CCH Tax Briefing

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SUPREME COURT UPHOLDS HEALTH CARE LAW

June 29, 2012

Special Report

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INSIDE

Supreme Court Upholds Health Care Law; All Tax Measures Preserved

The U. S. Supreme Court has upheld the constitutionality of the 2010 health care reform legislation, including its linchpin individual mandate that requires individuals to pay a penalty if they fail to carry minimum essential health insurance (*National Federation of Independent Business, et al. v. Sebelius, SCt, 2012-2 USTC ¶50,423).* In its landmark 5 to 4 decision handed down on June 28, 2012, the Court cleared the path for President Obama's signature health care law, the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA), to move forward on schedule. However, the mechanism used to force states to expand Medicaid eligibility did not pass constitutional muster.

This special Briefing describes the tax measures preserved by the Court's decision along with the related guidance issued by the Treasury Department, the IRS, United States Department of Health and Human Services (HHS), and the United States Department of Labor (DOL).

IMPACT. *The PPACA was passed by Congress and signed into law by President Obama in March 2010. Since then, the IRS and other federal agencies have issued final regulations, temporary regulations, proposed regulations, and other guidance on many of the tax provisions in the PPACA (also known as the ACA). Many businesses and employers have waited to fully implement these regulations until the Supreme Court determined the fate of the health care reform law. Now that the Court has spoken, all taxpayers—businesses large and small, as well as individuals—must prepare in earnest for implementation of the PPACA. Some requirements have been effective since 2010 and 2011, others have been in force only this year, and many other major provisions apply starting in 2013, 2014 or later.*

COMMENT. *Uncertainty over the health care legislation has been abated by the Supreme Court's decision, but clearly not eliminated. Concerns remain over how the IRS will interpret parts of the law as it continues issuing guidance to implement it. Also adding to uncertainty are renewed pledges made by the presumptive GOP-nominee for president Mitt Romney to repeal the PPACA if elected, and by GOP leaders on Capitol Hill to dismantle the health care legislation. In the meantime, however, employers and taxpayers must assume that key provisions will go into effect in 2013, 2014, and beyond, or risk being unprepared to fully comply in time for the law's complex provisions.*

SUPREME COURT'S ANALYSIS

The Supreme Court heard three days of oral arguments in March 2012 on whether the Anti-Injunction Act (Code Sec. 7421) applies, whether the individual mandate (Code Sec. 5000A) is a proper exercise of Congress' taxing power or its power under the Constitution's Commerce or Necessary and Proper Clauses; and whether the PPACA's expansion of Medicaid exceeds the government's spending authority. The Court also heard arguments on the viability of the PPACA without the individual mandate.

Writing for the majority, Chief Justice John Roberts said that the government's reading

of the statute – that it imposes a tax on individuals without insurance – is a reasonable one. "Under the mandate, if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS..." The Chief Justice continued, "our precedent demonstrates that Congress had the power to impose the exaction in Section 5000A under the taxing power, and that Section 5000A need not be read to do more than impose a tax. That is sufficient to sustain it." Chief Justice Roberts was joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan in upholding the law under Congress' power to tax.

COMMENT. *The majority acknowledged that Congress did not label Code Sec. 5000A as a tax but held that labels do not control. The majority used the following example: "Suppose Congress enacted a statute providing that every taxpayer who owns a house without energy efficient windows must pay $50 to the IRS. The amount due is adjusted based on factors such as taxable income and joint filing status, and is paid along with the taxpayer's income tax return. Those whose income is below the filing threshold need not pay. The required payment is not called a 'tax,' a 'penalty,' or anything else. No one would doubt that this law imposed a tax, and was within Congress's power to tax. That conclusion should not change simply because Congress used the word 'penalty' to describe the payment."*

In their dissent, Justices Scalia, Kennedy, Thomas, and Alito said, "We have never held that *any* exaction imposed for violation of the law is an exercise of Congress' taxing power—even when the statute *calls* it a tax, much less when (as here) the statute repeatedly calls it a penalty." The dissent noted that "eighteen times in Section 5000A itself and elsewhere throughout the Act, Congress called the exaction in Section 5000A(b) a 'penalty.'" The dissent would have struck down the entire law.

COMMENT. *In addressing the unconstitutionality of denying Medicaid funding to states that refuse to implement PPACA's Medicaid expansion, the majority found: "Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding." Since an estimated 17 million currently uninsured individuals would benefit from the Medicaid expansion, the impact that this part of the Court's decision will have on PPACA's overall goals remains to be seen.*

CAUTION. *Several PPACA cases remain outstanding and need to be resolved. For example, a case pending in the Fifth Circuit Court of Appeals,* Physician Hospitals v. Sebelius, *challenges the constitutionality of PPACA Section 6001, which imposes restrictions on physician-owned hospitals. Another case,* Coons v. Geithner, *currently pending in the district court of Arizona, raises several other issues, including the constitutionality of the Independent Payment Advisory Board, which PPACA created to find savings in Medicare. As a result of the Supreme Court's decision, the core of the PPACA remains intact, and other challenges to the law based on those same grounds will not continue. However, other issues are still playing out, and one of them may provide the vehicle for invalidating significant PPACA provisions that are not related to the individual mandate or the Medicaid expansion.*

HIGHLIGHTS OF PPACA/ HCERA AND IRS GUIDANCE

The Supreme Court has left standing all tax provisions within PPACA and HCERA. This decision, which was unexpected by many Court-watchers, brings with it a sense of urgency to employers, individuals and other stakeholders that time is now growing short both to prepare for those major changes soon to take place in 2013 and 2014 and also to implement provisions or benefits that are already effective and available.

The PPACA and HCERA add to or amend numerous sections of the Internal Revenue Code, resulting in the largest set of tax law changes in more than 20 years. The IRS has been working on many fronts to issue guidance on these provisions, to flesh out certain benefits and requirements, and to set up procedures necessary for compliance.

The remainder of this Briefing highlights the major tax provisions of PPACA and HCERA, and the guidance that has been developed since enactment.

COMMENT. *In June 2012, the Treasury Inspector General for Tax Administration (TIGTA) reported that overall, the IRS has developed appropriate plans to implement most tax-related provisions in the PPACA. TIGTA reported that the IRS would benefit from estimating resources beyond fiscal year (FY) 2013. The IRS agreed with TIGTA and announced that it would complete an evaluation of the major PPACA provisions for which implementation has not been completed and evaluate the resources needed for implementation. Nevertheless, many observers contend that the IRS is significantly underfunded at current levels to handle its expected multi-faceted role in implementing the health care law over the 2013-2018 period.*

INDIVIDUAL TAX PROVISIONS

Individual Mandate

The PPACA requires applicable individuals to carry minimum essential health coverage for themselves and their dependents (also known as the individual mandate) or otherwise pay a shared responsibility penalty for each month of noncompliance. The individual mandate provision is scheduled to be effective beginning in calendar year 2014. "The individual mandate requires most Americans to maintain 'minimum essential' health insurance coverage," Chief Justice Roberts wrote. "For individuals who are not exempt and do not receive health insurance

through a third party, the means of satisfying the requirement is to purchase insurance from a private company."

