Quickfinder®

Health Care Reform Quickfinder® Handbook (2020 Edition)

Updates for the Further Consolidated Appropriations Act, 2020; and the Release of Final IRS Forms

Instructions: This packet contains "marked up" changes to the pages in the *Health Care Reform Quickfinder® Handbook* that were affected by final forms released and new legislation, which was enacted after the *Handbook* was published. To update your *Handbook*, you can make the same changes in your *Handbook* or print the revised page and paste over the original page.

THOMSON REUTERS
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2020 Edition
TAX PLANNING

Health Care Reform Quickfinder® Handbook

Individual Mandate
Premium Tax Credit
Employer Mandate
Reporting Requirements

Health Care Inflation-Adjusted Rates and Amounts				
	2020	**2019**	**2018**	**2017**
Applicable Large Employer Shared Responsibility Penalty				
Section 4980H(a) penalty	$2,570/ $214.17 per mo.	$2,500/ $208.33 per mo.	$2,320/ $193.33 per mo.	$2,260/ $188.33 per mo.
Section 4980H(b) penalty	$3,860/ $321.67 per mo.	$3,750/ $312.50 per mo.	$3,480/ $290 per mo.	$3,390/ $282.50 per mo.
Premium Tax Credit				
Affordability Threshold	9.78%	9.86%	9.56%	9.69%
FPL one person (start PTC)	$12,490	$12,140	$12,060	$11,880
400% FPL one person (end PTC)	$49,960	$48,560	$48,240	$47,520
FPL four persons (start PTC)	$25,750	$25,100	$24,600	$24,300
400% FPL four persons (end PTC)	$103,000	$100,400	$98,400	$97,200
Individual Shared Responsibility Penalty				
Required contribution percentage[1]	8.24%	8.3%	8.05%	8.16%
Flat dollar amount per individual	N/A	N/A	$695	$695
Maximum penalty per family	N/A	N/A	$2,085	$2,085
National average bronze monthly premium	N/A	N/A	$283	$272
Health Flexible Spending Accounts				
Annual employee contribution limit	$2,750	$2,700	$2,650	$2,600
Cost Sharing Limitations				
Self-only maximum out-of-pocket	$8,150	$7,900	$7,350	$7,150
Family maximum out-of-pocket	$16,300	$15,800	$14,700	$14,300
Health Savings Accounts				
Annual deductible:				
Self-only	$1,400 and up	$1,350 and up	$1,350 and up	$1,300 and up
Family	$2,800 and up	$2,700 and up	$2,700 and up	$2,600 and up
Out-of-pocket costs limit:				
Self-only	Up to $6,900	Up to $6,750	Up to $6,650	Up to $6,550
Family	Up to $13,800	Up to $13,500	Up to $13,300	Up to $13,100
Contribution limit:[2]				
Self-only	$3,550	$3,500	$3,450	$3,400
Family	$7,100	$7,000	$6,900	$6,750
Qualified Small Employer Health Reimbursement Accounts				
Maximum permitted benefit:				
Self-only	$5,250	$5,150	$5,050	$4,950
Family	$10,600	$10,450	$10,250	$10,050
Small Employer Health Insurance Credit				
Average annual wages phaseout begins	$27,600	$27,100	$26,600	$26,200
Average annual wages phaseout maximum	$55,200	$54,200	$53,200	$52,400

[1] For 2019 and 2020, this is used only when determining if an individual qualifies to purchase catastrophic coverage.
[2] Individual age 55 or older may contribute an additional $1,000 each year.

Health Insurance Mandate for Individuals

Tab 1 Topics

Overview

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (P.L. 111-148), signed March 23, 2010, as amended by the Health Care and Education Reconciliation Act, signed March 31, 2010, is collectively referred to as the Affordable Care Act (ACA).

Individual mandate. The ACA requires most individuals to have health insurance coverage that meets certain standards, obtain an exemption from the mandate or pay a penalty. Under this provision, individuals must maintain minimum essential coverage (MEC) for themselves and their dependents. See *Minimum Essential Coverage (MEC) Chart* on Page 1-7. For an applicable year, individuals who do not maintain MEC or qualify for an exemption may be required to pay an individual shared responsibility penalty for each month of noncompliance.

Law Change Alert: The 2017 Tax Cuts and Jobs Act reduces the individual shared responsibility penalty to zero, effectively eliminating the individual mandate, for months beginning on or after January 1, 2019.

Note: In response to the reduction of the penalty to zero, the individual mandate was again challenged as unconstitutional because it no longer triggers a tax. In December 2019, the Fifth Circuit affirmed the decision of the trial court in finding that the individual mandate is unconstitutional (*Texas v. U.S.*). However, the question of severability of the individual mandate from the remainder of the ACA has been remanded back to the trial court. It's still a waiting game for the final word in this litigation as the Supreme Court has been petitioned to review the case.

For 2019, individuals don't have to report on their personal income tax returns whether they have MEC. Additionally, Form 8965 (Health Coverage Exemptions) doesn't have to be filed to report exemptions.

For tax years 2014–2018, individuals were required to report their health coverage status through any of the following methods, as applicable:

- Checking the box on Form 1040 to indicate full-year health coverage.
- Filing Form 8965 with Form 1040 to report coverage exemptions for which they or a family member were eligible.
- Calculating and paying the individual shared responsibility penalty with Form 1040 if they did not maintain coverage or qualify for an exemption.

Note: Although there is no federal penalty beginning with tax year 2019, several states have established an individual mandate for health insurance coverage. Massachusetts, New Jersey, and Washington, DC, have state mandates in effect for 2019. State individual mandates go into effect for tax year 2020 in Vermont, California, and Rhode Island. When this *Handbook* was published, several other states (including Hawaii, Connecticut, Maryland, and Washington) were considering individual mandate legislation.

Is Health Insurance Required?

The individual mandate under IRC Sec. 5000A requiring individuals and their dependents to have MEC for each month of the year or qualify for an exemption is still the law. However, the penalties for not having the required coverage are reduced to zero for months beginning on or after January 1, 2019. For the 2019 tax year, individuals are not required to report on their personal income tax return whether they and their dependents had MEC. Additionally, Form 8965—used to report exemptions from the individual mandate—is obsolete for 2019 reporting.

The individual mandate generally applies to U.S. citizens and permanent residents. Additionally, any foreign nationals residing in the U.S. long enough during a calendar year to qualify as resident aliens for income tax purposes are subject to the mandate. However, foreign nationals who do not qualify as resident aliens are not subject to the mandate, even if they are required to file a federal income tax return.

Individuals Who Were Exempt From the Shared Responsibility Penalty

Applicable individuals who didn't maintain MEC for one or more months in tax years 2014–2018 generally were subject to the shared responsibility penalty. However, an individual who didn't maintain MEC wasn't subject to the individual shared responsibility penalty for any month during which he qualified for one or more of the following exemptions for any day during the month:

- Member of a recognized religious sect who had a religious conscience exemption.
- Member of a health care sharing ministry.
- Incarcerated individual, other than incarcerated pending the disposition of charges.
- Member of a federally recognized Indian tribe.
- Individual qualifying for services through an Indian health care provider or the Indian Health Service.
- Individual with a short coverage gap.
- Individual whose household income or gross income was below the threshold for filing an income tax return.
- U.S. citizen living abroad or noncitizen meeting certain criteria.
- Individual who was born or adopted, or who died during the calendar year.
- Individual ineligible for Medicaid solely because the state of residence did not participate in Medicaid expansion.
- Individual with household income below 138% of the applicable year federal poverty line (FPL) for the family size who resided in a state that did not expand Medicaid coverage.
- Individual enrolled in certain limited benefit Medicaid or CHIP programs that are not considered MEC.
- Individual who qualified for a general hardship exemption.
- Individual who could not afford coverage based on actual household income.
- Individual who could not afford coverage based on projected household income.
- Individual in a family where the aggregate cost of self-only coverage for two or more employed individuals was unaffordable and family coverage was unaffordable.

