

## TIMELINE OF 2013–2018

## TAX CHANGES IN HEALTH CARE REFORM LEGISLATION

• OCTOBER 2013

**2014**  
is a critical year  
for individuals  
and businesses

**Thomson Reuters**  
offers a comprehensive  
set of tools and learning  
opportunities to help you  
navigate the tax and  
other provisions of the  
health care reform law.

Although Congress passed health care reform in 2010, many of its most sweeping provisions have delayed effective dates. **2014 is a critical year for individuals and businesses.** The enclosed timeline highlights the key tax provisions that take effect from 2013-18.

For example, we address:

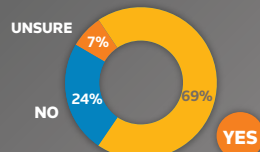
- The higher deductibility threshold for medical expenses, which will need to be reflected on individual tax returns for 2013.
- The individual responsibility penalty, which applies beginning in January 2014 to most individuals who do not maintain health insurance coverage for themselves and their tax dependents.
- Premium tax credits becoming available in January 2014 to assist low- and moderate-income families to purchase health insurance coverage on Exchanges established by the law.
- New restrictions starting in 2014—on allowing employees to pay for individual policies on a pre-tax basis through a cafeteria plan.
- Penalties for larger employers that do not offer health coverage to their employees—or that offer coverage that is considered unaffordable or inadequate. A related provision requires larger employers to report information about their employees and their coverage to the IRS. These provisions will take effect in 2015.

Beyond the tax provisions, health care reform also includes far-reaching insurance market reforms, notice requirements, and health plan benefit mandates. **Thomson Reuters offers a comprehensive set of tools and learning opportunities to help you navigate the tax and other provisions of the health care reform law.**

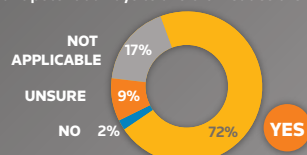
## HEALTH CARE REFORM 2014: NOW IS THE TIME

Your business clients face significant new obligations under the Affordable Care Act. With open enrollment season approaching, the time for planning is now, and they are counting on you for advice.

Are your business clients aware of their potential exposure to employer shared responsibility penalties?



Are your business clients counting on you for advice concerning their exposure to the penalties and potential ways to avoid or reduce them?



\*Based on a Thomson Reuters Tax & Accounting survey of 135 accounting professionals in February 2013.

## What are the Top Challenges you and your business clients are experiencing with implementing the new health care legislation?

- 1 Assessing the impact of employer shared responsibility (Play or Pay) requirements—determine large employer status, assess affordability and minimum value of coverage, estimate possible penalties
- 2 Understanding nondiscrimination requirements for employer-provided health insurance plans
- 3 Calculating premium assistance and cost sharing reduction subsidies to allow individuals to see the subsidy they would receive based on varying income levels, family size, etc.
- 4 Reporting health insurance coverage information to the IRS by employers that self insure
- 5 Participant notice and disclosure requirements for health plans, insurers, and employers
- 6 Determining eligibility and calculating the credit for small employer health insurance premiums
- 7 Calculating the individual penalty
- 8 Responding to DOL audit letters

**20,000**  
pages of  
regulations



In **March 2010**, Congress enacted legislation that overhauls the U.S. health care system, affects nearly all taxpayers and employers, and changes many elements of the health care industry (the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, 3/23/2010) and the Health Care and Education Reconciliation Act of 2010 (HCERA, P.L. 111-152, 3/30/2010)). The legislation contains a host of tax changes, many of which are both complex and novel. Some already have gone into effect, some apply for the first time in 2013, and still others will take effect between 2014 and 2018.



This article helps practitioners get a fix on the rules that are effective this year, as well as those looming on the horizon, by presenting a **TIMELINE OF 2013 - 2018 TAX CHANGES IN HEALTH CARE LEGISLATION** and a concise summary of each new tax provision.



**RIA CAUTION:** These new requirements are a work in progress, particularly in light of the lengthy time span for their implementation. Some of the rules originally in PPACA and HCERA have been repealed, while the effective date of other rules has been delayed by IRS. In addition, opponents of the health care reform legislation—which has been dubbed “Obamacare”—have waged a long and as of this date unsuccessful battle to defer or repeal other parts of the law, defund it, or repeal it outright.