IMPACT. *Chief Justice Roberts, writing for the majority, recognized the tremendous impact of the individual mandate: "By requiring that individuals purchase health insurance, the mandate prevents cost-shifting by those who would otherwise go without it. In addition, the mandate forces into the insurance risk pool more healthy individuals, whose premiums on average will be higher than their health care expenses. This allows insurers to subsidize the costs of covering the unhealthy individuals the reforms require them to accept."*

Individuals who are exempt. Some individuals are exempt from the individual mandate. They include (not an exhaustive list) individuals covered by Medicaid and Medicare, incarcerated individuals, individuals not lawfully present in the United States, health care ministry members, members of an Indian tribe, and members of a religion conscientiously opposed to accepting benefits. No penalty will be imposed on individuals without coverage for fewer than 90 days (with only one period of 90 days allowed in a year). Generally, individuals with employer-provided health insurance, if it satisfies minimum essential coverage and affordability requirements, are also exempt.

Additionally, no penalty will be imposed on individuals who are unable to afford coverage (generally, an individual will be treated as unable to afford coverage if the required contribution for employer-sponsored coverage or a bronze-level plan on an Exchange exceeds eight percent of the individual's household income for the tax year). Those applicable individuals whose household income is below their income thresholds for filing income tax returns are also exempt.

Minimum essential coverage. Under the PPACA, minimum essential coverage generally includes (not an exhaustive list) coverage under an eligible employer-sponsored plan, an individual market plan, a grandfathered health plan (discussed below), coverage under Medicaid and Medicare, and other government-sponsored coverage, subject to some exceptions.

Calculating the penalty. The penalty is generally calculated by taking the greater of a flat dollar amount and a calculation based on a percentage of the taxpayer's household income, and is imposed on a monthly basis (one-twelfth per month of this 'greater of' amount). The annual flat dollar amount is assessed per individual or dependent without coverage and is scheduled to be phased in over three years ($95 for 2014; $325 for 2015; and $695 in 2016 and subsequent years, indexed for inflation after 2016; one-half of these amounts for individuals under the age of 18). The flat dollar amount is compared to a percentage of the extent to which the taxpayer's household income exceeds the income tax filing threshold. The applicable percentage is 1 percent for 2014, 2 percent for 2015, and 2.5 percent for 2016 and subsequent years. The taxpayer's penalty is equal to the greater of the flat dollar amount or the percentage of household income. The amount cannot exceed the national average of the annual premiums of a "bronze level" health insurance plan offered through a health exchange.

> "The Supreme Court has left standing all tax provisions within PPACA and HCERA."

IRS guidance pending. In March 2012, IRS Chief Counsel William Wilkins said that guidance on the individual mandate would wait until after the Supreme Court hands down its decision.

Premium Assistance Tax Credit

Beginning in 2014, eligible lower-income individuals who obtain coverage under a qualified health plan through an insurance exchange may qualify for a premium assistance tax credit under Code Sec. 36B unless they are eligible for other minimum essential coverage, including employer-sponsored coverage that is affordable and provides minimum value.

COMMENT. *The 3% Withholding Repeal and Job Creation Act of 2011 amended the Code Sec. 36B credit to include Social Security benefits in a taxpayer's modified adjusted gross income (MAGI) for purposes of the credit.*

Minimum value. A plan fails to provide minimum value if the plan provides less than 60 percent coverage of the total allowed costs. If employer-sponsored coverage fails to provide minimum value, an employee may be eligible for the Code Sec. 36B credit. In Notice 2012-31, the IRS requested comments on how to determine if health coverage under an employer-sponsored plan provides minimum value. The IRS described several approaches: An actuarial value calculator (AV calculator) or a minimum value calculator (MV calculator); design-based safe harbors in the form of checklists; and for plans with nonstandard features that preclude the use of the AV calculator or the MV calculator without adjustments, an appropriate certification by a certified actuary that the plan provides minimum value.

Eligibility. In final regulations (TD 9590, 5/18/12), the IRS explained that eligibility for the Code Sec. 36B credit is determined by the relationship of the taxpayer's household income to the federal poverty level (FPL). A taxpayer's household income for the tax year must be at least 100 percent but not more than 400 percent of the FPL for the taxpayer's family size. A taxpayer's family includes the individuals for whom the taxpayer claims a deduction for a personal exemption under Code Sec. 151 for the tax year. The final regulations clarify that a family may include individuals who are not subject to the penalty for failing to maintain minimum essential coverage.

Employer-sponsored coverage. The final regulations treat an employer-sponsored

plan as affordable for an employee and related individuals if the portion of the annual premium the employee must pay for self-coverage does not exceed the required contribution percentage (9.5 percent for tax years beginning before January 1, 2015) of the taxpayer's household income.

IMPACT. *The credit is fully refundable. The Congressional Budget Office estimates that the credit will provide an average subsidy of about $5,000 per year for individuals and families.*

EXAMPLE. *Kate has household income of $47,000 in 2014. She is an employee of ABC Co., which offers its employees a health insurance plan that requires her to contribute $3,450 for self-only coverage for 2014. This represents 7.3 percent of Kate's household income. The IRS explained that because Kate's required contribution for self-only coverage does not exceed 9.5 percent of household income, ABC's plan is affordable for Kate, and Kate is eligible for minimum essential coverage for all months in 2014.*

IMPACT. *A large employer may be liable for an assessable payment if any full-time employee receives a premium assistance tax credit. The assessable payment is discussed later in this Briefing.*

COMMENT. *In the final regulations, the IRS advised that additional guidance will be issued on determining affordability for related individuals, treatment of health reimbursement arrangements (HRAs), and how wellness programs affect affordability.*

Advance credit payments. The PPACA provides that advance payments of the premium assistance tax credit may be made directly to the insurer. Advance payments are reconciled against the amount of the family's actual premium tax credit, as calculated on the family's federal income tax return. Any excess payment must be repaid as additional tax but is subject to a cap for taxpayers with household income under 400 percent of FPL.

IMPACT. *Taxpayers receiving an advance payment must file a return.*

Medical Deduction Threshold

The PPACA increases the threshold to claim an itemized deduction for unreimbursed medical expenses from 7.5 percent of adjusted gross income (AGI) to 10 percent of AGI for tax years beginning after December 31, 2012. However, individuals (or their spouses) age 65 and older before the close of the tax year are exempt from the increased threshold, and the 7.5 percent threshold continues to apply until after 2016.

IRS guidance pending. The IRS has not (as of the date of this Briefing) issued guidance on the medical deduction threshold as amended by the PPACA.

