

PLAY OR PAY UNDER THE ACA: STRATEGIES TO REDUCE RISK AND AVOID PAYING THE IRS

**Tax Executives Institute
Salt Lake City Chapter
October 22, 2015**

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AGENDA

- Why does the Tax Department care about the ACA?
- Current state of the ACA
 - Overview
- Individual mandate
- Employer “play or pay” mandate
 - Excise tax guidance
- Information reporting
- Cadillac tax

WHY DOES THE TAX DEPARTMENT CARE?

- The Affordable Care Act (ACA) a health care law, but it's also a tax law
- What tax departments should know:
 1. The core health care coverage provisions are all tax provisions.
 2. The company could become subject to an unexpected, nondeductible excise tax if implementation is not done properly.
 3. Additional taxes and fees apply and some are deductible, others not.
 4. New significant information reporting requirements apply.
 5. How to prepare for an IRS excise tax assessment.

CORE REQUIREMENTS

- The ACA aims to expand health coverage through a series of provisions that generally took effect on January 1, 2014:
 - **Individual mandate:** Mandates all Americans, with some exceptions, to maintain a minimum level of health coverage or face a tax.
 - **Insurance Exchanges:** Creates health insurance Exchanges and provides Premium Tax Credits (PTCs) to assist eligible individuals with the purchase of coverage.
 - **Medicaid expansion:** Allows states to expand Medicaid up to 138% of federal poverty level.
 - **Employer mandate:** Mandates employers with 50 or more full-time equivalents to offer coverage to full-time employees and their dependents or pay taxes if an employee obtains Exchange coverage and a PTC. **Now Effective in 2015**

INTRODUCTION: THE ACA AS A PRISON CELL (FOR LARGE EMPLOYERS)

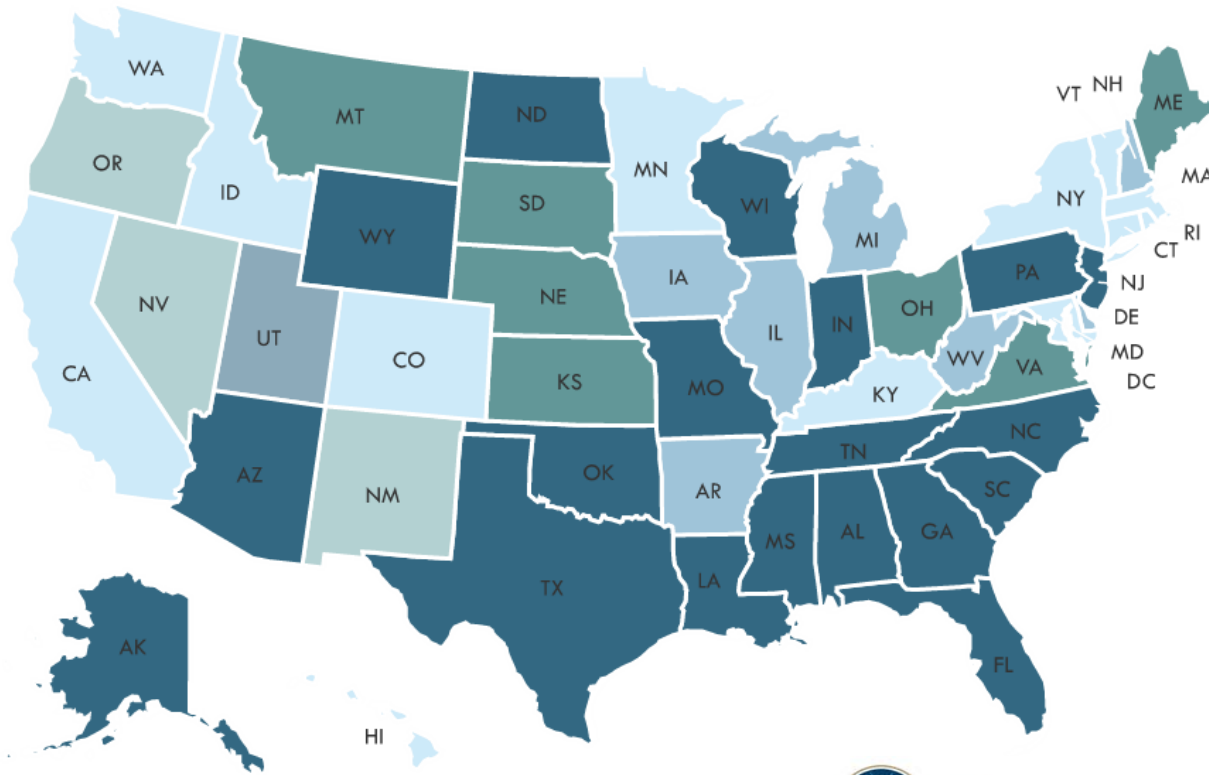
- Employer mandate is the “floor”
 - Employers owe an excise tax (Code Section 4980H) for failing to offer minimum essential coverage to a sufficient percentage of full-time employees, or for failing to offer affordable coverage that provides minimum value
- Cadillac plan excise tax is the “ceiling”
 - Employers and other providers owe an excise tax (Section 4980I) for offering coverage that is too valuable
- Market reform rules are the “bars”
 - Employers and insurers owe an excise tax (Section 4980D) if coverage fails to meet certain substantive requirements (e.g., dependent child coverage through age 26, preventive care with no cost-sharing)
- Non-discrimination rules are the “elephant”
 - Treasury is required by statute to issue non-discrimination rules for insured plans, but thus far has been unable to do so
 - Non-discrimination requirements for self-insured plans (Section 105(h)) have been on the books for decades, but are rarely enforced
 - Violation triggers taxation of benefits provided to highly-paid employees