## TAX CHANGES TAKING EFFECT IN 2013

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

The additional 0.9% HI tax on wages applies only to the employee's portion of FICA, not the employer's.



**RIA OBSERVATION:** Beginning in 2013, the employer portion of FICA consists of two parts, and the employee portion consists of three parts.

For 2013, an **employer** pays a 7.65% FICA tax, consisting of:

- (a) 6.20% Social Security tax on the first \$113,700 of an employee's wages (maximum tax is \$7,049.40 [6.20% of \$113,700]), plus
- (b) 1.45% Medicare tax on the employee's total wages (no ceiling).

For 2013, an **employee** pays:

- (a) 6.20% Social Security tax on the first \$113,700 of wages (maximum tax is \$7,049.40 [6.20% of \$113,700]), plus
- (b) 1.45% Medicare tax on the first \$200,000 of wages (\$250,000 for joint returns; \$125,000 for married taxpayers filing a separate return), plus
- (c) 2.35% Medicare tax (regular 1.45% Medicare tax plus; 0.9% additional Medicare tax) on all wages in excess of \$200,000 (\$250,000 for joint returns; \$125,000 for married taxpayers filing a separate return). (Code Sec. 3101(b)(2))

Employers must begin withholding the additional 0.9% Medicare tax in the pay period in which wages are in excess of \$200,000, and continue to withhold it until the end of the calendar year. All wages that are subject to Medicare tax are also subject to additional Medicare tax withholding if paid in excess of the \$200,000 withholding threshold. (Form 941 (2013))

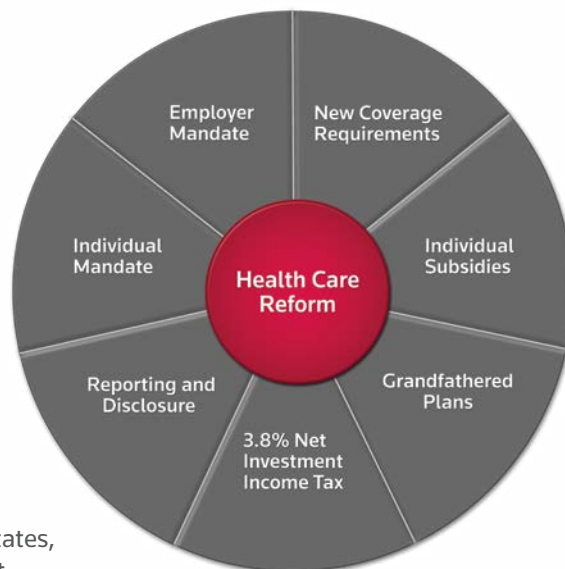


**RIA OBSERVATION:** Under IRS guidance, an employer must begin withholding at the \$200,000 threshold without regard to the employee's filing status, even if the employee might not ultimately be liable for the tax—e.g., if a married employee who files jointly makes over \$200,000, but the couple's combined income falls below the \$250,000 threshold. In this case, any excess Medicare tax withheld will be credited against the total tax liability shown on the employee's return.



**RIA CAUTION:** An individual must take the 0.9% additional tax on wages into account in figuring 2013 estimated taxes.

In addition to the tax changes described here, **health care reform** makes a number of other **fundamental changes** to the health care system designed to **expand access to coverage** and to **control health care costs**. These changes include **insurance market reforms**, **benefit mandates**, **Medicaid expansion**, **required participant disclosures**, and **online marketplaces** in each state to facilitate the purchase of coverage. Therefore, the **tax provisions—while important—are just one piece of a very complex puzzle.**



### Surtax on unearned income of higher-income individuals.

For tax years beginning **after December 31, 2012**, a Medicare contribution tax is imposed on net investment income of individuals, estates, and trusts. (Code Sec. 1411) For an individual, the “net investment income tax” (NII tax, or surtax) is 3.8% of the lesser of (1) net investment income or (2) the excess of modified adjusted gross income over the threshold amount (\$250,000 for a joint return or surviving spouse, \$125,000 for a married individual filing a separate return, and \$200,000 for all others).