COMMENT. *The PPACA did not change the alternative minimum tax (AMT) treatment of the itemized deduction for medical expenses. For changes in the rules governing health flexible spending arrangements (health FSAs), see the discussion later in this Briefing.*

COMMENT. *On June 7, 2012, the House approved the Health Care Cost Reduction Act of 2012 (HR 436). Among other provisions, the bill would repeal disqualification of expenses for over-the-counter drugs for health FSAs, Archer MSAs and HRAs. The provision would apply to expenses incurred after December 31, 2012. The cost of HR 436 would be offset by recapturing in full any overpayments of refundable Code Sec. 36B healthcare exchange subsidies. At the time this Briefing was prepared, it was unclear if the Senate would take up HR 436.*

Debit/credit cards. Debit cards, credit cards, and stored value cards may be used to reimburse participants in an FSA. In Notice 2010-59, the IRS indicated that it will not challenge the use of FSA and HRA debit cards for expenses incurred through January 15, 2011. In Notice 2011-5, the IRS modified Notice 2010-59, explaining that after January 15, 2011, FSA and HRA debit cards may continue to be used to purchase prescribed over-the-counter medicines from vendors (other than drug stores and pharmacies, non-health care merchants that have pharmacies, and mail order and web-based vendors that sell prescription drugs) having health care related Merchant Codes. Health FSA and HRA debit cards may be used to purchase over-the-counter medicines at "90 percent pharmacies" but only as provided in Notice 2010-59. For all other providers and merchants, other than those described in this notice, health FSA and HRA debit cards may not be used to purchase over-the-counter medicines or drugs after January 15, 2011.

Additional Tax On HSA/MSA Distributions

Distributions from a health savings account (HSA) or Archer medical savings account (Archer MSA) not used for the beneficiary's

HEALTH CARE TAX CREDIT

The Health Care Tax Credit (HCTC) was extended and enhanced by the Trade Adjustment Assistance Act of 2011 (TAA 2011). The HCTC is refundable and can also be advanced. Individuals eligible for the HCTC include individuals receiving Trade Adjustment Allowances; individuals receiving wage subsidies in the form of Reemployment Trade Adjustment Assistance (RTAA) benefits; and individuals between the ages of 55 and 64 receiving payments from the Pension Benefit Guaranty Corporation (PBGC). The HCTC is scheduled to sunset after 2013.

qualified medical expenses are generally included in the beneficiary's gross income. Distributions included in gross income are subject to an additional tax of 10 percent of the included amount, unless made after the beneficiary's death, disability, or attainment of the age of Medicare eligibility. Effective for distributions made after December 31, 2010, the additional tax on HSAs and Archer MSAs increases from 10 percent to 20 percent, in the case of HSAs, and from 15 percent to 20 percent, in the case of Archer MSAs, of the amount included in gross income.

Additional Medicare Tax

For tax years beginning after December 31, 2012, an additional 0.9 percent Medicare tax is imposed on wages and self-employment income of higher-income individuals. The additional Medicare tax applies to individuals with remuneration in excess of $200,000; married couples filing a joint return with incomes in excess of $250,000; and married couples filing separate returns with incomes in excess of $125,000.

IRS guidance pending. The IRS has not issued formal guidance on the additional Medicare tax as of the date of this Briefing.

IMPACT. *Unlike the general 1.45 percent Medicare tax, the additional 0.9 percent tax is on the combined wages of the employee and the employee's spouse, in the case of a joint return.*

COMMENT. *Employers must withhold on the higher rate if the employee receives wages in excess of $200,000. The employer may disregard the amount of wages received by the employee's spouse. If the Medicare tax is not withheld by the employer, the employee is required to pay the tax.*

Medicare Tax On Investment Income

The PPACA imposes a 3.8 percent Medicare contribution tax on unearned income effective for tax years beginning after December 31, 2012. The tax is imposed on the lesser of an individual's net investment income for the tax year or modified adjusted gross income in excess of $200,000 ($250,000 for married couples filing a joint return and $125,000 for married couples filing a separate return).

Net investment income is the excess of the sum of the following items less any otherwise allowable deductions properly allocable to such income or gain:

> "Employers and others must assume that key provisions will go into effect in 2013 and 2014 or risk being unprepared to fully comply in time."

- Gross income from interest, dividends, annuities, royalties and rents unless such income is derived in the ordinary course of any trade or business (excluding a passive activity or financial instruments/commodities trading);
- Other gross income from any passive trade or business; and
- Net gain included in computing taxable income that is attributable to the disposition of property other than property held in any trade or business that is not a passive trade or business.

IMPACT. *Investors will be scrambling to determine the parameters of this additional 3.8 percent tax, especially within the context of passive investment income. The IRS has not issued formal guidance as of the date of this Briefing, although IRS officials had said in April 2012 that proposed regulations would be released soon. However, they said not to expect resolution at that time of the relationship between this tax and the Code Sec. 469 rules governing passive activity losses, which has been an area that continues to generate confusion.*

IMPACT. *This 3.8 percent tax would be on top of any increase in the dividends/capital gains/ordinary income rates that some lawmakers are currently considering upon expiration of the Bush-era tax cuts at the end of 2012.*

Home sales. A home sale may result in a capital gain that increases net investment income. Net investment income includes interest, dividends, annuities, royalties, certain rents, and certain other passive business income as well as the amount of capital gain on a home sale that exceeds the amount that can be excluded from taxation. Under current law, single individuals may exclude up to $250,000 in capital gain, and married couples may exclude up to $500,000 in capital gain. A home sale may also generate a capital gain that increases a taxpayer's modified adjusted gross income above the general threshold for the 3.8 percent tax.

Adoption Credit

The PPACA made the adoption credit refundable for 2010 and 2011. The PPACA also increased the amount of the credit to $13,360 for 2011. The IRS issued guidance on the temporary enhancements to the adoption credit in Notice 2010-66.

COMMENT. *The PPACA's enhancements to the adoption credit have expired. Pending legislation would permanently extend the enhancements (HR 4373).*

Indoor Tanning Excise Tax

Amounts paid for indoor tanning services performed after June 30, 2010, are subject to a 10 percent excise tax. Tanning salons are responsible for collecting the excise tax and paying over the tax on a quarterly basis. Tanning salons that fail to collect the tax from patrons are liable for the excise tax.

IMPACT. *The excise tax does not apply to phototherapy performed by a licensed medical professional.*

The IRS quickly issued final regulations (TD 9486, 6/14/10) on the indoor tanning

tax only weeks before its starting date. The final regulations explain that payment for indoor tanning services is treated as made, and liability for the tax is imposed, at the time it can be reasonably determined that payment is made specifically for indoor tanning services. The regulations also address "bundled services," where indoor tanning is bundled with other goods and services, membership fees to a qualified physical fitness facility, and payment by gift card for indoor tanning services.