INDIVIDUALS, EMPLOYEES AND EMPLOYERS

INDIVIDUAL MANDATE

- Beginning in 2014, individuals must pay a penalty for each month in which they do not have minimum essential coverage (MEC)
 - MEC includes employer-sponsored group health plans, exchange coverage, government-sponsored plans, etc.
 - Penalty is the greater of a flat dollar amount or a percentage of income above filing threshold, up to penalty cap.
 - Annual per person flat dollar amount is \$325 for 2015, and \$695 thereafter.
 - Percentage is 2% for 2015, and 2.5% thereafter.
- Exemptions for affordability, hardship, short coverage gap
- Individuals report and pay the penalty

STATE EXCHANGES: CURRENT STATUS



Legend

- State-run marketplace (13 plus DC)
- State-run marketplace using federal website (3)
- State-federal partnership; state conducting plan management and consumer assistance (7)
- State running small-business marketplace; federal government running individual marketplace (1)
- Federally facilitated marketplace; state conducting plan management (7)
- Federally facilitated marketplace (19)

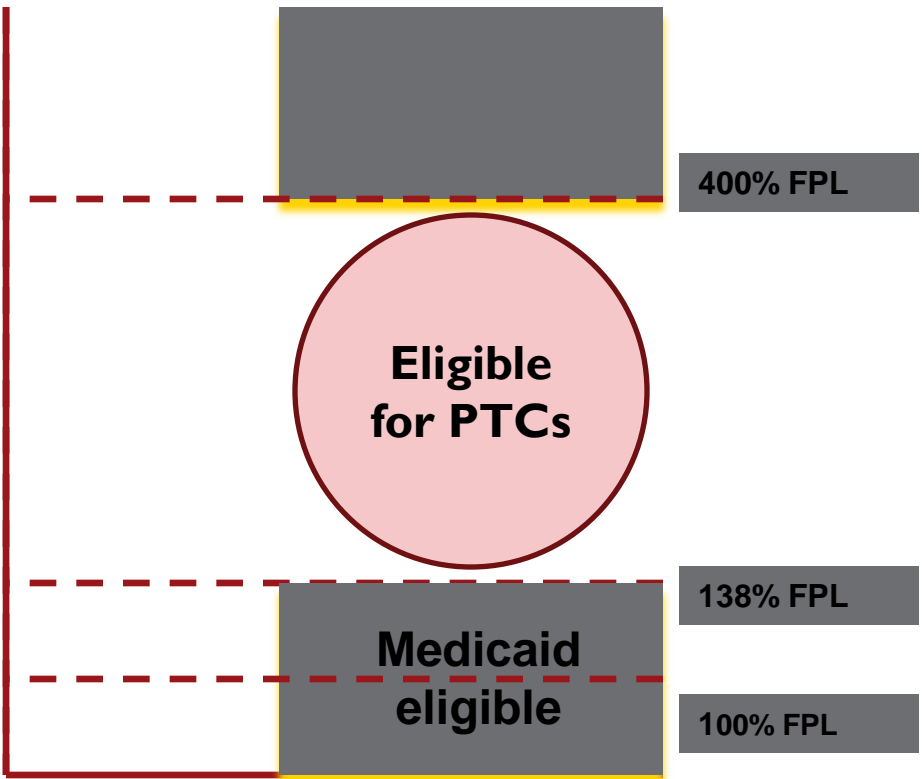
Source: The Commonwealth Fund,
www.commonwealthfund.org/interactives-and-data/maps-and-data/state-exchange-map