In general, net investment income includes interest, dividends, capital gains, rental and royalty income, non-qualified annuities, income from businesses involved in trading of financial instruments or commodities, and businesses that are passive activities to the taxpayer reduced by certain expenses properly allocable to the income. The surtax doesn’t apply to distributions from tax-favored retirement plans (e.g., qualified employer plans and IRAs) and excluded items, such as interest on tax-exempt bonds, veterans’ benefits, and excluded gain from the sale of a principal residence.



**ILLUSTRATION:** For 2013, a single taxpayer has net investment income of \$100,000 and modified adjusted gross income of \$220,000. He pays the surtax only on the \$20,000 amount by which his modified adjusted gross income exceeds his threshold amount of \$200,000, because that is less than his net investment income of \$100,000. Thus, the surtax is \$760 (\$20,000 x 3.8%).



**RIA OBSERVATION:** Home-sale gain in excess of the \$250,000 Code Sec. 121 home sale exclusion (\$500,000 for joint filers)—as well as all of the gain on the sale of a second home—is subject to the NII surtax.



**RIA CAUTION:** An individual must take the 3.8% NII tax into account in figuring 2013 estimated taxes.

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



**RIA OBSERVATION:** The 7.5% floor will apply to a married taxpayer for 2013 through 2016 if either the taxpayer or the taxpayer’s spouse is 65, whether they file a joint return or separate returns. This is significant, because spouses can sometimes benefit by filing separate returns in order to deduct a larger portion of medical expenses. Even if a spouse who files a separate return is under age 65, the 7.5% floor will apply to that spouse for 2013 through 2016 if the other spouse is age 65 or over.



### Dollar cap on contributions to health FSAs.

For plan years beginning **after December 31, 2012**, for a health FSA (flexible spending account) to be a qualified benefit under a cafeteria plan, annual salary reduction contributions can't exceed \$2,500 (indexed for inflation after 2013). (Code Sec. 125(i)) This is a maximum limit only. As in the past, an employer may establish its own plan limitation, as long as the plan limit doesn't exceed this statutory limit.



**RIA OBSERVATION:** The \$2,500 limit only applies to health FSAs. It doesn't apply to health savings accounts (HSAs), Archer medical savings accounts (Archer MSAs), health reimbursement arrangements (HRAs), or any pre-tax contributions an employee makes toward employer-sponsored health coverage.



**RIA OBSERVATION:** The new health FSA limit applies on an employee-by-employee basis. If two people are married, and each has the opportunity to participate in a health FSA, whether through the same employer or through different employers, each may contribute up to \$2,500.



**RIA OBSERVATION:** If a plan provides a grace period (a period of up to two months and 15 days after the end of the plan year during which employees can use up their FSA balance), unused salary reduction contributions to the health FSA that are carried over into the grace period will not count against the \$2,500 limit for the subsequent plan year.

### Deduction eliminated for retiree drug coverage.

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



**RIA OBSERVATION:** The elimination of the exclusion results in treating the subsidy the same as most items that may be excluded from income. Thus, for example, while medical insurance reimbursements aren't included in a taxpayer's income, they aren't also deductible as medical expenses under Code Sec. 213.

**Fee on health plans.** The Patient-Centered Outcomes Research (PCOR) Institute was established under PPACA to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing comparative clinical effectiveness research. It's funded in part by fees paid by issuers of health insurance policies and sponsors of self-insured health plans. For each policy year ending **after September 30, 2012** and **before October 1, 2019**, each specified health insurance policy and each applicable self-insured health plan will have to pay a fee equal to the product of \$2 (\$1 for policy years ending during 2013) multiplied by the average number of lives covered under the policy. The issuer of the health insurance policy or the self-insured health plan sponsor is liable for and must pay the fee by July 31 of the year following the last day of the policy year. (Code Sec. 4375, Code Sec. 4376, and Code Sec. 4377) IRS has concluded that these PCOR fees are deductible as ordinary and necessary business expenses under Code Sec. 162.