Optional calculation methods. The IRS has developed two calculation methods, the iterative calculation method and the simplified calculation method, to calculate the SEHID for specified premiums and the PTC amount (Rev. Proc. 2014-41). Worksheets are provided in IRS Pub. 974 for taxpayers to use for the calculations under each of the methods. Modified calculations are needed when there are months for which no Section 162(l) deduction is allowed. This could occur when an individual only operates a business for a few months during the calendar year.

Example: Aaron is self-employed, married and has two dependent children. His SE income from his business is $75,000. Household income (before calculating the SEHID) for 2019 is $84,425. Aaron, his wife and two children were enrolled in the state's SLCSP for all of 2019. The annual premium was $10,500, and they received APTC of $2,670. Therefore, the amount of specified premiums they paid for health care coverage was $7,830. The SE tax deduction is $5,299 {[($75,000 × .9235) × .153] ÷ 2}. They did not have any unspecified premiums in 2019. The 2018 FPL (that is, the applicable year FPL) for a family of four is $25,100.

Because the family received APTC, before calculating their SEHID and PTC amount, they must determine the limitation on the additional tax that may be due if any of the APTC must be repaid. Using a worksheet in IRS Pub. 974, Aaron calculates that the limitation on the APTC they may have to repay is $2,650 (see *Limitation on repayments of excess APTC* on Page 3-12).

Here is the simplified calculation for Aaron:

1) Aaron determines that the SEHID limit for specified premiums is $10,480, which is the lesser of the sum of $7,830 (the specified premiums paid) plus $2,650 (the limitation on the amount of APTC that may have to be repaid) or $69,701 (Aaron's earned income from self-employment less the SE tax deduction). Aaron's Step 1 household income is $73,945 ($84,425 household income − $10,480), which is 294% of the applicable year FPL for a family of four, so the applicable percentage is 9.68% (see the Applicable Figure table in the Form 8962 instructions Page 3-24).
2) Based on household income of $73,945, the affordable premium is $7,158 (9.68% × $73,945) and the initial PTC is $3,342 ($10,500 − $7,158).
3) Aaron's SEHID under this step is $7,158, determined as specified premiums (that is, $10,500) less the PTC calculated in Step 2 (that is, $3,342), which is less than the deduction limitation amount of $10,480 calculated in Step 1.
4) Based on a SEHID of $7,158, household income is $77,267 ($84,425 − $7,158). The affordable premium is $7,479 (9.68% × $77,267) and the PTC is $3,021 ($10,500 − $7,479).

When filing their 2019 Form 1040, Aaron's SEHID is $7,479 and the family's PTC is $3,021. Because APTC received during the year was $2,670, an additional PTC amount of $351 ($3,021 − $2,670) is claimed on the tax return.

Limitation on repayments of excess APTC. Generally, the SEHID is based on the actual cash premiums paid for health insurance and other qualifying insurance (for example, long-term care) during a calendar year. When a self-employed individual enrolls in a QHP and receives APTC, the APTC is not considered paid by the self-employed individual for SEHID purposes and, therefore, is not included in the calculations. However, any APTC that has to be repaid once the actual PTC amount for the year is calculated is included as premiums paid. Therefore, before a self-employed individual can calculate the SEHID and PTC, any repayment limitation on excess advance payments must be determined.

The maximum amount of the APTC that must be repaid is based on the taxpayer's household income as a percentage of the applicable year FPL. See the *Part III—Repayment of Excess APTC* on Page 3-8.

If the taxpayer's calculated household income is 400% or more than the applicable year FPL, there is no limitation on the repayment of excess APTC.

A worksheet in IRS Pub. 974 is used for the limitation calculation.

Example: For calendar year 2019, Don and Donna and their two dependent children enroll in a QHP through the marketplace with annual premiums of $10,500. The family received an APTC of $4,500 and had no other insurance premiums for which a SEHID applies. For purposes of this calculation, their specified premiums are $6,000 ($10,500 – $4,500).

Donna is self-employed for all of 2019 and has earnings from her business of $75,000. The family's total household income for the year, without the SEHID, is $78,000.

Before calculating the SEHID and PTC, the couple must determine the limitation on repayment of excess APTC.

The 2018 applicable FPL for a family size of four is $25,100.

Don and Donna determine they meet the requirements for the $1,600 repayment limitation for taxpayers with household income of at least 200% and less than 300% of the FPL. Their household income in applying that limitation is $70,400 [$78,000 − ($6,000 specified premiums + 1,600 limitation)]. This amount is 280% of the FPL. Therefore, the $1,600 repayment limitation applies. Don and Donna can now calculate the amount of their SEHID and PTC, using $70,400 as their beginning household income amount.

Reduced Cost-Sharing for Low-Income Taxpayers

Generally, health insurance does not pay 100% of health care costs. The amount of the health care costs other than insurance premiums paid by a covered individual is the cost-sharing portion. These out-of-pocket costs include deductibles, coinsurance and copayments. Employees with health flexible spending accounts (health FSAs) could elect to pay up to a maximum of $2,700 of these costs with pre-tax dollars in 2019. Taxpayers are also eligible for an itemized deduction for amounts paid with after-tax dollars for both premiums and unreimbursed medical costs in excess of **7.5%** of their AGI for 2019.

Cost-Sharing

A cost-sharing subsidy that reduces required out-of-pocket costs for certain individuals and families whose household income exceeds 100%, but does not exceed 250%, of the applicable year FPL for the family size involved is available.

Cost-sharing defined. *Cost-sharing* is any expenditure required by or on behalf of an insured individual with respect to essential health benefits. The term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services. Also, if a plan uses a network of providers, cost-sharing paid by or on behalf of an insured individual for benefits provided outside of the network is excluded, but insurers can elect to include these costs.

Eligible Insured Individuals

An *eligible insured individual* is a person who enrolls in a Silver-level QHP offered through the individual market of a state marketplace, and is expected to have household income that is at least 100% but does not exceed 250% of the applicable year FPL, and meets the APTC requirements, discussed under *Premium Tax Credit (PTC)* on Page 3-1.

Coordination with eligibility for Medicaid. Generally, individuals eligible for Medicaid are not eligible for a cost-sharing-reduction subsidy.

Household income, family size, MAGI, coverage month, MEC exception, affordable coverage and coverage providing minimum value. For cost-sharing assistance, these terms are

Other Taxes

Tab 7 Topics

Overview

Additional Fees and Taxes

The Affordable Care Act imposed additional taxes and fees on certain individuals; coverage providers; medical device manufacturers, producers or importers; and providers of tanning services. This tab provides information on these additional fees and taxes.

3.8% net investment income tax (NIIT). Individuals, estates and trusts are subject to an additional 3.8% tax on investment income above certain levels (IRC Sec. 1411).

0.9% Medicare tax. Individuals are subject to an additional 0.9% Medicare tax on earned income above certain levels [IRC Secs. 3101(b)(2) and 1401(b)(2)].

Excise tax on Cadillac Plans. Effective for tax years beginning after 2021, a 40% excise tax was scheduled to be levied on certain high cost employer-sponsored health insurance coverage (IRC Sec. 4980I). However, this tax has been repealed.

Excise tax on medical devices. A 2.3% excise tax was imposed on the manufacturer, producer or importer of certain medical devices (IRC Sec. 4191). However, this tax has been repealed, effective for sales made after December 31, 2019.

Excise tax on indoor tanning services. A 10% excise tax applies to any indoor tanning service (IRC Sec. 5000B).