PREMIUM TAX CREDITS AVAILABLE TO INDIVIDUALS

- Section 36B: Eligible individuals entitled to a premium tax credit to purchase health care coverage on an Exchange
 - Taxpayer pays no more than the “applicable percentage” of household income as a premium; tax credit equals remaining premium based on second lowest cost “silver” plan on the Exchange (paid by Treasury directly to the insurer)
- Who is eligible?
 - Household incomes must be between 100% and 400% of FPL
 - Not eligible for other coverage
 - Medicaid, Medicare, or other governmental coverage
 - Offer of affordable employer coverage that provides minimum value

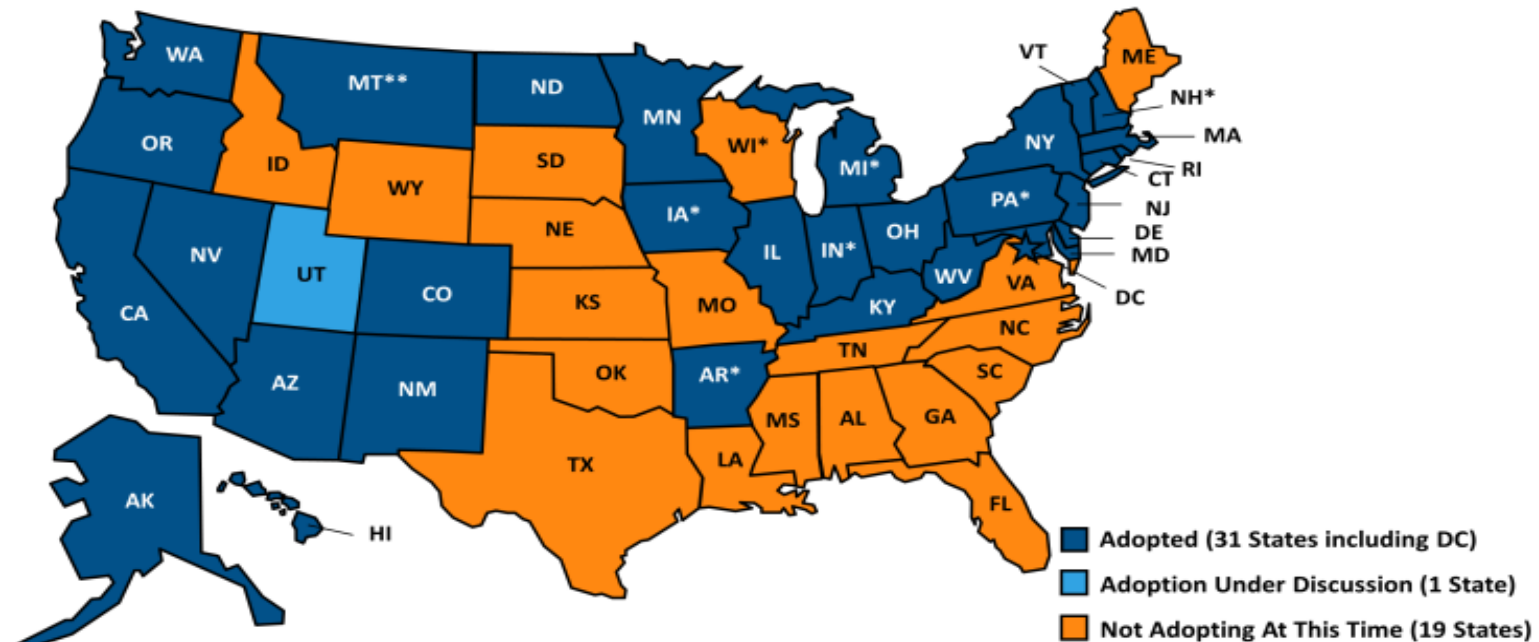
PREMIUM TAX CREDITS



| 2014 Federal Poverty Level (Dictates PTC eligibility for 2015) | | | |
|---|----------|----------|----------|
| Family or Household | 100% | 138% | 400% |
| 1 | \$11,670 | \$16,104 | \$46,680 |
| 2 | 15,730 | 21,707 | 62,920 |
| 3 | 19,790 | 27,310 | 79,160 |
| 4 | 23,850 | 32,913 | 95,400 |
| 5 | 27,910 | 38,515 | 111,640 |
| 6 | 31,970 | 44,118 | 127,880 |
| 7 | 36,030 | 49,721 | 144,120 |
| 8 | 40,090 | 55,324 | 160,360 |

MEDICAID EXPANSION: CURRENT STATUS

Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. **MT has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated September 1, 2015. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