In 2012, the IRS followed up on the final regulations with more guidance. The IRS released final, temporary and proposed regulations adding the Code Sec. 5000B indoor tanning services excise tax to the list of excise taxes for which disregarded entities are treated as separate entities effective for taxes imposed on amounts paid on or after July 1, 2012 (TD 9596, NPRM REG-125570-10 06/25/12). The temporary regulations also treat a single-owner eligible entity that is disregarded as an entity separate from its owner for any purpose under Reg. §301.7701-2 as a corporation with respect to the indoor tanning services excise tax.

IMPACT. *Tanning services providers report the tax on Form 720, Quarterly Federal Excise Tax Return, and pay the excise tax on a quarterly basis: April 30 to report tax collected in January, February and March; July 31 to report tax collected in April, May and June; October 31 to report tax collected in July, August and September; and January 31 to report tax collected in October, November and December.*

As a result of the 2012 temporary regulations, Form 720, Quarterly Federal Excise Tax Return, reporting of indoor tanning services excise taxes imposed on amounts paid on or after July 1, 2012, must be filed under the name and employer identification number (EIN) of the entity rather than under the name and EIN of the disregarded entity's owner. This affects returns of this tax that are due on or after October 31, 2012.

Dependent Coverage Until Age 26

The PPACA also requires group health plans and health insurance issuers providing dependent coverage for children to continue to make the coverage available for an adult child until turning age 26. The coverage requirement is effective for the first plan year beginning on or after September 23, 2010.

COMMENT. *For plan years beginning before January 1, 2014, grandfathered group plans do not have to offer dependent coverage as amended by the PPACA if a young adult is eligible for group coverage outside his or her parent's plan.*

The IRS issued temporary regulations in TD 9482 (5/10/10). The IRS explained that, with respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage for children other than in terms of a relationship between a child and the participant. A plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors.

EXAMPLE. *A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18. The IRS explained that the group health plan violates the regulations because the plan varies the terms for dependent coverage of children based on age.*

Medical Benefits For Children Under 27

The PPACA amended Code Sec. 105(b) to extend the exclusion from gross income for medical care reimbursements under an employer-provided accident or health plan to any employee's child who has not attained age 27 as of the end of the tax year. The amendment was effective March 30, 2010.

The IRS issued guidance in Notice 2010-38, which explains that the exclusion applies for reimbursements for health care of individuals who are not age 27 or older at any time during the tax year. The tax year is the employee's tax year (generally a calendar year). The IRS also explained that a child for purposes of the extended exclusion is an individual who is the son, daughter, stepson, or stepdaughter of the employee. A child includes an adopted individual and an eligible foster child.

IMPACT. *The exclusion applies only for reimbursements for medical care of individuals who are not age 27 or older at any time during the tax year. The IRS explained in Notice 2010-38 that employers may assume that an employee's tax year is the calendar year: a child attains age 27 on the 27th anniversary of the date the child was born. For example, an individual born on May 1, 1986 attains age 27 on May 1, 2013, and is therefore covered under this provision through 2012. Employers may rely on the employee's representation as to the child's date of birth.*

IMPACT. *There is no requirement that a child generally qualify as a dependent for tax purposes. There is also no requirement that an employer provide this coverage (as opposed to dependent coverage under age 26, described above).*

Student Loan Repayment Programs

The PPACA provides for exclusion of assistance provided to participants in state student loan repayment programs for health professionals. The assistance is intended to increase the availability of health care in areas traditionally underserved by health professionals. As of the date of this Briefing, the IRS has not issued official guidance on the exclusion.

Indian Tribes

The PPACA excludes from gross income qualified health care benefits provided to the member of an Indian tribe, the member's spouse or the member's dependents. The exclusion applies to benefits and coverage provided after March 23, 2010.

BUSINESS TAX PROVISIONS

Shared Responsibility For Employers

The PPACA's employer shared responsibility provisions (also known as the "employer mandate") specify that an applicable large employer may be subject to a shared responsibility payment (also known as an "assessable payment") if any full-time employee is certified to receive an applicable premium tax credit or cost-sharing reduction payment. Generally, this may occur where either:

- The employer does not offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; or
- The employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that either is unaffordable relative to an employee's household income or does not provide minimum value (that pays at least 60 percent of benefits).

COMMENT. *The provision applies to months beginning after December 31, 2013.*

For purposes of the employer shared responsibility payment, an applicable large employer is an employer that on average employed 50 or more full-time equivalent employees on business days during the preceding calendar year. A full-time employee is an employee who is employed on average at least 30 hours per week.

COMMENT. *By January 1, 2014, each State must establish an American Health Benefit Exchange and a Small Business Health Options Program (SHOP Exchange) to provide qualified individuals and qualified small business employers, respectively, access to qualified health plans, thus rounding out coverage from the large employer down to the self-employed individual, and all workers in-between.*

In Notice 2011-36, the IRS requested comments on the issue of who is a full-time employee, including a potential "look-back/stability period safe harbor" method for determining full-time status of an employee. In Notice 2012-17, the IRS posted frequently asked questions about employer shared responsibility, noting that the "look-back/stability safe harbor" is expected to allow look-back and stability periods not exceeding 12 months. In Notice 2011-73, the IRS described a safe harbor allowing employers to use an employee's Form W-2 wages (as reported in Box 1) instead of household income in determining whether coverage offered is affordable.

IMPACT. *In Notice 2012-17, the IRS reported that future guidance is expected to provide that, at least for the first three months following an employee's date of hire, an employer that sponsors a group health plan will not, by reason of failing to offer coverage to the employee under its plan during that three-month period, be subject to the employer shared responsibility. The guidance is also expected to provide that, in certain circumstances, employers have six months to determine whether a newly-hired employee is a full-time employee and will not be subject to a shared responsibility payment during that six-month period with respect to that employee.*

Small Employer Health Insurance Tax Credit

The PPACA created the temporary Code Sec. 45R small employer health insurance tax credit. For tax years 2010 through 2013, the maximum credit is 35 percent of health insurance premiums paid by small business employers (25 percent for small tax-exempt employers). The credit is scheduled to increase to 50 percent for small business employers (35 percent for small tax-exempt employers) after 2013 (but will terminate after 2015). However, in tax years that begin after 2013, an employer must participate in an insurance exchange in order to claim the credit, and other modifications and restrictions on the credit apply.

In Notice 2010-44, the IRS provided guidance on the small employer health insurance tax credit, including transition relief for tax years beginning in 2010 with respect to the requirements for a qualifying arrangement. The IRS expanded on the guidance in Notice 2010-82. The IRS explained in Notice 2010-82 that a qualified employer must have:

- Fewer than 25 full-time equivalent employees (FTEs) for the tax year;

EXCHANGES

The PPACA requires each state to establish an American Health Benefit Exchange and Small Business Health Options Program (SHOP Exchange) to provide qualified individuals and qualified small business employers access to health plans. Exchanges will have four levels of coverage: bronze, silver, gold, or platinum. In early 2012, HHS reported that 34 states and the District of Columbia have received grants to fund their progress toward building Exchanges. HHS also provided an Exchange blueprint that states may use. If a state decides not to operate an Exchange for its residents, HHS will operate a federally-facilitated Exchange (FFE).