3.8% Net Investment Income Tax

A 3.8% NIIT applies to all or a portion of the net investment income (NII) of certain individuals, estates and trusts. This 3.8% NIIT is in addition to regular federal income tax and AMT (IRC Sec. 1411).

How the NIIT Is Reported and Paid

For individuals, the NIIT is reported on, and paid with, Form 1040. For estates and trusts, it is reported on, and paid with, Form 1041.

The NIIT is subject to the estimated tax provisions. Individuals, estates and trusts that expect to be subject to the tax should adjust their income tax withholding or estimated payments to account for the tax increase in order to avoid underpayment penalties.

The NIIT is calculated on Form 8960 (Net Investment Income Tax—Individuals, Estates, and Trusts) which is attached to either Form 1040 or Form 1041. The additional tax for 2019 is included in the amount reported on Line 8 of Form 1040, Schedule 2 or Line 5 on Schedule G of Form 1041.

Corporations and Limited Liability Companies (LLCs)

The 3.8% NIIT does not apply to the investment earnings of corporations or LLCs treated as corporations. However, it may apply to dividend, interest or other payments such entities make to individuals, estates or trusts.

Individuals Subject to the 3.8% NIIT

Generally, individuals required to file a U.S. individual income tax return are subject to the additional tax on income above certain thresholds.

Nonresident Alien Married to a U.S. Citizen or Resident

Default treatment. If a U.S. citizen or resident is marrie to a nonresident alien, the spouses are generally treated as married filing separately for purposes of the 3.8% NIIT. In calculating the tax, the U.S. citizen or resident spouse is subject to the threshold amount for a married taxpayer filing a separate return (see *Threshold Amounts* on Page 7-2) and the nonresident alien spouse is not subject to the 3.8% NIIT. In accordance with the rules for married individuals filing separate returns, the spouse that is a U.S. citizen or resident must determine his own NII and modified adjusted gross income (MAGI) (see *Modified Adjusted Gross Income* on Page 7-2).

Taxpayer election. A nonresident alien married to a U.S. citizen or resident can elect to be taxed as a U.S. citizen for purposes of the NIIT [IRC Sec. 6013(g)]. Making this election permits the taxpayers to include the combined income of the U.S. citizen or resident spouse and the nonresident spouse in the 3.8% NIIT calculation and apply the threshold amount for a taxpayer filing a joint return.

Grantor Trusts

Grantor trusts are not considered taxable entities separate from the grantor and are therefore not subject to the 3.8% NIIT, because any NII (including capital gains) flows through to grantor's income tax return and the tax is applied there [Reg. 1.1411-3(b)(1)(v)].

Bankruptcy Estates

A bankruptcy estate administered under either chapter 7 (liquidations) or chapter 11 (reorganizations) of the Bankruptcy Code of an individual debtor is treated as a married taxpayer filing a separate return for purposes of the 3.8% NIIT [Reg. 1.1411-3(b)(2)(ii)].

Bona Fide Residents of U.S. Territories

An individual who is a bona fide resident of a U.S. territory is subject to the 3.8% NIIT only if the individual is required to file a U.S. income tax return. The amount excluded from gross income under IRC Secs. 931 or 933 and any deduction properly allocable or chargeable against amounts excluded from gross income under

Example: Joni, who is married and files a joint return, receives $190,000 in wages from her employer for the calendar year. Kevin, her spouse, receives $150,000 in wages from his employer for the same calendar year. Neither Joni's nor Kevin's wages are in excess of $200,000, so neither of their employers withheld the 0.9% Medicare tax. Joni and Kevin, however, are liable for the 0.9% Medicare tax on $90,000, which equals $81 [($340,000 – $250,000) × .09%].

Excise Tax On Cadillac Plans

For tax years beginning after 2021, a 40% excise tax is levied on certain high-cost employer-sponsored health insurance coverage, also known as *Cadillac plans* [IRC Sec. 4980I(a)]. The amount subject to the 40% excise tax is the excess benefit of any applicable employer-sponsored coverage. The excise tax will be deductible for income tax purposes [IRC Sec. 4980I(f)(10)].

Law Change Alert: The 40% excise tax on high-cost employer-sponsored health insurance coverage was repealed by the Further Consolidated Appropriations Act, 2020.

Health Insurance Coverage

The term *health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer [IRC Secs. 4980I(f)(5)(A) and 9832(b)(1)]. Excepted benefits (such as dental or visions benefits) are included in the cost of health insurance coverage, unless exempted by regulations.

Aggregation Rules

For purposes of this excise tax, all employers treated as a single employer under IRC Sec. 414(b), (c), (m) or (o) (for example, controlled groups or affiliated service groups) are treated as a single employer [IRC Sec. 4980I(f)(9); Notice 2015-52].

Applicable Employer-Sponsored Coverage

Applicable employer-sponsored coverage is any employee coverage under any group health plan made available to the employee by the employer that is excludable from the employee's gross income under IRC Sec. 106, or would be excludable if it were employer-provided coverage [IRC Sec. 4980I(d)(1)(A)].

Applicable Employer-Sponsored Coverage

Included Coverage	Coverage Not Included
• Employer and employee contributions to premiums for a group health plan. • Health FSAs. • Archer MSAs and HSAs.[1] • Governmental plans maintained primarily for civilian employees. • Coverage for on-site medical clinics.[2] • Retiree coverage. • Multiemployer plans. • Executive physical programs. • HRAs and QSEHRAs. • Coverage for a specified disease or illness (for example, cancer policy) or a hospital indemnity or other fixed indemnity insurance (for example, $100/day) *if* excludable from the employee's gross income or deductible as a self-employed health insurance deduction under IRC Sec. 162(l).	• Governmental plans maintained primarily for members of the military and their families. • HIPAA excepted benefits (except coverage relating to on-site medical clinics). • Coverage for long-term care. • Dental or vision benefits offered under a separate policy, certificate or contract. • Employee after-tax contributions to HSAs and Archer MSAs. • Coverage for a specified disease or illness (for example, cancer policy) or a hospital indemnity or other fixed indemnity insurance (for example, $100/day) *if not* excludable from the employee's gross income or deductible as a self-employed health insurance deduction under IRC Sec. 162(l).

[1] Applicable coverage includes employer contributions (including salary reduction contributions to HSAs).
[2] The IRS anticipates that future proposed regulations will exclude on-site medical clinics that provide only *de minimis* medical care.

Source: IRC Sec. 4980I(d)(1)(B) and (d)(2); IRS Notice 2015-16.

Coverage Includes Employee-Paid Portion

Coverage is treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage, including contributions to health flexible spending arrangements (health FSAs) and employer contributions to health reimbursement accounts (HRAs) or health savings accounts (HSAs) [IRC Sec. 4980I(d)(1)(C) and (d)(2)].

Employee. The term *employee* includes any former employee, surviving spouse or other primary insured individual [IRC Sec. 4980I(d)(3)].

Self-employed individual. For an individual who is self-employed within the meaning of IRC Sec. 401(c)(1), coverage under any group health plan providing health insurance coverage is treated as applicable employer-sponsored coverage if a deduction is allowable under IRC Sec. 162(l) (the deduction for SE health insurance), for all or any portion of the cost of the coverage [IRC Sec. 4980I(d)(1)(D)].

Excess Benefit

Generally, the excess benefit is the sum of the monthly excess amounts during the tax year. An employee's monthly excess amount is the excess (if any) of [IRC Sec. 4980I(b)(2)]:

- The aggregate cost of the applicable employer-sponsored coverage of the employee for the month over
- An amount equal to 1/12 of the annual limitation (see *Annual Limitation* on Page 7-6) for the calendar year in which the month occurs.