PREMIUM TAX CREDIT: EMPLOYER COVERAGE

- To be eligible for a premium tax credit, an individual may not have been offered affordable, minimum value, minimum essential coverage by an employer
- Affordable: Employee portion of the premium or contribution for employee-only coverage under the lowest cost plan cannot exceed 9.5% of household income
- Minimum value: A plan fails to provide minimum value if plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs (on an actuarial basis)
- Eligibility for premium tax credit is relevant to employer penalties

EMPLOYER MANDATE EXCISE TAX

SECTION 4980H: GENERAL RULE

- “Large employers” (employer with ≥ 50 full-time equivalent employees within the employer’s controlled group) may be subject to an excise tax if at least one full-time employee whose household income is between 100% and 400% of the federal poverty level receives a premium tax credit for exchange coverage and an employer either:

Fails to offer coverage to full-time employees and their dependents

OR

Offers coverage to full-time employees that does not meet the law’s affordability or minimum value standards

SECTION 4980H: AMOUNT OF TAX

Tax for no coverage Section 4980H(a)

- A large employer member that does not offer coverage to a specified percentage of its full-time employees and their dependents may face a annual tax (calculated monthly) of:
 - \$2,000 x the total number of full-time employees if at least one full-time employee (FTE) is receiving a premium tax credit

Employers who do not offer coverage may subtract the first 30 workers (80 workers for 2015) when calculating their liability for taxes under IRC §4980H(a).

Tax for unaffordable coverage Section 4980H(b)

- A large employer member that offers coverage to its full-time employees and their dependents, but the coverage is unaffordable to certain full-time employees or does not provide minimum value may face an annual tax (calculated monthly) of:
 - \$3,000 x the number of FTEs receiving a premium tax credit

Taxes under IRC §4980H(b) are capped at an amount not to exceed an employer's potential tax under IRC §4980H(a).

SECTION 4980H: KEY FACTS

- Excise taxes are pro-rated and calculated separately for each month; inflation-adjusted after 2014.
- Excise tax payments are not deductible by the employer.
- Excise taxes are calculated separately for each controlled group member, and CG members are not liable for taxes incurred by other CG members.
- Excise tax under section 4980H(a) applies if the CG member fails to offer minimum value coverage to at least 95% of full-time employees and their dependents (70% for 2015).
- Raises the stakes for worker classification – failure to treat workers as employees could trigger the subsection (b) penalty, or worse, trigger the subsection (a) penalty for failing to satisfy the 95% (70%) safe harbor.
 - Where workers are misclassified, coverage offered by a staffing agency is treated as if it were offered by the employer, if certain requirements are satisfied.

SECTION 4980H: APPLICABLE LARGE EMPLOYER

- An “applicable large employer” is an employer with at least 50 full-time employees (FTEs) or FTE-equivalents during the preceding year.
 - A FTE works at least 30 hours per week or 130 hours per month.
 - Part-time employees are converted to full-time equivalents.
- Status is determined by dividing the number of FTEs and equivalents for each month by 12.
- All controlled group members are aggregated.
- Transition relief in 2015 for employers with 50-100 FTEs.
- Excise tax is not payable with respect to part-time employees, or first 30 full-time employees (80 for 2015).

SECTION 4980H: FULL-TIME EMPLOYEES

- Employers will need to track hours of service to determine the number of FTEs for each month.
 - Part-time employees are excluded and cannot trigger excise taxes.
 - Hours of service generally include all hours for which the employee is paid, regardless of whether work is performed (vacation, holiday, LOA, etc.).
 - For non-hourly employees, employers may use daily or weekly equivalencies.
 - Hours worked outside the U.S. generally are excluded, regardless of residency/citizenship status.
- Employers may use look-back/stability period safe harbors to determine the number of FTEs.
 - There can be an administrative period in between the look-back and stability periods.
 - Safe harbors do not change the 90-day waiting period rule for offering coverage to new hires, except for seasonal, variable hour, and high turnover employees.
 - 2015 status is determined based on lookback periods in 2014.

SECTION 4980H: MINIMUM VALUE

- Plan must cover at least 60% of total costs based on a standard population.
- IRS/HHS have created a minimum value calculator.
 - Based only on in-network utilization.
 - Design-based safe harbors will be deemed to comply. Each safe harbor will consist of an array of cost-sharing levels (deductibles, co-pays, etc.) and assume coverage for certain services.
- Value also may be determined by an actuary.
- Employer HSA contributions are taken into account.
- Employer HRA contributions are taken into account only if the HRA cannot be used to pay premiums. HRAs that can be used for premium payments count only towards affordability.
- Wellness incentives are disregarded, except for tobacco incentives.