- Average annual wages of its employees for the year of less than $50,000 per FTE; and
- A "qualifying arrangement" that is maintained.

The IRS also described in Notice 2010-82 how to calculate the Code Sec. 45R credit.

IMPACT. *The Code Sec. 45R credit has been heavily promoted by the Obama administration but appears to be underutilized. The Government Accountability Office (GAO) has reported that 170,300 small employers claimed the credit in tax year 2010 out of a pool estimated at between 1.4 million and 4 million eligible firms. One reason may be the perceived complexity of calculating the credit.*

COMMENT. *Sole proprietors, partners in a partnership, shareholders owning more than two percent of the stock in an S corp, and any owners of more than five percent of other businesses are not counted as employees for purposes of the credit. Family members of these owners and partners are also not considered employees.*

Free Choice Vouchers

The PPACA, beginning in 2014, would generally have required employers offering qualified health insurance to provide a free choice voucher to employees with incomes of less than 400 percent of federal poverty guidelines whose share of the premium exceeded 8 but was less than 9.8 percent of their income, and who chose to enroll in a plan in an Exchange. The amount of the free choice voucher generally would have been excluded from the employee's gross income. However, the Department of Defense and Full-Year Continuing Appropriations Act, 2011 (P.L. 112-10) repealed the free choice voucher provisions of the PPACA.

Exchange-Participating Qualified Health Plans Offered Through Cafeteria Plans

For tax years beginning after December 31, 2013, a cafeteria plan cannot offer a qualified health plan offered through an American Health Benefit Exchange.

Health FSAs Offered In Cafeteria Plans

Effective for tax years beginning after December 31, 2012, the PPACA limits contributions to health flexible spending arrangements (health FSAs) to $2,500, down from an overall $5,000 FSA limit. The $2,500 limitation is adjusted annually for inflation for tax years beginning after December 31, 2013.

Over-the-Counter Medicines

The PPACA revises the definition of medical expenses for health flexible spending arrangements (health FSAs), health reimbursement arrangements (HRAs), health savings accounts (HSAs) and Archer Medical Savings Accounts (Archer MSAs). After December 31, 2010, expenses incurred for a medicine or drug are treated as a reimbursement for a medical expense only if the medicine or drug is a prescribed drug or insulin.

IMPACT. *The limitation does not apply to items for medical care that are not medicines or drugs. Items such as crutches, supplies such as bandages, and diagnostic devices, such as blood sugar test kits, qualify for reimbursement by a health FSA or HRA if purchased after December 31, 2010. A distribution from an HSA or Archer MSA for the cost of such items will still be tax-free, regardless of whether the items are purchased using a prescription.*

The IRS issued guidance in Notice 2012-40. The IRS explained that the $2,500 limit on health FSA salary reduction contributions applies on a plan year basis and is effective for plan years beginning after December 31, 2012. Thus, employers with non-calendar year plans will not be required to comply until plan year renewal in 2013. The IRS also reported that it is considering possible modification of the "use-or-lose rule" to provide a different form of administrative relief (instead of, or in addition to, the current 2½ month grace period rule).

IMPACT. *The $2,500 limit on salary reduction contributions to a health FSA applies on an employee-by-employee basis. The IRS explained that $2,500 (as indexed for inflation) is the maximum salary reduction contribution each employee may make for a plan year, regardless of the number of other individuals (for example, a spouse, dependents, or adult children whose medical expenses are reimbursable under the employee's health FSA.*

IMPACT. *The $2,500 limit applies only to salary reduction contributions and not to employer non-elective contributions, sometimes called flex credits, which are subject to certain limitations. Generally, an employer may make flex credits available to an employee who is eligible to participate in the cafeteria plan, to be used (at the employee's election) only for one or more qualified benefits.*

COMMENT. *On June 7, 2012, the House approved the Health Care Cost Reduction Act of 2012 (HR 436). Among other provisions, the bill would amend the rules for taxable distributions of unused balances under health FSAs. Generally, up to $500 of unused balances under a health FSA could be distributed; the amount distributed would be included in the recipient's gross income in the tax year in which distributed and would be taken into account as wages or compensation. This provision would apply to plan years beginning after December 31, 2012. The cost of HR 436 would be offset by recapturing in full any overpayments of refundable Code Sec. 36B healthcare exchange subsidies. At the time this Briefing was prepared, it was unclear if the Senate would take up HR 436.*

Simple Cafeteria Plans

For tax years beginning after December 31, 2010, the PPACA establishes a simple cafeteria plan for small businesses. The PPACA provides a safe harbor from nondiscrimination requirements to qualified small businesses. Generally, the employer must have employed an average of 100 or fewer em-

ployees on business days during either of the two preceding years.

IMPACT. *The provisions allow small employers to retain potentially discriminatory benefits for highly compensated and key employees while allowing other employees to enjoy the benefits of a cafeteria plan.*

COMMENT. *A cafeteria plan is a separate written plan maintained by an employer for employees under Code Sec. 125. A cafeteria plan provides participants with an opportunity to receive certain benefits on a pretax basis.*

Retiree Prescription Drug Subsidy

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides a subsidy of 28 percent of covered prescription drug costs to employers that sponsor group health plans with drug benefits to retirees. PPACA requires the amount otherwise allowable as a business deduction for retiree prescription drug costs to be reduced by the amount of the excludable subsidy-payments received, effective for tax years beginning after December 31, 2012.

Guidance status. As of the date of this Briefing, the IRS has not issued formal guidance on the treatment of the retiree prescription drug subsidy under the PPACA.

Limitation on Employee Remuneration

The PPACA limits the allowable deduction to $500,000 for applicable individual remuneration and deferred deduction remuneration attributable to services performed by applicable individuals that is otherwise deductible by a covered health insurance provider in taxable years beginning after December 31, 2012.

In Notice 2011-2, the IRS explained that the provision may affect deferred compensation attributable to services performed in a tax year beginning after December 31, 2009. The IRS also provided a de minimis rule.

Economic Substance Doctrine

HCERA codified the economic substance doctrine. A transaction is treated as having economic substance under a conjunctive two prong test only if the transaction changes in a meaningful way the taxpayer's economic position (not including federal, state, or local tax effects), and the taxpayer has a substantial business purpose for the transaction. Codification of the economic substance doctrine, and its related penalty of either 20 percent or 40 percent designed to enforce it, apply to transactions entered into or after March 30, 2010, the effective date of HCERA.