Cost of Applicable Employer-Sponsored Coverage

The cost of applicable employer-sponsored coverage is determined under rules similar to the rules used to determine the applicable premium for COBRA purposes. However, any portion of the cost of the coverage that is attributable to the Cadillac tax is not taken into account. The cost is calculated separately for self-only coverage and other coverage.

For applicable employer-sponsored coverage that provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained age 65 and a retired employee who has attained age 65 as similarly situated beneficiaries [IRC Sec. 4980I(d)(2)(A)].

Health FSAs. For applicable coverage under a health FSA, the cost of the coverage equals the sum of [IRC Sec. 4980I(d)(2)(B)]:

1) The employer contributions under a salary reduction election under the FSA plus
2) Any reimbursement under the FSA in excess of the contributions described in item 1 (employer flex contributions).

Archer MSAs and HSAs. For applicable coverage consisting of coverage under an HSA or Archer MSA, the cost of the coverage equals the amount of employee contributions under the arrangement (including salary reduction contributions) [IRC Sec. 4980I(d)(2)(C)].

Annual Limitation

The excise tax is applied to the amount by which the cost of applicable coverage exceeds an annual dollar limit set by statute. The annual dollar limit differs for self-only and other-than-self-only coverage. The annual limit was originally set at $10,200 for self-only coverage and $27,500 for other-than-self-only coverage. The amounts were scheduled to be inflation-adjusted for years beginning after 2018. However, adjustments haven't been announced because imposition of the tax has been delayed.

Employers may be able to apply an adjustment to the annual dollar limits if the age and gender characteristics of their workforce are significantly different in comparison to the national workforce [IRC Sec. 4980I(b)(3)(C)(iii)]. The IRS may provide adjustment tables to simplify the calculation of age and gender adjustments (Notice 2015-52).

An adjustment to the dollar limits also may apply for (1) retired individuals age 55 and older who are not eligible for enrollment in Medicare and (2) individuals who participate in an employer-sponsored plan with a majority of its enrollees engaged in high-risk professions or employed to repair or install electrical or telecommunication lines [IRC Sec. 4980I(b)(3)(C)(iv)].

High-risk professions include law enforcement, fire protection, out-of-hospital emergency medical care providers (for example, paramedics and first-responders) and long shore workers. Individuals engaged in construction, mining, agriculture (not including food processing), forestry and fishing industries are also considered high-risk [IRC Sec. 4980I(f)(3)].

Liability to Pay Tax

The excise tax applies to self-insured plans and plans sold in the small or large group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for SE individuals).

Each insurance coverage provider will be responsible for payment of the tax, based on its applicable share (see *Applicable share* on Page 7-7) of the amount of excess benefit for an employee (see *Cost of Applicable Employer-Sponsored Coverage* on Page 7-6).

Insurance coverage provider. An insurance coverage provider is [IRC Sec. 4980I(c)(2); Notice 2015-52]:

1) The health insurance issuer if the applicable coverage is under a group health plan. The health insurance issuer, not the group health plan, is the responsible party.

   Note: A health insurance issuer is an insurance company, insurance service or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance.

2) The employer, if the applicable coverage consists of HSAs or Archer MSA contributions.

3) For any other applicable coverage, the person that administers the plan benefits, which includes the plan sponsor.

Applicable share. An insurance coverage provider's applicable share of an excess benefit for any period is based on the coverage provider's cost of the applicable coverage in relation to the aggregate cost of all applicable coverage provided to the employee by all coverage providers during the period.

Example: Rhoda has employer-sponsored health insurance that is not self-only coverage and a health FSA that is not self-only coverage. The applicable cost for the insurance coverage for the tax year is $30,000. In addition, Rhoda contributed $2,000 to her health FSA during the tax year. The aggregate cost of her health coverage is $32,000 ($30,000 + $2,000). Assuming the annual other-than-self-only limit is $29,100, Rhoda's excess benefit is $2,900 ($32,000 – $29,100). The insurance issuer's applicable share of the excess benefit is 93.75% ($30,000 insurance cost ÷ $32,000 aggregate cost). Assuming Rhoda's employer administers the health FSA, the employer's share of the excess benefit is 6.25%.

Responsibility to Calculate the Tax

The employer must calculate the amount of excise tax each insurance coverage provider will pay and report the amounts to the insurance coverage providers and the IRS [IRC Sec. 4980I(c)(4)(A)].

For multi-employer plans, the plan sponsor is responsible for calculating the excess benefit amount and providing the information to the IRS and the coverage provider.

Penalty for Improperly Calculating the Excess Benefit

If the excess benefit amount calculated by the employer or plan sponsor was incorrect, and therefore, the insurance coverage providers paid too little tax based on the employer's (or plan sponsor's) calculation, the coverage providers must pay any additional tax that is due [IRC Sec. 4980I(e)(1)(A)].

In addition, the employer or plan sponsor must pay a penalty equal to the total additional excise tax due from all coverage providers, plus interest at the underpayment rate for the period beginning on the due date for the unpaid taxes and ending on the payment date [IRC Sec. 4980I(e)(1)(B)].

Note: This is a 100% penalty in addition to the actual additional excise tax that must be paid.

Limitations on penalty. The penalty does not apply if the employer or plan sponsor exercised reasonable diligence. Also, the penalty does not apply if the failure was due to reasonable cause and not to willful neglect and is corrected within 30 days from the date the employer knew, or exercising due diligence, would have known, the failure existed. The IRS also has the authority to waive the penalty (all or in part) to the extent paying the penalty would be excessive or otherwise inequitable relative to the failure involved [IRC Sec. 4980I(e)(2)].

Excise Tax On Medical Devices

A 2.3% excise tax on the sales price of taxable medical devices (see *Taxable Medical Devices* on Page 7-8) is imposed on the manufacturer, producer or importer of the device. (See *Who Is Responsible for the Tax?* on Page 7-9.) [IRC Sec. 4191(a); Reg. 48.4191-1(a)].

Law Change Alert: The Further Consolidated Appropriations Act, 2020, repeals the medical device excise tax effective for sales made after December 31, 2019.

The IRS has issued regulations, Notice 2012-77 and frequently asked questions (FAQs) regarding the medical device excise tax, which are referenced in this section. The FAQs are available at **www.irs.gov**. Search for "medical device tax."

The excise tax is imposed when title to the taxable medical device passes from the manufacturer to a purchaser. Additionally, the manufacturer may be liable for the tax (as if the taxable device had been sold) if it uses a taxable device for a purpose other than in the manufacture of another taxable device.

Note: Regs. 48.4218-1(b) and 48.4218-5 provide information on when a device is taxable because of its use and how to calculate the price on which the tax is based.

Moratorium on the Excise Tax

The medical device excise tax is suspended for sales during the period January 1, 2016 through December 31, 2019 [IRC Sec. 4191(c)]. ~~The excise tax is scheduled to apply to sales occurring on or after January 1, 2020.~~ The short-term government spending bill signed into law on January 22, 2018 provided for a two-year suspension of the excise tax (for 2018 and 2019). The tax had previously been suspended for 2016 and 2017 by the 2015 Protecting Americans from Tax Hikes Act.

Medical Device Defined

Generally, a *medical device* is a device, as defined in Section 201(h) of the Federal Food, Drug, and Cosmetic Act (FFDCA) intended for humans. The FFDCA defines a *device* as an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component, part or accessory, that is any of the following:

- Recognized in the official national formulary, the U.S. pharmacopeia or any supplement to them.

Continued on the next page

Group health plans are required to have procedures for how covered employees or their qualified beneficiaries can provide notice of these types of qualifying events. The plan can set a time limit for providing this notice, but the time limit cannot be shorter than 60 days, starting from the latest of:

- The date the qualifying event occurs;
- The date the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event or
- The date the qualified beneficiary is informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

If a group health plan does not have a prescribed form or procedures for providing notice, the notice can be given either in writing or orally to the person or unit that handles employee benefits matters. If the plan is a multi-employer plan, notice can also be given to the joint board of trustees. If the plan is administered by an insurance company, notice can be given to the insurance company.