SECTION 4980H: AFFORDABLE COVERAGE

- Coverage is affordable if the employee's share of premiums for the lowest-cost self-only coverage does not exceed 9.5% of the employee's household income (9.56% for 2015).
- Three safe harbors:
 - Box I wages on Form W-2
 - Rate of pay at the beginning of the year
 - Federal poverty level (employee premium does not exceed 9.5% of the FPL)
- Employer HSA contributions are disregarded because they cannot be used to pay premiums.
- Employer HRA contributions are taken into account only if the HRA can be used to pay premiums.
- Wellness incentives are disregarded, except for tobacco incentives.

SECTION 4980H: ASSESSMENT PROCEDURES

- An exchange will notify the employer when an employee is eligible for subsidized exchange coverage.
 - The exchange cannot assess the tax, but the employer may appeal the exchange's determination.
- The IRS will notify employers that they owe a penalty.
 - The IRS will provide this notification after employees have filed their tax returns, and the employer has filed its information returns.
 - The initial taxes for 2015 will not be payable until 2016.
- Employers may respond to the initial IRS notice before the IRS sends a formal notice and demand for payment.
- Penalty payments will not be part of the employer's tax return.

INFORMATION REPORTING



REPORTING REQUIREMENTS: KEY FACTS

- **WHAT:** New reporting requirements for 2015
 - Same filing schedule as W-2
- **WHO:** Requirements apply separately to each CG member.
 - Parent may file on behalf of each employer, but liability ultimately on employer
 - Liability ultimately falls on each employer
- **WHEN:** First mandatory filing due in early 2016, for the 2015 year.
 - Optional for 2014 (“strongly encouraged”) but no penalty
- Failure to file may trigger penalties under Code sections 6721 and 6722.
 - Generally, up to \$250 per return, to \$3 million annual maximum for each violation.
 - May be waived if due to reasonable cause and not willful neglect
 - Good faith standard for 2015

SUMMARY OF EMPLOYER REPORTING PROVISIONS

Due January 31 each year
FORM W-2

§ 6051
(Wage reporting)

- **Purpose:** Provide employees with cost of employer-provided coverage, to determine if Cadillac tax applies
- **Who:** Large employers
- **Information Reported:** Aggregate cost of employer provided group health plan for each covered employee

Starting 2016, due each January 31 to employee & March 31 to IRS

FORMS 1094-B & C, 1095-B & C

§ 6055
(MEC reporting)

- **Purpose:** Provide individuals and IRS with information to administer individual mandate
- **Who:** Employers who sponsor self-insured plans, insured plans, govt entities
- **Information Reported:** Employer and employee specific data, plus months in which individual is covered

§ 6056
(ESR reporting)

- **Purpose:** Provide IRS with information to administer employer mandate and IRS and individuals information to administer premium tax credit
- **Who:** Large employers
- **Information Reported:** Employer details; info on all FT employees; plan data month-by-month

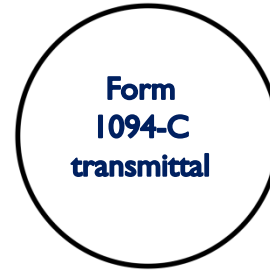
WHICH FORM DO I USE?

IRS Filings

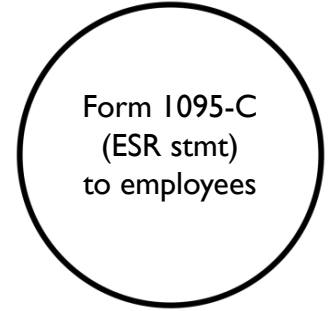
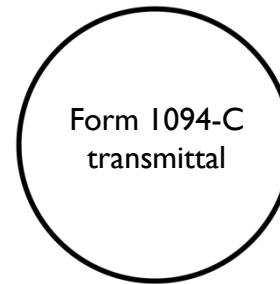
Transmittal Forms

Individual Statements

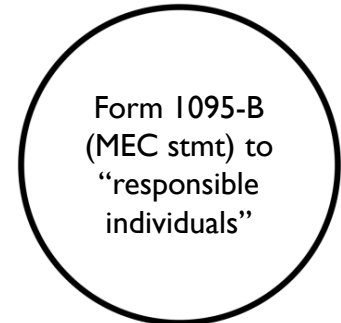
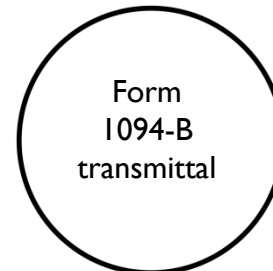
**Large employer
with self-funded
plan**