In Notice 2010-62, the IRS explained that it will continue to rely on relevant case law under the common-law economic substance doctrine in applying the two-prong conjunctive test. The IRS subsequently issued several directives to its personnel about application of the economic substance doctrine. In LB&I Directive 4-0711-015, the IRS identified various factors that examiners must consider to determine if application of the economic substance doctrine is appropriate. In CC-2012-008, IRS Chief Counsel provided instructions to its personnel on the economic substance doctrine in examinations, reviews of proposed deficiency notices (or notices of final partnership administrative adjustment (FPAAs)), litigation, and administrative pronouncements.

IMPACT. *In Notice 2010-62, the IRS rejected calls to publish an "angel list" of transactions. The IRS emphasized that it does not intend to issue general administrative guidance regarding the types of transactions to which the economic substance doctrine either applies or does not apply.*

COMMENT. *HCERA imposes a strict liability penalty of 20 percent (40 percent for undisclosed transactions) of any underpayment attributable to the disallowance of claimed tax benefits by reason of the application of the economic substance doctrine or failing to meet the requirements of any similar rule of law. The IRS has explained in LB&I Directive 4-0711-015 that until further guidance is issued, the related penalty provisions are limited to the application of the economic substance doctrine and may not be imposed due to the application of any other "similar rule of law" or judicial doctrine, (for example, the step transaction doctrine, substance over form, or sham transaction).*

EFFECTIVE DATES OF SELECTED PPACA/HCERA PROVISIONS

Small Employer Sec. 45R Credit	Tax years beginning in 2010
Economic Substance Doctrine	After 03/30/2010
OTC Limitations For Health Accounts	Tax years beginning after 12/31/2010
Indoor Tanning Services Excise Tax	On or after 07/01/2010
Itemized Deduction For Medical Expenses	Tax years beginning after 12/31/2012
Additional 0.9% Medicare Tax:	After 12/31/2012
3.8% Medicare Contribution Tax:	After 12/31/2012
Medical Device Excise Tax	Sales after 12/31/2012
Employer Shared Responsibility	After 12/31/2013
Branded Prescription Drug Fees	Calendar years beginning after 12/31/2010
Sec. 36B Premium Assistance Credit	Tax years ending after 12/31/2013
Excise Tax On High Dollar Insurance	Tax years beginning after 12/31/2017

Excise Tax on High-Cost Health Coverage

Employer-sponsored health coverage that exceeds a threshold amount is scheduled to be subject to a 40-percent excise tax starting in 2018. The dollar limits for determining the tax thresholds are $10,200 (for 2018) multiplied by the health cost adjustment percentage for an employee with self-only coverage; and $27,500 (for 2018) multiplied by the health cost percentage for an employee with coverage other than self-only coverage.

COMMENT. *The IRS has not issued official guidance on the excise tax on high-cost health coverage as of the date of this Briefing.*

Branded Prescription Drug Fee

The PPACA imposes an annual fee on each covered entity engaged in the business of manufacturing or importing branded prescription drugs. A covered entity is any manufacturer or importer with gross receipts from branded prescription drug sales. A *branded prescription drug* is any prescription drug whose application was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (FFDCA) or any biological product the license for which was submitted under section 351(a) of the Public Health Service Act.

In TD 9544 (8/18/11), the IRS issued temporary regulations defining covered entities, the information requested from covered entities, and how to calculate the annual fee. The IRS will send each covered entity its final fee calculation no later than August 31 of each fee year and also provides that covered entities must pay their fee by September 30 of the fee year. In Notice 2011-92, the IRS reported that for the 2012 fee year, the IRS would mail each covered entity a paper notice of its preliminary fee calculation by April 2, 2012. There is no tax return to be filed for the fee.

COMMENT. *Under the temporary regulations, a covered entity may provide information relevant to the determination of the fee by annually submitting Form 8947, Report of Branded Prescription Drug Information. Submission of Form 8947 is voluntary.*

COMMENT. *The PPACA treats the branded prescription drug fee as an excise tax so that only civil actions for refund may be pursued under the procedures of subtitle F. The fee may be assessed and collected without regard to the deficiency procedures of Code Secs. 6211-6216. The temporary regulations provide that the IRS must assess the amount of the section 9008 fee for any fee year within three years of September 30th of that fee year.*

Medical Device Excise Tax

The PPACA imposes an excise tax on the sale of certain medical devices by the manufacturer, producer, or importer of the device in an amount equal to 2.3 percent of the sale price. The excise tax applies to sales of taxable medical devices after December 31, 2012.

In NPRM REG-113770-10, the IRS issued proposed regulations on the medical device excise tax, explaining that the PPACA links the definition of "taxable medical device" to the definition of "device" in the Federal Food, Drug & Cosmetic Act. The IRS also described dual use devices (devices with medical and non-medical uses) and research-only devices.

Retail exemption. The PPACA exempts certain devices from the excise tax, such as eyeglasses, contact lenses and hearing aids. In the proposed regulations, the IRS provided a facts and circumstances approach to evaluating whether a taxable medical device is of a type that is generally purchased by the general public at retail for individual use. A device is considered to be of a type generally purchased by the general public at retail for individual use if (i) the device is regularly available for purchase and use by individual consumers who are not medical professionals, and (ii) the device's design demonstrates that it is not primarily intended for use in a medical institution or office, or by medical professionals.

COMMENT. *The IRS also provided a safe harbor in the proposed regulations identifying certain categories of taxable medical devices that fall within the retail exemption.*

COMMENT. *On June 7, 2012, the House approved the Health Care Cost Reduction Act of 2012 (HR 436). Among other provisions, the bill would repeal the 2.3 percent medical device excise tax. The cost of HR 436 would be offset by recapturing in full any overpayments of refundable Code Sec. 36B healthcare exchange subsidies. At the time this Briefing was prepared, it was unclear if the Senate would take up HR 436.*

Credit For Therapeutic Discovery Projects

Eligible taxpayers may qualify for a 50-percent tax credit for investments in therapeutic discovery projects. The PPACA also established the qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for the credit. The credit was available for qualified investments made or to be made in 2009 and 2010. Additionally, the PPACA provides for grants in lieu of tax credits for investments in therapeutic discovery projects.

In Notice 2010-45, the IRS explained who is an eligible taxpayer for the credit, how a project will be certified, application procedures, and grants in lieu of tax credits.

COMMENT. *The credit is part of the investment credit. Pending legislation in the Senate would extend the credit for therapeutic discovery projects through 2012 (Sen. 3232).*

Tax Treatment Of Certain Health Organizations

Under the PPACA, certain health organizations that previously qualified for Code Sec. 833 tax treatment will not qualify un-

less the health organization's medical loss ratio during the tax year is not less than 85 percent. An organization's medical loss ratio is equal to the amount expended on reimbursement for clinical services provided to enrollees under its policies during the tax year divided by the organization's total premium revenue.

In Notice 2010-79, the IRS provided transition relief and interim guidance on the computation of an organization's medical loss ratio. In Notice 2011-51, the IRS extended the transition relief and interim guidance for another year to any tax year beginning in 2010 and the first tax year beginning after December 31, 2010. In Notice 2012-37, the IRS extended the transition relief and interim guidance in Notice 2010-79 and Notice 2011-51 through the first tax year beginning after December 31, 2012.