The DOL has a model election notice that satisfies the COBRA notice requirements. Use of a properly completed model election notice is considered to be good faith compliance with the notice requirements.

The model election notice is available in modifiable, electronic form on the DOL's website at **www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra**.

Health Insurance Coverage Reporting on Form 1095-C

Applicable large employers must file an information return [Form 1095-C (Employer-Provided Health Insurance Offer and Coverage)] with the IRS that reports whether or not health insurance coverage was offered, and if offered, the terms and conditions of the health care coverage offered to Section 4980H full-time employees for the year (IRC Sec. 6056). A copy of Form 1095-C also must be furnished to the employee. (See Page 8-37 for a copy of Form 1095-C.)

Note: The 2019 Forms 1095-C and 1094-C were released in December by the IRS. There were no substantial changes to the forms from the 2018 versions.

An *applicable large employer* (ALE) is an employer who employed an average of at least 50 full-time employees (including full-time equivalents) on business days during the preceding calendar year. (See *Applicable Large Employers (ALEs)* on Page 4-1 and *Full-Time Employee Who Must Be Offered Coverage* on Page 4-4

Note: Employers that aren't ALEs that offer self-insured health plan coverage to their employees may have reporting requirements under IRC Sec. 6055. See *Health Insurance Coverage Reporting on Form 1095-B* on Page 8-6.

For self-insured plans the plan sponsor is responsible for the plan's reporting. The employer is considered the sponsor for a self-insured group plan maintained by a single employer. For a plan maintained by more than one employer that isn't a multiemployer plan (as defined in ERISA) the plan sponsor is each participating employer. For a plan that is a multiemployer plan (as defined in ERISA), the plan sponsor is the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the plan. For a plan maintained solely by an employee organization, the plan sponsor is the employee organization. For any plan for which a plan sponsor is not identified previously, the sponsor is the person designated by the plan's terms or, if no person is designated, each entity that maintains the plan.

Caution: Reporting arrangements between health care providers and other parties are not prohibited. However, entering into a reporting arrangement does not transfer the potential liability of the provider for failure to report information and furnish statements under IRC Sec. 6056.

Information Required on Form 1095-C

In general, every ALE must file a Form 1095-C with the IRS for each Section 4980H full-time employee and provide a copy of the form to the employee. The form provides information to the IRS to help the agency enforce the employer mandate (see Tab 4). The IRS also uses the information to identify individuals who are ineligible for the premium tax credit because they were offered adequate employer-sponsored coverage.

Part I. In Part I of Form 1095-C, the employee and employer's identifying information is entered. Additionally, the telephone number that provides direct access to a person who can answer questions that an employee may have about Form 1095-C must be entered. The individual listed can be an employee or agent of the employer.

Part II, employee offer and coverage. Part II of Form 1095-C is the main reporting section of the form. On line 14, the Series 1 codes entered for each month tell the IRS if the employee, his spouse and dependents were offered coverage; the type of coverage they were offered and if the employer may be liable for a Section 4980H shared responsibility penalty with respect to the employee. The Series 2 codes used on line 16 identify whether the employer is using an affordability safe harbor and other circumstances in which the employer may be entitled to penalty relief.

Part II, line 14, offer of coverage. This line is used to report whether an offer of coverage was made to an employee for each month of the year, and, if an offer was made, what type of coverage was offered. The Series 1 codes are used on line 14. Generally, coverage is considered offered for purposes of line 14 if it was at least MEC. Most employer-sponsored coverage that provides benefits that are more than excepted benefits (such as limited-scope vision or dental benefits that are not an integral part of a group health plan) is considered MEC. For Section 4980H(b) purposes, coverage offered to the employee must be minimum value insurance. Minimum value insurance is insurance that pays at least 60% of the covered benefits and provides substantial coverage of inpatient hospital services and physician services.

An offer of coverage to an employee's spouse includes an offer that is subject to a reasonable, objective condition, regardless of whether the spouse meets that condition. For example, an employer that offers coverage to a spouse only if the spouse or the employee certifies that the spouse isn't eligible for coverage through another employer-sponsored plan is considered an offer of coverage. Conditional offers don't count as an offer of coverage to an employee's dependents unless the employer knows that the dependent met the condition and is eligible for the coverage offered.

For line 14 purposes, an offer of coverage is considered to have been made for a month only if the coverage is offered for every day of that month. If the same code applies for all 12 calendar months, the applicable code can be entered in the "All 12 Months" box, instead of completing all of the individual calendar month boxes. If an employee terminates coverage before the last day of the month, the employee doesn't actually have an offer of coverage for that month. Additionally, if the employee begins working for the employer on any day other than the first day of the month (and coverage is provided on the employee's start date), coverage isn't considered offered for the first month of employment.

A code must be entered for each calendar month, even if the employee wasn't a full-time employee for that month or didn't work for the employer for one or more of the calendar months. The code

Limited Non-Assessment Period

A *limited non-assessment period* refers to a period during which an ALE isn't subject to a Section 4980H(a) penalty, and in certain cases a Section 4980H(b) penalty, even if a full-time employee isn't offered adequate health insurance coverage during the period.

The limited non-assessment periods are:

1) January through March of the first calendar year in which an employer is an ALE, but only for an employee who wasn't offered MEC by the employer at any point during the prior calendar year;
2) The waiting period under the monthly measurement method;
3) The waiting period under the look-back measurement method;
4) The initial measurement period and associated administrative period under the look-back measurement method;
5) The period following a change in status that occurs during a initial measurement period under the look-back measurement method and
6) The employee's first calendar month of employment if the employee's first day of employment is a day other than the first day of the calendar month.

The periods described in items 1–5 are limited non-assessment periods for purposes of the penalty under IRC Sec. 4980H(a) only if the employee is offered MEC by the first day of the first month following the end of the period. They are limited non-assessment periods under IRC Sec. 4980H(b) only if the health coverage that is offered to the employee by the first day of the first month following the end of the period is minimum value insurance.

For more information on measurement periods, see *Determining Which Employees Must Be Offered Coverage* on Page 4-4.

Time and Manner for Filing Returns

Generally, Forms 1095-C and 1094-C must be filed with the IRS on or before February 28 (March 31, if filed electronically) of the year immediately following the calendar year to which the return relates.

An automatic 30-day extension to file the returns with the IRS can be obtained by filing Form 8809 (Request for Extension of Time to File Information Returns) on or before the due date. One additional 30-day extension can be requested by filing a second Form 8809 on paper by the initial extended due date. The extension request must be signed by a person duly authorized to sign a return. To receive the additional extension, the employer must confirm on the Form 8809 that it meets one of the five criteria specified on the form.

Forms 1095-C and transmittal Form 1094-C are required to be filed electronically with the IRS unless the ALE files fewer than 250 Forms 1095-C for the calendar year. ALEs that are not required to file electronically may choose to do so. The IRS encourages electronic filing by all filers.

Caution: Under proposed regulations issued in May 2018, an employer required to file a total of 250 or more information returns, including Forms 1095-C, would be required to file all information returns electronically [Prop. Reg. 301.6011-2(b)(4)]. Subsequently, the Taxpayer First Act of 2019 replaced the 250-return threshold with an "applicable number" of returns standard. The threshold remains 250 for calendar years before 2021, but is reduced to 100 returns for 2021, and to 10 returns for calendar years after 2021. The proposed regulations had not been finalized when this *Handbook* was published. Presumably, changes will be made to the regulations to conform to the changes made by the Taxpayer First Act before they are finalized. Practitioners should be alert for additional guidance.