Large employer
with insured plan



Insurer





IRS REPORTING INSTRUCTIONS



SECTION 6055: MEC REPORTING – PURPOSE

- MEC = Minimum Essential Coverage
- Every self-insured employer providing MEC to an individual during the CY must furnish a MEC statement to each “responsible individual” and file those statements with the IRS
 - If fully insured, the insurer will transmit this info to IRS
- The MEC statement reports only *enrollments*, not mere offers of coverage
- What’s the point?
 - Notifies an individual whether he or she had MEC
 - Tells the IRS who received MEC from an employer plan in the prior CY
 - Enables the IRS to verify whether each person satisfied the ACA individual mandate



SECTION 6055: MEC REPORTING – WHO

- Who gets a MEC statement?
 - “Responsible individual” = primary participant
 - Includes COBRA enrollees who elect separately (i.e., divorced spouse)
 - Includes non-U.S. citizens working in U.S., and also U.S. citizens working abroad

- Who issues the MEC statement?
 - Employers – if self-insured
 - Third party may file on behalf of employer, but employer remains responsible
 - Large and small employers
 - Each member of Applicable Large Employer (ALE), with unique EIN
 - Insurers – if fully insured
 - Exchange – if qualified health plans
 - Union joint board – if multiemployer
 - Governmental entity sponsor – if self-insured
 - Can delegate to “designated governmental entity” within same government



SECTION 6055: WHAT IS MINIMUM ESSENTIAL COVERAGE?

MEC

- Employer-sponsored major medical
- Retiree-only plans offering coverage beyond excepted benefits
 - No retiree exception
- HRAs
- Preventive services-only plans
- Expatriate coverage
- Exceptions:
 - Govt. coverage
 - Individual coverage
 - Supplemental benefits

Not MEC

- Accident or disability coverage
- Worker's compensation
- Limited-scope dental or vision benefits
- Long-term, nursing home, and home- or community-based benefits
- Fixed indemnity insurance
- Specified disease insurance
- On-site medical clinics
- Medicare supplemental policies
- Health FSAs
- EAPs
- Stop loss coverage (not health coverage)



SECTION 6055: MEC REPORTING – DATA & DELIVERY

- Filing similar to Form W-2
 - Employee statement plus employer transmittal form

- Delivery method (to employees)
 - Electronic
 - advance consent specific to Form 1095-C
 - by email or intranet
 - First class mail (can be sent with Form W-2)
 - Hand delivery

- Reporting entity must include specific data:
 - Filer – EIN, contact name, number of individual statements
 - Plan sponsor – EIN, name, address
 - Individual data
 - Name & address for primary insured
 - Name of each “covered individual” (enrolled in MEC)
 - SSN for each covered individual
 - Months of coverage for each individual, if enrolled at least one day



SECTION 6056: ESR REPORTING – PURPOSE

- Large employers responsible for Employer Shared Responsibility (ESR) reporting must provide individual statements to any Full-Time Employee (FTE) and then file those statements with the IRS
- What's the point?
 - Helps an individual claiming premium tax credits determine whether he or she qualifies
 - Tells the IRS how many FTEs an employer has, and whether they received health coverage
 - Enables the IRS to verify whether the employer owes a shared-responsibility payment (line 16)
 - Enables the IRS to verify whether the individual is eligible for a premium tax credit (lines 14 & 15)



SECTION 6056: ESR REPORTING – WHO RECEIVES

- Who gets an ESR statement?
 - Each employee who had FT status for at least one month of the reporting year
 - Doesn't matter if employee enrolled in coverage
 - Contrast with MEC statement, which is provided to each responsible individual with coverage, regardless of status as FT, PT, or nonemployee.
 - Self-funded employers must combine MEC and ESR reporting on “C” form
 - In practice, this means that Form 1095-C is provided to all employees who are either (i) FTE or (ii) covered by MEC for one or more months of CY

- Special cases
 - New hires
 - Terminated employees
 - COBRA beneficiaries



SECTION 6056: ESR REPORTING – WHO PROVIDES

- Who issues the ESR statement?
 - Large employers – *each member of ALE*
 - Applicable Large Employer (ALE) = controlled group with more than 50 FTEs (100 for 2015)
 - Special rules for employee who works for more than one ALE entity
 - Can delegate to plan administrator, or third party, but each employer remains liable
 - Multiemployer plans
 - *Employer* remains liable for ESR reporting
 - Governmental employers
 - Can delegate to “designated governmental entity” within same government



SECTION 6056: ESR REPORTING – DATA

- What must be reported on Form 1095-C?
 - By month, whether the Minimum Value (MV) standard was met and to whom coverage was offered
 - By month, any reasons why a penalty is not due, if MV coverage was not offered
 - By month, employee share of premium for lowest cost, self-only MV option (if offered)

