provides for a 50% discount on covered name brand drugs that Medicare enrollees need.

5.10 How does the Medicare Part D Coverage work?

Healthcare.gov provides information that explains the updated Medicare Part D prescription drug discount program. The Congressional Research Service also provides a helpful explanation of the Donut Hole as it was in 2010.²⁶

How the program currently works:

- Patients pay out-of-pocket for monthly Part D premiums.
- Patients pay 100% of their drug costs until they reach the \$310 deductible amount.

- After fulfilling the deductible, a patient will pay 50% for brand name drugs and 86% for generic drugs, while the Part D plan pays the rest, until the total spent on an individual's drugs reaches \$2,830.
- Once the patient reaches \$2,830, the patient has reached the coverage gap referred to as the "Donut Hole," and he is now responsible for the full cost of his drugs until the total the catastrophic threshold of \$6,440 is reached. Specifically between the \$2,830 to \$6,440 threshold, each patient will pay 100% of the costs.
- After hitting this annual spending limit, patients are only responsible for a small amount of the cost, usually 5% of the cost of the drugs thereafter. This is referred to as Medicare catastrophic coverage.

Starting in 2013, patients will pay less and less for brand-name Part D prescription drugs in the Donut Hole. By 2020, the coverage gap will be closed, meaning there will be no more "Donut Hole," and they will only pay 25% of the costs of drugs until they reach the yearly out-of-pocket spending limit.

HHS has also provided further information in its "2010 Medicare & You Handbook."

5.11 What are the tax consequences of the Medicare Part D Program for employers?

Law Professor Edward A. Zelinsky, a well-known tax expert, provided a concise answer to this question when he wrote:

When Congress adopted Medicare Part D, providing drug coverage for seniors, Congress simultaneously created income tax-free subsidies to employers continuing their own drug coverage for their retirees. Congress also permitted employers to deduct, for income tax purposes, any outlays made with these subsidies to provide retiree drug coverage. Starting in 2013, PPACA deletes from the Code permission for employers to deduct such subsidized outlays for retirees' drug coverage.

Part D: Putting the Coverage Puzzle Together

5.12 How do all of the coverage options authorized by PPACA fit together?

PPACA uses an array of tax incentives, tax penalties, other funding mechanisms, and regulatory requirements to promote universal coverage. Whether that goal will be met or not is beyond the scope of this Reference Guide. However, it is important to understand the landscape of all of the coverage options so that brokers, employers and others understand how the federal government envisions that this will take place.

Law Professor Zelinsky provides a succinct overview when he writes:

Under PPACA, all individuals subject to the statute's insurance requirement must, starting in 2014, have in force "minimum essential coverage." Such coverage can take one of five forms:

- First, health services from approved government programs such as Medicaid, Medicare, CHIP, and federal veterans medical care qualify as minimum essential coverage, satisfying the individual insurance mandate.
- Second, participation in an “eligible employer-sponsored” plan constitutes such coverage.
- Third, health coverage acquired in a state’s “individual market” qualifies as “minimum essential coverage” and thus discharges the individual insurance mandate.
- Fourth, the individual mandate is satisfied through health coverage “under a grandfathered health plan,” which generally means any “group health plan or health insurance coverage” in effect on the day PPACA was enacted March 23, 2010.
- Finally, the Secretary of Health and Human Services, after consulting with the Secretary of the Treasury, may recognize any other program as constituting minimum essential coverage for purposes of the individual mandate.²⁷

5.13 What are the core themes that emerge when reviewing PPACA’s health-related tax provisions?

Law Professor Zelinsky identifies four themes that emerge from studying the “the generally applicable, health-related tax provisions of PPACA:”

- First, he notes that many of the provisions have not been finalized. He writes, “It is unclear whether these tax measures will take effect as scheduled or will take effect in their current forms.”
- Secondly, he points to the “enormous complexity” of PPACA’s tax provisions. “Such complexity will impose daunting enforcement challenges upon the IRS and will create equally formidable compliance burdens for firms and individuals, most notably, for small businesses and taxpayers of modest means.”
- Thirdly, he concludes that the pathway to implementing PPACA’s coverage goals will be “incremental” because PPACA builds upon and reinforces the “existing systems of privately-provided health insurance and of employer-sponsored medical care.”
- Finally, he observes that the fourth theme to emerge “from a survey of the tax provisions of PPACA” is the lack of any “significant efforts to control health care costs.” He fears that PPACA will “accelerate U.S. health care spending.”

We have covered a lot of territory in this Reference Guide, focusing primarily on the tax and funding implications of PPACA for employers, employees and others. BenefitMall will continue to provide updates that help interested parties better understand and anticipate the compliance obligations of PPACA.

Please visit our websites to stay up-to-date on the latest health care reform news.

www.benefitmall.com

www.healthcareexchange.com

Footnotes:

- 1 For a list of exempt individuals, please see IRC § 5000A(d).
- 2 For more information about minimum essential coverage, please see IRC § 5000A(f).
- 3 The amount of this tax penalty is specified in IRC § 5000A(c)(2), which provides that the monthly tax penalty is equal to one-twelfth of the greater of either a fixed “flat dollar amount” or an amount based on a percentage of the taxpayer’s household income.
- 4 For more information about the tax amount assessed against children under 18, please see IRC § 5000A(c)(3)(c).
- 5 If the tax penalty is assessed as a portion of household income, we then turn to Section 5000A(c)(2)(B).
- 6 For more information, please see: <http://www.nonprofitquarterly.org/policysocial-context/20578-what-to-expect-now-that-the-supreme-court-has-upheld-obamas-health-care-law.html>
- 7 See IRC § 45R(b)(2).
- 8 See IRC § 45R(c).
- 9 See PPACA § 1513.
- 10 For more information, including sample calculations of full and part-time employees, please see: <http://www.ncsl.org/documents/health/EmployerPenalties.pdf>
- 11 See IRC § 4980H(c)(2)(E).
- 12 See PPACA § 1513.
- 13 See PPACA § 1513.
- 14 See: <http://www.irs.gov/pub/irs-drop/n-12-32.pdf>
- 15 For more information, please see: <http://www.ncsl.org/documents/health/EmployerPenalties.pdf>
- 16 See IRS Code 6051(a)(14). This section was added to the Code by § 9002 of PPACA.
- 17 This requirement is contained in IRS Code § 6051(a)(14).

- 18 These terms are defined in IRS Code § 106.
- 19 Ibid.
- 20 The information in this list was taken from:
<http://www.irs.gov/pub/irs-drop/n-11-28.pdf>
- 21 For more information, see IRS Code § 139A, which was amended by PPACA § 9012.
- 22 See IRS Code § 4980l(a).
- 23 See IRS Code §§ 220(f)(4)(A) and 223(f)(4)(A).
- 24 See IRS Code § 125(i).
- 25 For more information, please see PPACA § 1413, 1414, 2001, 2002, 2101, and 2201.
- 26 Please keep in mind that amounts listed in this example are for 2010. Eligible amounts may have changed since the release of the Congressional Service Report.
- 27 Editor's note: bullet points added to quote.

This reference guide is provided by BenefitMall. The views expressed in this Reference Guide do not necessarily reflect the official policy, position, or opinions of BenefitMall or Sage. This update is provided for informational purposes only. Please consult with a licensed accountant or attorney regarding any legal and tax matters discussed herein.

The information contained in these materials was drafted prior to the July 2 announcement that many employer reporting requirements and the Employer Shared Responsibility provision would be delayed to 2015. We have worked to revise these materials to reflect the change, but we will await further federal guidance before updating this information in a comprehensive manner.

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