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

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

Proposed reliance regulations provide, among other things, that an employer isn't a covered health insurance provider solely because it maintains a "self-insured medical reimbursement plan." IRS has also provided a de minimis rule, under which an employer isn't treated as a covered health insurance provider if the premiums received for providing health insurance coverage that are from providing minimum essential coverage for the tax year are less than 2% of the employer's gross revenues for that tax year. (Reg § 1.162-31(b)(4))

**Information reporting of health insurance coverage.** Employers filing 250 or more Forms W-2 for 2011, were required to report the aggregate cost of the applicable employer-sponsored health insurance coverage (as defined in Code Sec. 49801(d)(1)) provided to employees during 2012 on the Form W-2, Wage and Tax Statement, filed before the end of January, 2013, and then filed with the Social Security Administration (SSA). The reporting to employees is for their information only. It is intended to inform them of the cost of their health care coverage, and doesn't cause excludable employer-provided health care coverage to become taxable. (Code Sec. 6051(a)(14), Notice 2012-9, 2012-4 IRB 315)



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



**RIA OBSERVATION:** For tax years beginning **after December 31, 2017**, Form W-2 reporting of health insurance coverage will take on practical importance. Under Code Sec. 4980I, a 40% nondeductible excise tax will be levied on insurance companies and plan administrators for employer-sponsored health coverage to the extent that annual premiums exceed certain thresholds.

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





## TAX CHANGES TAKING EFFECT IN 2014

**Individuals not carrying health insurance face a penalty.** For tax years beginning **after December 31, 2013**, nonexempt U.S. citizens and legal residents must pay a penalty if they do not maintain minimum essential coverage, which includes government sponsored programs (e.g., Medicare, Medicaid, Children's Health Insurance Program), eligible employer-sponsored plans, plans in the individual market, certain grandfathered group health plans and other coverage as recognized by the Department of Health and Human Services (HHS) in coordination with IRS. (Code Sec. 5000A) This requirement is sometimes referred to as the "individual mandate." There are a number of exceptions, such as one for certain lower-income individuals (i.e., where the required contribution for minimum essential coverage exceeds a percentage of the taxpayer's household income—8% for 2014).

Thus, individuals who don't qualify for an exemption have a choice of either maintaining minimum essential coverage for themselves and a family member (i.e., an individual for whom the taxpayer properly claims a personal exemption deduction under Code Sec. 151 for the tax year), or paying a penalty. Married taxpayers filing a joint return for any tax year are jointly liable for any shared responsibility payment imposed for the year. (Reg § 1.5000A-1(c))

The monthly penalty amount is equal to 1/12 of the greater of the following amounts:

- (1) the flat dollar amount—i.e., the lesser of:
  - (a) the sum of the applicable dollar amounts (\$95 in 2014, \$325 in 2015, and \$695 in 2016) for all nonexempt individuals without minimum essential coverage for whom the taxpayer is liable, or
  - (b) 300% of the applicable dollar amount. The applicable dollar amount is inflation adjusted for calendar years beginning after 2016. If an individual hasn't attained the age of 18 as of the beginning of a month, the applicable dollar amount is one-half of the regular applicable dollar amount; or
- (2) the percentage of income, which is calculated as the excess of the taxpayer's household income over his Federal income tax return filing threshold under Code Sec. 6012(a)(1), multiplied by a percentage figure (1% for tax years beginning in 2014, 2% for tax years beginning in 2015, and 2.5% for tax years beginning after 2015. (Code Sec. 5000A(c), Reg § 1.5000A-4)



**Refundable tax credit for low- or moderate-income families buying certain health insurance.**

For tax years ending **after December 31, 2013**, a new refundable tax credit (the “premium assistance credit”) under Code Sec. 36B applies to qualifying taxpayers who get health insurance coverage by enrolling in a qualified health plan through an Exchange.



**RIA OBSERVATION:** This credit is also sometimes referred to as the “premium tax credit” or the “health care affordability tax credit.”