Furnishing Forms 1095-C to Employees

Generally, ALEs must furnish a copy of Form 1095-C to each Section 4980H full-time employee on or before January 31 of the year immediately following the calendar year to which the information relates. However, the IRS extended the date for furnishing a copy of the 2019 Form 1095-C to employees to March 2, 2020 (IRS Notice 2019-63). Additionally, if the ALE sponsors a self-insured health plan, a copy of Form 1095-C must be given to any employee (whether or not he was a full-time employee at any time of the year) who enrolled (or had family members who enrolled) in the self-insured coverage.

The social security number (SSN) of the employee or any family member receiving coverage on Form 1095-C can be truncated on the copy of the form given to the employee by showing only the last four digits of the SSN and replacing the first five digits with asterisks (*) or Xs. Truncation isn't allowed on forms filed with the IRS. The employer's EIN may not be truncated on either the statement furnished to the employee or the forms filed with the IRS. Forms 1095-C must be furnished to employees on paper by mail or hand-delivered, unless the recipient affirmatively consents to receive the statement in an electronic format. If mailed, the statement must be sent to the employee's last known permanent address, or if no permanent address is known, to the employee's temporary address.

Consent to furnish statement electronically. The requirement to obtain affirmative consent to furnish a statement electronically ensures that statements are sent electronically only to individuals who are able to access them. An individual may consent on paper or electronically, such as by email. If consent is on paper, the individual must confirm the consent electronically. A statement may be furnished electronically by email or by informing the individual how to access the statement on the employer's website.

Penalties

Penalties may be assessed under IRC Sec. 6721 for failure to file Forms 1095-C and 1094-C with the IRS and under IRC Sec. 6722 for failure to furnish a correct copy of Form 1095-C (or an approved substitute form) to each full-time employee.

For 2019 information returns filed in 2020, the Section 6721 penalty ranges from $50–$270 for each incorrect return (that is, Form 1095-C) sent to the IRS, depending on when (or if) the failure is corrected. The maximum annual penalty is $3,339,000 [IRC Sec. 6721(a)(1); Rev. Proc. 2018-57]. For filers with average annual gross receipts of $5 million or less for the three most recent tax years, the maximum penalty is $1,113,000. The penalties are higher if there is intentional disregard for the filing requirements.

The Section 6722 penalty ranges from $50–$270 for each incorrect return (that is, Form 1095-C) sent to a full-time employee (or for a return not sent), depending on when (or if) the failure is corrected. The maximum penalty that can be assessed for failure to furnish the correct statement to full-time employees is $3,339,000 [IRC Sec. 6722(a)(1); Rev. Proc. 2018-57]. For filers with average annual gross receipts of $5 million or less for the three most recent tax years, the maximum penalty is $1,113,000. The penalties are higher if there is intentional disregard for the filing requirements.

Note: Penalties assessed under IRC Secs. 6721 and 6722 may be waived if the failure is due to reasonable cause. (IRC Sec. 6724) Additionally, the IRS is providing penalty relief for employers that report incorrect or incomplete information if the employer makes a good-faith effort to comply with the reporting requirements (IRS Notice 2019-63).

Health Insurance Coverage Reporting on Form 1095-B

Certain health insurance providers (and employers providing self-insured health benefits) must file Form 1095-B (Health Coverage) with the IRS and provide a copy of the form to individuals. Form 1095-B reports information required by IRC Sec. 6055 on the type of health insurance provided to individuals. (See Page 8-31 for a copy of Form 1095-B.)

Note: The IRS released the 2019 Forms 1095-B and 1094-B in December 2019. Although there were no substantial changes to the forms, some reporting relief and penalty relief is available under certain circumstances. See the discussion on Page 8-8.

Fully insured coverage sponsored by employers, multiemployer plans and individual insurance coverage that is purchased outside of a state's health insurance marketplace is reported on Form

1095-B. Coverage obtained by employees of small employers through the Small Business Health Options Program (SHOP) marketplace (see Tab 6) also is reported on Form 1095-B. However, coverage in qualified health plans (QHPs) that individuals enroll in through the individual market of a state's health insurance marketplace for which individuals may receive a premium tax credit is reported on Form 1095-A (Health Insurance Marketplace Statement). (See a copy of Form 1095-A on Page 8-29.)

Note: Catastrophic coverage that can be purchased through a state insurance marketplace should be reported on Form 1095-B. However, the IRS isn't requiring insurers to report this coverage on Form 1095-B until required by final regulations. The IRS does encourage insurers to voluntarily report on catastrophic plan coverage enrolled in through a marketplace. Individuals enrolled only in catastrophic coverage are not eligible for a premium tax credit to help pay for the coverage.

Generally, Form 1095-B is filed by health insurance issuers or carriers to report fully-insured coverage, or by government agencies for government-sponsored programs (such as Medicare). Therefore, individuals with fully-insured health insurance coverage through an employer should receive a Form 1095-B from the insurer. If the employer is an ALE, the employee will also receive a Form 1095-C from the employer.

A small employer that isn't an ALE must file Form 1095-B for any employee who enrolled in a self-insured group health plan sponsored by the employer. ALEs with self-insured plans use Part III of Form 1095-C to satisfy their Section 6055 reporting obligations (see *Health Insurance Coverage Reporting on Form 1095-C* on Page 8-3). Therefore, employers with self-insured plans should be sure they file the correct form.

Information Reported on Form 1095-B

Part I, responsible individual. In Part I of Form 1095-B, information on the responsible individual, to whom the form is sent is entered. The *responsible individual* is (1) the primary name on the insurance coverage or (2) the person who, based on a relationship to individuals covered by the insurance or some other circumstances, is the individual who should receive the statement. Generally, the responsible individual is the taxpayer who is liable for the individual shared responsibility penalty for the covered individual. For employer-sponsored insurance that is fully-insured and reported on Form 1095-B, the responsible individual generally is the employee or former employee [Reg. 1.6055-1(b)(11)].

Note: The responsible individual's SSN can be truncated on the copy of Form 1095-B given to the individual.

On line 8, the origin of the applicable insurance coverage is identified by entering one of the following letter codes:

A—Small Business Health Options Program (SHOP).
B—Employer-sponsored coverage.
C—Government-sponsored program.
D—Individual market insurance.
E—Multiemployer plan.
F—Other designated minimum essential coverage (MEC).

Part II, employer-sponsored coverage. Part II of Form 1095-B is completed by issuers or carriers only if code A (SHOP coverage) or code B (employer-sponsored coverage) is entered on line 8. The identifying information for the employer is entered in this section. Employers reporting self-insured group health plan coverage on Form 1095-B enter code B on line 8, but don't complete Part II.

The employer's EIN reported in Part II may be truncated on copies of Form 1095-B furnished to recipients. However, the filer's EIN may not be truncated on the statement. Truncation of TINs, including EINs, isn't allowed on returns filed with the IRS.

Part III, issuer or other coverage provider. The *plan provider* identifying information is entered in Part III of Form 1095-B. The plan provider is the sponsor of a self-insured employer plan, an issuer or carrier of insured coverage, government agency providing government-sponsored coverage or other coverage sponsor. The EIN of the plan provider can't be truncated on any copy of Form 1095-B. A contact telephone number is entered on line 18 that provides direct access to an individual who can answer questions that a responsible individual or covered individual may have about information reported on Form 1095-B.

Part IV, covered individuals. In Part IV of Form 1095-B, information about all of the individuals covered by the plan or policy is reported. If more than six individuals were covered under the policy or plan, a Form 1095-B, Part IV Continuation Sheet is used to report information for the additional individuals.

The name of each covered individual is entered on a separate line in column (a). The individual's SSN (or TIN) is entered in column (b). If an SSN (or TIN) is not available, the individual's date of birth is entered in column (c).