REPORTING

Forms W-2

The PPACA generally requires employers to disclose the aggregate cost of applicable employer-sponsored coverage on an employee's Form W-2 for tax years beginning on or after January 1, 2011. Reporting is for informational purposes only.

In Notice 2010-69, the IRS made reporting optional for all employers for 2011. In Notice 2012-9, the IRS provided transition relief for small employers. For 2012 Forms W-2 (and W-2s issued in later years, unless and until further guidance is issued), an employer is not subject to reporting for any calendar year if the employer was required to file fewer than 250 Forms W-2 for the preceding calendar year, the IRS explained. Whether an employer is required to file fewer than 250 Forms W-2 for a calendar year is determined based on the Forms W-2 that it would be required to file if it filed Forms W-2 to report all wages paid by the employer and without regard to use of an agent under Code Sec. 3504.

COMMENT. *Certain types of coverage, such as major medical, must be reported. Other types of coverage are optional. The IRS identified the types of optional coverage in Notice 2012-9.*

Health Care Coverage Reporting

The PPACA requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and other entity that provides minimum essential coverage to file an annual return reporting information for each individual for whom minimum essential coverage is provided (Code Sec. 6055 reporting). Additionally, every applicable large employer (within the meaning of Code Sec. 4980H(c)(2)) that is required to meet the shared employer responsibility requirements of the PPACA during a calendar year must file a return with the IRS reporting the terms and conditions of the health care coverage provided to the employer's full-time employees for the year (Code Sec. 6056 reporting). The reporting requirements apply to calendar years beginning on or after January 1, 2014.

In Notice 2012-32, the IRS requested comments on how to implement reporting. The IRS asked for comments on how to determine when an individual's coverage begins and ends for purposes of reporting the dates of coverage; how to minimize duplicative reporting, and more.

COMMENT. *Reporting under Code Secs. 6055 and 6056 is separate from reporting of health care coverage on an employee's Form W-2.*

Disclosures

Because the PPACA is being implemented by multiple federal agencies, the statute authorizes the IRS to disclose return information to HHS and other agencies. Return information is scheduled to be disclosed for, among other purposes, eligibility for the Code Sec. 36B premium assistance tax credit.

In NPRM REG-119632-11, the IRS explained that it will disclose taxpayer identity information, filing status, the number of individuals for which a deduction under Code Sec. 151 was allowed ("family size"), modified adjusted gross income, and the tax year to which the information relates or, alternatively, that the information is not available. Where modified adjusted gross income is not available, the IRS will disclose adjusted gross income.

COMMENT. *The proposed regulations further provide where some or all of the*

IRS GUIDANCE FOR SELECTED PPACA/HCERA PROVISIONS

Branded Prescription Drug Fees:	TD 9544
Code Sec. 36B Credit:	TD 9590
Code Sec. 45R Credit:	Notice 2010-44/Notice 2010-82
Disclosure Of Return Information:	NPRM REG-119632-11
Grandfathered Plans:	TD 9506
Health Coverage Information Reporting:	Notice 2012-32/Notice 2012-33
Health FSA $2,500 Limitation	Notice 2012-40
Indoor Tanning Services Excise Tax	TD 9486
Medical Device Excise Tax:	NPRM REG-113770-10
Minimum Value:	Notice 2012-31
OTC Limitations For Health Accounts:	Notice 2010-59/Rev. Rul. 2010-23
Summary Of Benefits:	TD 9575

items of return information prescribed by statute or regulation is unavailable, the IRS will provide information indicating why the particular item of return information is not available.

Nonprofit Health Insurance Issuers

The PPACA establishes the Consumer Operated and Oriented Plan (CO-OP) Program. The CO-OP Program is intended to encourage the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets. The PPACA also enacted Code Sec. 501(c)(29) to provide requirements for tax exemption under Code Sec. 501(a) for qualified nonprofit health insurance issuers (QNHIIs).

In Notice 2011-23, the IRS requested comments on Code Sec. 501(c)(29) and followed up with temporary regulations (TD 9574). The IRS explained that a QNHII which has received a loan through the CO-OP program may be recognized as exempt from taxation under Code Sec. 501(a) only if, among other things, the QNHII gives notice to the agency. In Rev. Proc. 2012-11, a QNHII seeking recognition of exemption under Code Sec. 501(c)(29) must submit a letter application (rather than a form) with Form 8718, User Fee for Exempt Organization Determination Letter Request.

Tax-Exempt Charitable Hospitals

The PPACA imposes additional requirements on Code Sec. 501(c)(3) charitable hospitals. Tax-exempt hospitals must conduct a community health needs assessment (CHNA) and adopt a financial assistance policy. The PPACA also places limitations on charges to individuals who qualify for financial assistance and prohibits certain collection actions. Tax-exempt hospitals must satisfy these additional requirements to maintain their exempt status.

In Notice 2011-52, the IRS described which organizations must conduct a CHNA and related requirements. The IRS also cautioned that it will impose the $50,000 excise tax under Code Sec. 4959 on any hospital organization that fails to satisfy the CHNA requirements.

The IRS also revised Form 990, Return of Organization Exempt From Taxation, Schedule H, Hospitals, to reflect compliance with the new requirements. The IRS issued Ann. 2011-37 which made filing Part V, Section B of Schedule H optional for tax year 2010. In Notice 2012-4, the IRS explained that for tax year 2011, hospitals are required to complete all parts and sections of Schedule H, with the exception of lines 1–7 of Part V, Section B, which relate to community health needs assessments.

In proposed regulations, the IRS provided guidance on the PPACA's financial assistance policy for tax-exempt charitable hospitals, describing how a hospital should determine the maximum amounts it may charge individuals eligible for financial assistance for emergency and other medically necessary care (NPRM REG-130266-11, 06/25/12). The proposed regulations also set limits on various collection actions.

Patient-Centered Outcomes Research Trust Fund

The PPACA establishes the Patient-Centered Outcomes Research Institute. The Institute is funded by the Patient-Centered Outcomes Research Trust Fund. The Trust Fund is to be financed, in part, by fees to be paid by issuers of specified health insurance policies (Code Sec. 4375) and sponsors of applicable self-insured health plans (Code Sec. 4376).

In NPRM REG-136008-11 (4/17/12), the IRS explained that the Code Sec. 4375 fee is calculated using the applicable dollar amount in effect for the policy year and one of the permitted methods for determining the average number of lives covered under the policy during the policy year. The Code Sec. 4376 fee is calculated using the applicable dollar amount in effect for the plan year.

CLASS Program

The PPACA created the Community Living Assistance Services and Supports (CLASS) Program, which was intended to be a consumer-funded, voluntary long-term insurance program. In October 2011, HHS announced that it could not implement a financially sustainable, voluntary, and self-financed CLASS Program.