An individual is eligible for the premium tax credit if he or she:

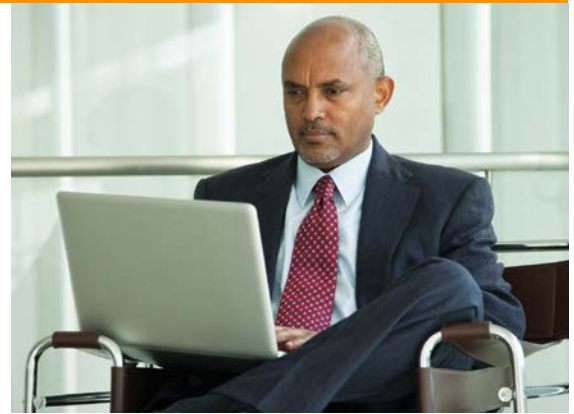
- Purchases coverage through an Exchange;
- Has household income that falls between 100% and 400% of the federal poverty line (For 2013, for the 48 contiguous states, household income between \$11,490 and \$45,960 for one individual; \$15,510 and \$62,040 for a family of two; \$23,550 and \$94,200 for a family of four);
- Isn’t offered “affordable coverage” through an employer-sponsored plan that provides “minimum value;”
- Isn’t actually enrolled in an employer-sponsored plan regardless of minimum value or affordability;
- Isn’t eligible for coverage through a government program (such as Medicaid, Medicare, CHIP or TRICARE);
- Files a joint return, if married; and
- Isn’t claimed as a dependent by another person.

An eligible employer-sponsored plan is “affordable” for related individuals for tax years beginning **before January 1, 2015** if the portion of the annual premium the employee must pay for self-only coverage doesn’t exceed 9.5% of the taxpayer’s household income. (Reg § 1.36B-2(c)(3)(v)(A)(2)) The affordability test applies only to the employee portion of the annual cost for self-only coverage and doesn’t include any additional cost for family coverage. If the employer offers multiple health coverage options, the affordability test applies to the lowest-cost option available to the individual that also satisfies the minimum value requirement. If the employer offers any wellness programs, the affordability test is based on the premium the individual would pay if he received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

An employer-sponsored plan provides minimum value if the plan covers at least 60% of the expected total allowed costs for covered services. (Code Sec. 36B(c)(2)(C)(ii)) Beginning in 2014, employers will provide employees with a summary of benefits and coverage indicating whether the plan provides minimum value.



**RIA CAUTION:** Controversy has surrounded the regulations on this credit because while the Code language refers to the premium tax credit applying to coverage purchased through “an Exchange established by the State,” the regulations issued under Code Sec. 36B provide that the premium tax credit also is available for coverage purchased on federally-facilitated Exchanges. (Reg Sec. 1.36B-1(k)) Whether a successful challenge to these regulations materializes remains to be seen.



**“Qualified health plans” may be offered through cafeteria plans, but only by “qualified employers.”** For tax years beginning **after December 31, 2013**, a reimbursement (or direct payment) for the premiums for coverage under any “qualified health plan” purchased in a group market through a health insurance Exchange is a qualified benefit under a cafeteria plan, but only if the employer is a qualified employer (generally, smaller businesses). (Code Sec. 125(f)(3)(B)) In very broad terms, a qualified health plan for this purpose is one that meets certain certification requirements, provides “an essential health benefits package,” and is offered in a group market by an insurer meeting detailed requirements. And a health insurance “Exchange” is a federally supervised marketplace for health insurance policies meeting specific eligibility and benefit criteria, to be made available not later than January 1, 2014, to qualifying individuals and employer groups of graduated sizes.



**RIA CAUTION:** The provision cited above applies only to coverage purchased in the group market. Qualified health plans purchased on the **individual** market through an Exchange are not qualified benefits for cafeteria plans. Also, in Notice 2013-54, IRS appeared to preclude employers from reimbursing (or directly paying) employees’ premiums for individual health insurance policies on a non-taxable basis, since such an “employer payment plan” would not comply with the PPACA’s prohibition on annual dollar limits for essential health benefits or the requirement to provide first-dollar coverage for preventive care.

#### **Excise tax on health insurance providers.**

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





## TAX CHANGES TAKING EFFECT IN 2015

### Larger employers not offering affordable, minimum value health coverage face penalty.

For months beginning **after December 31, 2014**, an applicable large employer is liable for an annual assessable payment if any full-time employee is certified to the employer as having bought health insurance through an Exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee, and either the employer:

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



**RIA OBSERVATION:** The employer shared responsibility provision under Code Sec. 4980H (also referred to as the “employer mandate”) had originally been scheduled to take effect for 2014, but was postponed one year. (Notice 2013-45, 2013-31 IRB 116)



**RIA OBSERVATION:** If none of the employees of an employer are eligible for premium tax credits (i.e., because the coverage offered by the employer is affordable and provides minimum value), then the employer isn’t subject to an excise tax.