- What must be reported on transmittal Form 1094-C?
 - General information on employer health plans and workforce
 - Number of individual statements filed (1095-Cs)
 - Whether transmittal is “authoritative” reporting of all aggregate data
 - By month, whether the employer offered MEC to “substantially all” FT employees and dependents (Y/N)
 - 70% in 2015, 95% in 2016+
 - Exclude employees in “non-assessment periods”
 - Include employees deemed to have received offer under transition relief
 - By month, number of FT employees using lookback or monthly measurement method
 - By month, total number of employees
 - Whether employer is part of aggregated group
 - List up to 30 other group members, in descending order by number of FTEs
 - Whether simplified method or transition relief is used

Q Q Q Q
AAUGH!
Q Q Q





SECTION 6056: “SIMPLIFIED” ALTERNATIVES

Certification/ Qualifying Offer Method

- For employees that received “qualifying offer” for all months as FTE
- May provide generic letter instead of 1095-C...but only for employees with qualifying offer in all 12 months

98% Offer Method

- If employer can certify it offered minimum value coverage to at least 98% of employees for whom it is filing 1095-C (even if some of those are not FTEs), for entire year
- Need not identify total number of FTEs in a month or whether an employee was FT in particular month

Transition Relief

- 2015 Qualifying Offer Transition Relief
 - Certification that qualifying offer was made to 95% of FTEs in 2015
- 50-99 Transition Relief



6055 & 6056 REPORTING: TIMING FOR 2015 PY

- Feb. 1, 2016: Individual statements to employees
 - MEC statement to “responsible individuals”
 - ESR statements to FTEs
- Feb. 29, 2016: Paper filers (< 250 returns)
 - MEC/ESR information returns + transmittal
- Mar. 31, 2016: Electronic filers (> 250 returns)
 - MEC/ESR information returns + transmittal
- Non-calendar year plans:
 - Same deadlines apply
- Extensions: Up to 30 days with good cause shown
 - “undue hardship”

6055 & 6056 REPORTING: PENALTIES

- Penalties increased by recent trade legislation
 - \$250 per return that is missing or inaccurate
 - \$250 per individual statement that is missing or inaccurate
 - Cap of \$3 million for each category
 - \$500 per return or statement for flagrant disregard
 - IRS can reduce if corrected
- No penalties in 2016 for incorrect or incomplete 2015 reports
 - Good faith effort required

6055 & 6056 REPORTING: OTHER KEY ISSUES

- Potential relief
 - IRS Extensions
 - Legislation - bipartisan HR 2712 (Commonsense Reporting and Verification Act of 2015)
 - Would direct regulators to create voluntary, prospective ESR reporting system
 - Would allow employers to certify the type of MEC that will be available to FTEs during the upcoming year, thus eliminating detailed statements under 6056
 - Would allow use of DOB for 6055 reporting, where SSN is unavailable
 - Ease electronic delivery
 - Not available for 2015 year
- Correcting mistaken filings
 - Must correct any errors, even if report was accurate when prepared

“CADILLAC PLAN” EXCISE TAX

GENERAL OVERVIEW

- Code section 4980I imposes a non-deductible, 40% excise tax to the extent the “aggregate cost” of “applicable” employer-sponsored health coverage exceeds a specified dollar limit
 - Tax is paid by the insurer for insured plans, by the employer for an HSA or Archer MSA, and by the plan administrator (which may be the employer or a TPA) for self-insured plans
 - Tax is payable for coverage provided to current employees, former employees (including retirees), surviving spouses, and any other primary insured
 - Scheduled to take effect for coverage provided in calendar year 2018
- IRS has provided preliminary guidance in Notices 2015-16 and 2015-52, but taxpayers are NOT permitted to rely on the Notices
- IRS intends to issue proposed regulations (with a notice and comment period) and final regulations by late 2016

POLICY CONSIDERATIONS

- The purpose of the tax is to reduce healthcare spending, and shrink the tax expenditure for employer-provided health coverage.
 - Concern is that valuable plans incentivize individuals to purchase excessive amounts of care.
- The Congressional Budget Office estimates that the tax will raise \$91B of additional revenue through 2025.
 - This is based largely on the debatable assumption that employers will cut back non-taxable health benefits to avoid the tax, and provide a corresponding increase in taxable wages.
- Health economists argue that repealing the tax will cause employee costs to increase in the long-run.
 - But the threat of the tax has already led many employers to increase deductibles, co-pays and out of pocket maximums.