ADDITIONAL PROVISIONS

Grandfathered Plans

Certain plans or coverage existing as of March 23, 2010 (the date of enactment of the PPACA) are subject to only some provisions of the PPACA. These plans are known as "grandfathered plans."

The IRS, HHS and DOL issued interim final regulations in 2010 and subsequently amended the interim final regulations (TD 9506). The agencies explained that a group health plan or group or individual health insurance coverage is a grandfathered health plan with respect to individuals enrolled on March 23, 2010 regardless of whether an individual later renews the coverage. Additionally, a group health plan that provided coverage on March 23, 2010 generally is also a grandfathered health plan with respect to new employees (whether newly hired or newly enrolled) and their families that enroll in the grandfathered health plan after March 23, 2010.

IMPACT. *In the IRS/HHS/DOL guidance, the agencies explained that there are circumstances where a group health plan may need to make administrative changes that do not affect the benefits or costs of a plan. For example, an insurer may stop offering coverage in a market or a company may change hands. In those cases, the employer can maintain grandfathered status for their employee plan.*

Automatic Enrollment

Under the PPACA, an employer with more than 200 full-time employees must auto-

matically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law), and to continue the enrollment of current employees in a health benefits plan offered through the employer. Employees may opt out of any coverage in which he or she was automatically enrolled.

In 2010, the IRS, HHS and DOL announced that employers would not need to comply with the automatic enrollment requirement until regulations are issued. The agencies have indicated in frequently asked questions (FAQs) on the DOL website that regulations are expected by 2014.

Summary Of Benefits/Uniform Glossary

The PPACA directed the IRS, HHS and DOL to develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage in compiling and providing a summary of benefits and coverage (SBC) that accurately describes the benefits and coverage under the applicable plan or coverage. The PPACA also required the development of standards for the definitions of terms used in health insurance coverage.

In TD 9575 (2/9/12), the IRS described the required elements for the SBC including a description of coverage, cost-sharing requirements, exceptions or limits under the plan, and coverage examples. The IRS explained that an SBC must be provided by a group health insurer to a group health plan; by a group health insurer and a group health plan to participants and beneficiaries; and by a health insurer to individuals and dependents in the individual market. An SBC must be provided on application for coverage, upon renewal or reissuance, and upon request. The IRS also provided a glossary of terms used in health insurance coverage.

IMPACT. *The SBC requirements apply to both grandfathered and non-grandfathered health plans. Employers reportedly have been preparing their SBCs for the Fall 2012 health plan enrollment period.*

Internal Appeals/External Reviews

The PPACA generally requires non-grandfathered health plans to provide internal and external claims and appeals processes for adverse determinations. Adverse determinations include denials, reductions, or terminations of coverage.

In 2010, the IRS, HHS and DOL issued interim final regulations, RIN 1545-BJ63/TD 9494 (7/22/10), subsequently amended in 2011, RIN 1210-AB45, to implement the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under the PPACA. The interim final regulations describe internal appeals' processes and external reviews of adverse determinations.

COMMENT. *Notices of adverse determinations must be provided in a culturally and linguistically appropriate manner. The DOL has posted model notices of adverse determinations on its website.*

Preventive Services

The PPACA requires that non-grandfathered group health plans and health insurance issuers offering non-grandfathered group or individual health insurance coverage provide benefits for certain preventive health services without cost sharing.

The IRS, HHS and DOL issued interim final regulations in 2010, followed by final rules for women's health services in 2012. The IRS, HHS and DOL subsequently requested comments on accommodating religious organizations while ensuring contraceptive coverage.

Patient's Bill Of Rights

The PPACA generally provides that a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion. The PPACA also prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime or annual limits on the dollar value of health benefits. Additionally, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact.

COMMENT. *A group health plan or group health insurance coverage must comply with the prohibition against preexisting condition exclusions; however, a grandfathered health plan that is individual health insurance coverage is not required to comply with the prohibition.*

The IRS, HHS and DOL issued interim final regulations in 2010. The agencies explained that the prohibition against preexisting condition exclusions generally is effective with respect to plan years (in the individual market, policy years) beginning on or after January 1, 2014. However, the prohibition became effective for enrollees who are under 19 years of age for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

The agencies also explained that the annual limits do not apply to health flexible spending accounts (health FSAs), Archer medical savings accounts (Archer MSAs) and health savings accounts (HSAs); and plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact.

Business Information Reporting

The PPACA requires businesses, charities and government entities to file an information return (Form 1099) when they would make annual purchases aggregating $600 or more to a single vendor, other than to a vendor that is a tax-exempt organization, for payments made after December 31, 2011 and reported in 2013 and years thereafter. The PPACA also repealed the long-

standing reporting exception for payments made to corporations.

The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011 repealed the expansion of business information reporting under the PPACA as if it had never been enacted.

COMMENT. *The cost of repeal was offset by increasing the amount of any excess Code Sec. 36B premium assistance tax credit that must be repaid by a taxpayer, subject to certain caps.*

IRS Implementation Of PPACA/HCERA

Since passage of the PPACA and HCERA, the IRS has moved quickly to issue guidance on provisions with immediate effective dates or effective dates in the near future. In June 2012, the Government Accountability Office (GAO) reviewed the IRS's implementation of the PPACA/HCERA. According to GAO, more than one half of the provisions in the PPACA/HCERA requiring action by the IRS were effective in 2010, which forced the IRS to conduct short term implementations and long term strategic planning simultaneously. GAO reported that the IRS generally followed a risk management plan for implementing provisions of the PPACA/HCERA, including outreach to affected stakeholders. GAO also discovered that the IRS has made progress implementing the PPACA/HCERA; however, work remains to be done in a number of areas, such as design of information technology systems and guidance for the health exchanges.

IT systems. GAO reported that the IRS must modify existing IT systems or design new IT systems to support the health exchanges. Data must be transmitted from the IRS to HHS (and vice versa) about taxpayer income, filing status, family status, and more.

Medicaid

The PPACA generally requires states to expand Medicaid to qualified individuals who are under age 65 with incomes up to 133 percent of the federal poverty level (FPL). The PPACA also requires states to maintain current Medicaid coverage levels through 2013 for adults and 2019 for children. Additionally, the PPACA requires that for states to obtain Medicaid matching funds, a state cannot make Medicaid eligibility standards, methodologies, or procedures more restrictive than those in effect on March 23, 2010 (the date of enactment of the PPACA). The PPACA also makes some changes to the Children's Health Insurance Program (CHIP).

The Supreme Court's health care decision restrains the federal government's imposition of this program on the states. While states are free to adopt the expanded requirements (and to accept some federal funding), the Court held that the federal government cannot punish recalcitrant states by eliminating existing Medicaid funding benefits to states that choose not to expand their program.

COMMENT. *HHS issued final regulations on Medicaid eligibility under the PPACA in CMS-2011-0139-0489 (03/23/2012).*