Proposed regulations provide that employee status is determined under the common law standard, and an employer is the person that is the employer of an employee under that standard (which essentially looks to whether the person for whom the services are performed has the right to control and direct the person performing the services, both in respect to what is done and how it is done). Leased employees aren’t considered employees for Code Sec. 4980H purposes. In addition, a sole proprietor, partner in a partnership, or 2% S corporation shareholder isn’t considered an employee for this purpose.

The payment under Code Sec. 4980H(a) is based on all (excluding the first 30) full-time employees, while the payment under Code Sec. 4980H(b) is based on the number of full-time employees who receive a premium tax credit or cost-sharing reduction. A full-time employee for any month is an employee who is employed on average at least 30 hours of service per week (or 130 hours per month).



**RIA OBSERVATION:** Recognizing that employees' hours may fluctuate from month to month, IRS has provided a lookback methodology that provides more predictability to employers. Under this optional methodology, employers measure employees' hours during measurement periods and, based on hours worked during the measurement periods, the employees' status (full-time or part-time) generally would be locked in for a corresponding stability period.



**ILLUSTRATION:** In 2015, Employer A fails to offer minimum essential coverage and has 100 full-time employees, 10 of whom receive a tax credit for the year for enrolling in a state Exchange-offered plan. For each employee over the 30-employee threshold, the employer owes \$2,000, for a total penalty of \$140,000 (\$2,000 times 70 (100 - 30)). This penalty is assessed on a monthly basis. (Joint Committee on Taxation's JCX-18-10)

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

An individual is eligible for employer-sponsored MEC (and ineligible for the subsidy/tax credit) for a month only if the employee's share of the premiums is "affordable" and the coverage provides "minimum value" (i.e., pays at least 60% of the plan's total allowed cost of benefits provided). In general, under Code Sec. 36B(c)(2)(C)(i), an employer-sponsored plan is not affordable if the employee's required contribution with respect to the plan exceeds 9.5% of his household income for the tax year. This percentage may be adjusted after 2014. Under one of three safe harbors, employers can use the employee's W-2 income instead of household income for the 9.5% calculation (since information on an employee's household income typically isn't readily available to an employer). Other affordability safe harbors are based on the employee's rate of pay and the federal poverty line. (Prop. Reg. §54.4980H-5.)



An applicable large employer for a calendar year is an employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year. For determining whether an employer is an applicable large employer, employees averaging fewer than 30 hours per week (or 130 hours per month) are converted to full-time equivalent employees (FTEs), and the number of FTEs is added to full-time employees. (Code Sec. 4980H(c)(2))



**RIA OBSERVATION:** Thus, to be a large employer subject to the employer mandate, an employer must employ at least 50 full-time employees or a combination of full-time and FTEs that equals at least 50.



**RIA OBSERVATION:** While part-time employees are included in the FTE calculation to determine whether an employer is considered "large," they aren't included in the penalty calculations. An employer won't pay a penalty for any part-time worker, even if that part-time employee receives a premium credit.

**New information reporting of employer-provided health coverage.** For periods beginning **after December 31, 2014**, new information reporting and related statement obligations apply under Code Sec. 6056 for applicable large employers (generally, employers that may be liable for the shared responsibility tax if they fail to offer their full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan). Generally, these reports seek information on whether the employer offers health coverage to its full-time employees, whether the coverage is affordable and provides minimum value, and which employees are enrolled in the coverage. Similar information would be provided on written statements to employees. Further, under Code Sec. 6055, insurers (including employers who self-insure) that provide minimal essential coverage to any individual during a calendar year must report certain health insurance coverage information to both IRS and the covered individual for coverage provided **on or after January 1, 2015** (the first information returns will be filed in 2016). Proposed regulations would specify the information that must be reported under both of these sections. (Prop. Reg. §1.6055-1 and §301.6056-1)



**RIA OBSERVATION:** These reporting requirements are intended to help IRS administer the premium tax credits available to certain individuals who purchase coverage under qualified health plans through an Exchange as well as the individual and employer shared responsibility penalties under the Code.