CADILLAC TAX THRESHOLDS

- For 2018, the dollar limits will be at least \$10,200 for self-only coverage, and at least \$27,500 for other types of coverage
 - The 2018 limits may be higher, depending on the rate of increase in the standard BCBS plan in the FEHBP between 2010 and 2018
- Larger limits may apply to retiree plans, and plans that cover employees in high-risk professions
- Limits can be adjusted based on age and gender to the extent the employer's workforce differs from national averages
- Starting in 2019, the dollar limits are adjusted for inflation in accordance with the Consumer Price Index, but healthcare costs have tended to increase faster than CPI.

CALCULATING THE COST OF COVERAGE

- The cost of coverage includes both the employee's and the employer's share of any premium, and generally includes pre-tax and after-tax employee contributions.
 - As a result, it is not possible to avoid the tax by increasing the employee's share of premiums
 - However, it is possible to avoid the tax by increasing deductibles, co-payments, and co-insurance; many employers are already taking these steps

CALCULATING THE COST OF COVERAGE

- Applicable coverage generally refers to any type of coverage that is excludable under Code section 106, or would be excludable under Section 106 if provided by an employer.
- FSAs, HSAs and HRAs are included
- Wellness programs and employee physical programs are included
- Stand-alone dental or vision coverage is excluded if insured; regulations may extend this exclusion to self-insured coverage
- On-site medical clinics are included if they provide more than a de minimis amount of medical care
 - IRS has requested comments re: definition of “de minimis” and how to value the availability of an on-site medical clinic
- Regulations may clarify that employee assistance programs (EAPs) are excluded

CALCULATING THE COST OF COVERAGE

- For most plans, premium cost is determined in accordance with COBRA rules
 - Guidance will address who is “similarly situated” for purposes of determining the applicable COBRA premium.
 - Guidance also will describe how to calculate COBRA premiums for self-insured coverage and HRAs
- For FSAs, HSAs and Archer MSAs, cost of coverage is based on employer contributions, including salary reduction contributions
- For employees who are enrolled in “self-only” and “other” coverage, the IRS may apply the 4980I limit that applies to the primary coverage (coverage that accounts for a majority of the cost) or a blending of the self-only and “other” coverage limits.
 - E.g., Employee elects family medical coverage, but also contributes to an FSA, which is always treated as self-only coverage.

MECHANICS OF PAYING THE TAX

- Employers will need to calculate the excise tax and report the excess benefit to the IRS and coverage providers
 - Tax probably will be payable with Form 720, Quarterly Excise Tax Return, in an as-yet unspecified quarter of the calendar year.
- Tax liability is calculated separately for each month, based on the cost of coverage provided for that month
- If an employee receives coverage from multiple sources, the tax is allocated ratably among the coverage providers
- The employer is responsible for calculating the tax and telling each provider how much they owe.

AN EXAMPLE OF HOW CRAZY THIS IS

- Coverage providers (insurers and TPAs) that owe the excise tax generally will charge that cost back to the employer.
- The chargeback will result in additional taxable income for the coverage providers, but the excise tax is not deductible.
- As a result, in order to recover the full cost of the excise tax, coverage providers will need to charge an additional “gross-up” amount to cover the income taxes due on the excise tax reimbursement, and the income taxes due on the gross-up.
- The statute excludes the excise tax reimbursement from the cost of applicable coverage, but does not exclude the additional income tax reimbursement.
- IRS has suggested that regulations may exclude the entire chargeback from the cost of applicable coverage, but only if it is billed separately.

PENALTIES

- If the employer calculates the tax incorrectly, the employer owes a penalty equal to the amount of any resulting underpayment, plus underpayment interest under Code section 6621.
- Penalties are not assessed against other providers
- Penalty does not apply if the underpayment results from reasonable cause and is corrected within 30 days after the employer becomes aware or should have become aware of the failure; the IRS also has discretion to waive the penalty if the employer misses the 30-day deadline

KEY UNANSWERED QUESTIONS

- Will there be delayed effective dates or transition rules?
- What if the Cadillac tax threshold falls below the minimum value threshold?
- Who pays the tax for self-insured plans?
- When will the applicable dollar limits be updated?
- When can the cost of coverage be calculated?
- To what extent should HSA, FSA and HRA contributions be included in the cost of coverage?
- What aggregation and disaggregation options will be available?
- Will geographic adjustments be permitted?

REPEAL EFFORTS

- Bills introduced in both houses of Congress, with sponsors from both parties, would repeal the tax.
- One open question is whether such a bill would require a corresponding revenue-raising provision to offset the lost tax revenue.
- Another question is whether, if the tax is repealed, Congress may pursue similar goals in other ways, including a cap on the exclusion for employer-provided health benefits.



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