Caution: The filer of Form 1095-B (for example, an employer with self-insured coverage) should obtain the SSN or other TIN for every person enrolled in the coverage on the application for coverage. If an SSN isn't provided on the application, the filer should make another request within 75 days of the application. The IRS may impose penalties on the filer if a date of birth is used and the filer did not properly solicit each individual's SSN [Prop. Reg. 1.6055-1(h); Notice 2015-68].

Columns (d) and (e) are used to indicate the months in which the individual was covered by the plan for at least one day during the month. If the individual had coverage for at least one day per month for all 12 months of the year, the box in column (d) is checked and column (e) is left blank. If coverage was not provided for at least one day during each month of the year, the applicable monthly boxes in column (e) are marked.

Filing Form 1095-B and Furnishing Copy to Responsible Individual

Forms 1095-B are filed with the IRS using Form 1094-B (Transmittal of Health Coverage Information Returns). The returns must be filed on or before February 28 (March 31, if filed electronically) of the year immediately following the calendar year to which the return relates.

A copy of Form 1095-B must be provided to the responsible individual on or before January 31 of the year immediately following the calendar year to which the return relates. However, the IRS extended the date for furnishing the 2019 Form 1095-B to responsible individuals to March 2, 2020 (IRS Notice 2019-63). Additionally, when certain conditions are met, an employer can forgo providing a copy of Form 1095-B to the responsible individual and not be subject to a Section 6722 penalty (IRS Notice 2019-63). See the discussion on Page 8-8.

An automatic 30-day extension to file the returns with the IRS can be obtained by filing Form 8809 (Request for Extension of Time to File Information Returns) on or before the due date. One additional 30-day extension can be requested by filing a second Form 8809 on paper by the initial extended due date. The extension request must be signed by a person duly authorized to sign a return. To receive the additional extension, the employer must confirm on the Form 8809 that it meets one of the five criteria specified on the form.

Forms 1095-B and transmittal Form 1094-B are required to be filed electronically with the IRS unless the reporting entity files fewer than 250 Forms 1095-B for the calendar year. Reporting entities that are not required to file electronically may choose to do so. The IRS encourages electronic filing by all filers.

Caution: Under proposed regulations issued in May 2018, an employer required to file a total of 250 or more information returns of any type, including Forms 1095-B, would be required to file all information returns electronically [Prop. Reg. 301.6011-2(b)(4)]. Subsequently, the Taxpayer First Act of 2019 replaced the 250-return threshold with an "applicable number" of returns standard. The threshold remains 250 for calendar years before 2021, but is reduced to 100 returns for 2021, and to 10 returns for calendar years after 2021. The proposed regulations had not been finalized when this *Handbook* was published. Presumably, changes will be made to the regulations to conform to the changes made by the Taxpayer First Act before they are finalized. Practitioners should be alert for additional guidance.

Penalties

Penalties may be assessed under IRC Sec. 6721 for failure to file Form 1095-B with the IRS and under IRC Sec. 6722 for failure to furnish a correct copy of the form (or an approved substitute form) to each responsible individual. See *Penalties* on Page 8-6 for additional information on the penalty amounts and penalty relief if the employer makes a good-faith effort to comply with the reporting requirements.

Reporting Relief and Section 6722 Penalty Relief for 2019 Form 1095-B

Because the individual shared responsibility penalty is reduced to zero for 2019, and individuals don't need the information reported on Form 1095-B to complete their federal income tax return, the IRS is providing filers with penalty relief under IRC Sec. 6722. The IRS will not assess a Section 6722 penalty against a reporting entity for failing to furnish a 2019 Form 1095-B to a responsible individual if the following conditions are met (IRS Notice 2019-63):

1) The reporting entity posts a notice on its website that a copy of the 2019 Form 1095-B can be requested. The notice must include an email address and a physical address to send the request.
2) Form 1095-B is provided within 30 days of the date requested.

Caution: Applicable large employers (ALEs) that sponsor self-insured health plans must comply with the Section 6056 reporting requirements (see the discussion on Form 1095-C on Page 8-3). The Section 6722 penalty relief is not extended to an ALE that is required to furnish a Form 1095-C to a full-time employee. However, the penalty relief does extend to any employee enrolled in the ALE's self-insured plan who is not a full-time employee for any month during 2019.

Medical Loss Ratio Rebates

Insurance companies are required to spend a specified percentage of premium dollars on medical care and quality improvement activities, rather than administrative costs. This is called the *medical loss ratio* (MLR). Insurers that don't meet this ratio must provide rebates to their policyholders, which is typically an employer that sponsors a group health plan.

The MLR is the percentage of total premiums received that a health insurance issuer spends for claims and health care quality improvements. The total premium amount used in the calculation is reduced by certain taxes, fees and other allowable adjustments.

Plans issued through the large group market must maintain an MLR of at least 85% or provide a premium rebate to policyholders. For plans issued through the small group and individual markets, issuers must maintain an MLR of at least 80%.

Caution: States are permitted to establish a higher MLR standard than the 80%/85% provided in the ACA.

Insurance companies generally pay the rebates to the individual policyholders as cash payments. For group plans, the rebates are generally handled by reducing premiums for some or all months of the next plan year.

Rebate paid to an individual policyholder. The insurance company isn't required to file a Form 1099-MISC with respect to a cash rebate (or premium reduction) or furnish a Form 1099-MISC to the individual policyholder unless:

- The total rebate payments made to that policyholder during the year total $600 or more.
- The insurance company knows that the rebate constitutes taxable income to the individual policyholder or it can determine how much of the payment constitutes taxable income.

Caution: If a taxpayer deducted the premium as an itemized deduction or received a tax benefit from the premium by claiming the deduction for self-employed health insurance premiums, he must include the rebate in income, even if a Form 1099-MISC is not issued by the insurance company.

Example: In 2019, Aaron purchased and paid premiums for a health insurance policy for himself. Aaron doesn't receive any reimbursement or subsidy for the premiums. Based on his enrollment during 2019, Aaron receives a $250 MLR rebate on July 1, 2020. The insurance company doesn't have to issue a Form 1099-MISC to Aaron because the rebate is less than $600.

Aaron deducted the premiums as a Schedule A itemized deduction on his 2019 federal income tax return. Because the premiums were deducted, Aaron has taxable income to the extent that he received a tax benefit from the deduction. The treatment is the same regardless of whether the rebate is received as a cash payment or applied as a reduction in the amount of premiums due.

Rebate paid on a group plan. Generally, rebates for group plans are handled by reducing premiums for some or all months of the next plan year (that is, the plan year in which the rebate is received), and the insurance company isn't required to file a Form 1099-MISC unless:

- The group policyholder isn't an exempt recipient for Form 1099 purposes.
- The total rebate payments to that group policyholder during the year total $600 or more.
- The insurance company knows that the rebate constitutes taxable income to the group policyholder or it can determine how much of the payment constitutes taxable income.

Observation: Because an insurer generally won't know the amount of rebate each participant is entitled to or whether that participant received a tax benefit, it's unlikely that a Form 1099-MISC will be issued for rebates to group health plans.

Example: Daniel participated in his employer's group health plan and received health coverage under the group health insurance policy purchased directly by his employer under the plan. The plan provides that Daniel's employer pays for 60% of the premium for each employee, and he pays for 40% of the premium on an after-tax basis. Daniel doesn't deduct the premiums on his Form 1040. In July of the following year, Daniel's employer receives an MLR rebate of part of the prior year group health insurance policy premiums. The MLR rebate is made in the form of a reduction in the current year premium for coverage under the group health insurance policy. In accordance with the terms of the group health plan and consistent with applicable DOL guidance, 60% of the rebate is used to reduce the employer portion of the premium due and 40% of the rebate is used to reduce the employee portion of the premium due but only for participants under the plan who also were participants under the plan during the prior plan year.