**RIA OBSERVATION:** The information reporting under Code Sec. 6055 and Code Sec. 6056 had originally been scheduled to take effect for 2014, but was postponed one year. Since this reporting is instrumental to administration of the employer shared responsibility penalties, IRS also decided to delay the employer shared responsibility provisions for one year. (Notice 2013-45, 2013-31 IRB 116)



## TAX CHANGES TAKING EFFECT IN 2018

**Excise tax applies to high-cost employer-provided health insurance coverage.** For tax years beginning after Dec. 31, 2017, a 40% nondeductible excise tax will be levied on insurance companies and plan administrators for employer-sponsored health coverage to the extent that annual premiums exceed \$10,200 for single coverage and \$27,500 for family coverage, subject to cost-of-living and other adjustments. (Code Sec. 4980I) These amounts are increased by \$1,650 for single coverage and \$3,450 for family coverage with respect to retired individuals age 55 and older and for plans that cover employees engaged in high risk professions (e.g., public safety, construction, mining).



**RIA OBSERVATION:** The stated purpose of this excise tax, which was widely labeled as a tax on “Cadillac plans” by the press, is to get health insurers to offer, and employers to purchase, policies that cost less than the threshold amounts that would trigger the tax.



**RIA OBSERVATION:** The effective date for this provision is quite far off, and there are many open issues. It will be a “wait and see approach” to see how exactly it will be applied.





## HEALTH CARE REFORM GUIDANCE AND TRAINING

### [ACA Decision Support Tool](#)

With the *ACA Decision Support Tool*, simply input employer-specific data to generate a customized analysis of the ACA's impact, including a determination of whether a business is an applicable large employer subject to the employer shared responsibility rules and the potential play or pay penalties. You can also assess the impact of adding or dropping employees, converting employees from full-time to part-time status, or increasing or decreasing employees' share of premiums.

### [PPC's Guide to Health Care Reform](#)

*PPC's Guide to Health Care Reform* provides a single source of practical easy-to-understand guidance on the key provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Additionally, since Congress left much of the implementation to government agencies, it provides ongoing coverage of IRS, DOL, and HHS pronouncements to help you stay abreast of developments and expanded reporting requirements as they unfold.

- [Print](#): 1 Volume/Updated quarterly - \$310
- [Online](#) (updated monthly): \$360, 1 user

### [EBIA Health Care Reform for Employers and Advisors](#)

This manual is designed to help employers, insurers, and advisors comply with an array of new requirements. It includes rules and limitations relating to grandfathered health plans; additional plan mandates (including rules for dependent coverage, limits, caps, PCEs, appeals and external review, and new notices); tax incentives and penalties; Exchanges and qualified health plans.

Implementation guidance and timelines included.

- [Print](#): \$390
- [Online](#) (updated monthly): \$695, 1 user

### **NEW!** [Health Care Reform Quickfinder Handbook](#)

Health Care Reform will have wide-ranging implications for individuals and employers. Employer mandates to provide insurance coverage, individual mandates to obtain coverage, credits and subsidies to help individuals purchase coverage, exchanges for acquiring coverage, new reporting requirements and taxes are a few of the many changes that will impact your clients. They are likely to have questions. We've got the answers. Our new *Health Care Reform Quickfinder Handbook* makes it easy for you to quickly locate answers and respond to the many questions your clients are asking.

- [Print or eBook](#): \$45 - Buy both and save!





## HEALTH CARE REFORM CPE

### FULL-DAY WEBINAR

#### [Understanding Health Care Reform—How the New Laws Impact Employers and Individual Taxpayers](#)

WEBINAR | 8 CPE | \$189

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The biggest social reform since the implementation of Medicare and Medicaid, Health Care Reform also brings a unique opportunity for practitioners. Accountants are uniquely positioned to advise clients on the impact of Health Care reform and how to avoid associated taxes and penalties. This course will provide practitioners with the tools and strategies you need to effectively advise your clients in light of these reforms.

### FOUR ONLINE CLASSES AVAILABLE

#### *NEW!* [Affordable Care Act: Understanding the New Medicare Taxes](#)

ONLINE COURSE | 2 CPE

#### [Affordable Care Act: Employer and Individual Mandates](#)

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#### [Health Care Reform: What's Changing?](#)

ONLINE COURSE | 2 CPE

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