Because Daniel participated in the plan during the prior year, he is entitled to an MLR rebate. As a result of the rebate, he receives a corresponding premium reduction for his current year coverage. Further, since he didn't deduct the insurance premiums, he isn't taxed on the rebate for either income or employment taxes.

The result would be the same if the employer distributes the rebate to Daniel in cash rather than applying the payments to future premiums. If Daniel had deducted the insurance premiums, he would have taxable income to the extent he received a tax benefit. The insurance company doesn't have to issue a Form 1099-MISC for the total rebate given to the employer because the employer is a corporation and the insurer doesn't know if any of the rebate must be taken into account when determining either the employer's or any employee's taxable income.

Tax Return Preparers, Healthcare, and IRC Sec. 7216

The IRS takes the privacy rights of individuals seriously. Tax return preparers, including those who also offer services and education related to the ACA, are prohibited from knowingly or recklessly disclosing or using tax return information for unauthorized purposes (IRC Sec. 7216).

The tax return information a tax return preparer can disclose or use depends on obtaining consent from the taxpayer, or whether the Treasury Department provides an exception to the general prohibition (Reg. 301.7216-2).

The regulations permit tax return preparers to use a list of client names, addresses, email addresses, phone numbers and each client's income tax form number to provide clients general educational information, including general educational information related to the ACA.

Observation: A tax return preparer may mail general educational information to all clients regarding health care enrollment options available through a state insurance marketplace without obtaining consent. However to use tax return information to solicit

and facilitate health care enrollment services, the preparer must first obtain taxpayer consent.

Solicitation to offer health care enrollment services by all tax return preparers, including volunteer preparers, using tax return information, requires taxpayer consent. (See Rev. Proc. 2013-14, as modified by Rev. Proc. 2013-19, for requirements for consents from taxpayers who file a return in the Form 1040 series.)

Caution: Tax return preparers must use the mandatory language in Rev. Proc. 2013-14 (Rev. Proc. 2013-19).

Example: Return Preparer Zack would like to use tax return information to solicit and facilitate enrollment of eligible clients into QHPs available through the insurance marketplace in his state. Zack must obtain taxpayer consent prior to using information for solicitation and enrollment purposes.

Patient-Centered Outcomes Research Trust Fund Fee

IRC Secs. 4375, 4376, and 4377

A fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans is imposed to help fund the Patient-Centered Outcomes Research Institute (PCORI). The PCORI assists patients, clinicians, purchasers and policy-makers in making informed health decisions through research and by advancing the quality and relevance of evidence-based medicine.

The fee originally applied to policy or plan years ending before October 1, 2019. The fee, which is based on the average number of lives covered under a policy or plan, is reported annually on the second quarter Form 720 and must be paid by its due date, July 31.

Law Change Alert: The Further Consolidated Appropriations Act, 2020 extends the PCORI fee for 10 years. Therefore, the fee is applicable for policy or plan years ending before October 1, 2029.

See the *Application of the Patient-Centered Outcomes Research Trust Fund Fee to Common Types of Health Coverage or Arrangements* on Page 8-11.

The fee amount. The amount of the fee equals the average number of lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year. For policy and plan years ending on or after October 1, 2018, and before October 1, 2019, the fee amount is $2.45 per covered life (Notice 2018-85). ~~For calendar year plans, 2018 was the final year that PCORI fees applied.~~

Example: Sponsor Chad maintains Plan X, which is a self-insured health plan with a fiscal year ending June 30, 2019 and is responsible for the PCORI fee. The Form 720 that must be filed for this plan year is due no later than July 31, 2020. The fee is calculated by multiplying the average number of covered lives by $2.45 (the applicable dollar amount in effect for plans with plan years ending on or after October 1, 2018 and before October 1, 2019).

Issuers of specified health insurance policies are required to use one of four alternative methods to determine the average number of lives covered under a specified health insurance policy for a policy year. This discussion deals with the rules for plan sponsors.

Plan sponsors (self-insured). Plan sponsors are required to use one of three alternative methods to determine the average number of lives covered under the applicable self-insured health plan for a plan year:

- The actual count method,
- The snapshot method or
- The Form 5500 method.

Counting. All individuals who are covered during the plan year must be counted in computing the average number of lives covered for that year. Thus, an applicable self-insured health plan must count an employee and his dependent child as two separate covered lives unless the plan is an HRA or FSA. See *Special rule for FSAs and HRAs* on Page 8-10.

Actual count method. The average number of lives covered can be determined by adding the total number of lives covered for each day of the plan year and dividing that total by the number of days in the plan year [Reg. 46.4376-1(c)(2)(iii)].

Example: AAA Tree Service is the plan sponsor of a calendar year self-insured health plan. AAA calculates the sum of lives covered under the plan for each day of the plan year as 3,285,000. The average number of lives covered under the plan for that year is 9,000 (3,285,000 ÷ 365). To calculate the IRC Section 4376 fee, AAA must multiply 9,000 by the applicable per-life fee amount.

Snapshot methods. A plan sponsor may determine the average number of lives covered during a plan year by adding the total of lives covered on one or more dates during the first, second or third month of each quarter of the plan year and dividing by the number of dates on which a count was based.

Each date used for the second, third and fourth quarter must be within three days of the date that corresponds to the date used for the first quarter. If a plan sponsor uses multiple dates for the first quarter, the plan sponsor must use dates in the remaining quarters that correspond to the dates used for the first quarter. Dates chosen within three days of the original date are considered corresponding dates. All dates must fall within the plan year [Reg. 46.4376-1(c)(2)(iv)].

The 30th and 31st day of a month are treated as the last day of the month for determining the corresponding date for any month that has fewer than 31 days (for example, if either March 30 or March 31 is used for a calendar year plan, June 30 is the corresponding date for the second quarter).

The number of lives used for the snapshot may be determined based on either the snapshot count method or on the snapshot factor method.

Snapshot count method. Under the snapshot count method, the number of lives (that is, each employee, spouse and dependent covered under the plan) covered on a date equals the actual number of lives covered on the designated dates.

Example: Bob's Big Rig (BBR) is the sponsor of a calendar year self-insured health plan. BBR uses the snapshot count method to determine the average number of lives covered.

On January 4, the BBR self-insured health plan covers 2,000 lives.

On April 5, it covers 2,100 lives.

On July 5 it covers 2,050 lives.

On October 4, it covers 2,050 lives.

The total lives counted equal 8,200 (2,000 + 2,100 + 2,050 + 2,050). The total lives counted are divided by the number of days selected to obtain the snapshot total of 2,050 lives (8,200 ÷ 4). The snapshot total of 2,050 is multiplied by the applicable per-life fee amount.

Snapshot factor method. Under the snapshot factor method, the number of lives covered on a date equals the sum of:

- The number of participants with self-only coverage on that date plus
- The number of participants with coverage other than self-only coverage on the date multiplied by 2.35.

Example: Using the same facts as in the prior example except BBR used the snapshot factor method for the plan year end. BBR must total both the number of employees with self-only coverage and those with other coverage. The number of employees with other coverage must be multiplied by 2.35.

On January 10, the BBR self-insured health plan provides self-only coverage to 600 employees and other than self-only coverage to 800 employees.

On April 11, the plan provides self-only coverage to 608 employees and other than self-only coverage to 800 employees. On July 11 and October 10, the plan provides self-only coverage to 610 employees and other than self-only coverage to 809 employees.

Using the snapshot factor method, the average number of lives covered under the plan for the plan year is 9,990 {[600 + (800 × 2.35)] + [608 + (800 × 2.35)] + [610+ (809 × 2.35)] + [610 + (809 × 2.35)]} ÷ 4, or 2,497.

To calculate the fee, the employer uses the fee that corresponds to the plan's year end.