

Patient Protection and Affordable Care Act: Implementation Issues for the Individual and Employer Mandates

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INTRODUCTION

Under the Patient Protection and Affordable Care Act¹ (the “ACA”), will individuals in the U.S. have more options for obtaining affordable, comprehensive healthcare coverage? Or will there be an increase in healthcare costs under the ACA that will leave individuals with little choice but to forego insurance and pay the penalty, or otherwise enroll in a government regulated marketplace—the “Exchanges”—to purchase a healthcare plan? What will the Exchanges look like in years to come?

As Americans transition to the new rules governing healthcare coverage, there are some concerns that insurers will pass the additional costs of compliance with the ACA onto other stakeholders. Premiums could climb for employer sponsored insurance (“ESI”) plans, and employers, in turn, are likely to pass these costs onto their employees.² Costs to individuals may also rise as higher-risk/higher-cost populations turn to the Exchanges as an alternative for coverage.³ And not until June

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¹ Patient Protection and Affordable Care Act, Pub. L. 111 - 148, *codified as amended by the Health Care and Education Reconciliation Act of 2010*, Pub. L. 11-152, at 42 USC §18001 et seq. (2010).

² 2013 *Employer-Sponsored Healthcare: ACA’s Impact*, INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS, at page 3, *available at* <https://www.ifebp.org/Resources/research/Pages/empsponsoredhcimpact13.aspx>, (follow “Survey Result”) (last visited June 30, 2015).

³ WILLIAM H. FRIST, M.D., *Obamacare’s “Cadillac Tax” Could Help Reduce the Cost of Healthcare*, FORBES BLOG (February 26, 2014, 7:37 AM),

25, 2015, did the U.S. Supreme Court uphold, in a six to three decision, the right for individuals purchasing insurance through a federally-run Exchange to claim a premium tax credit.⁴ This credit is the linchpin for providing increased access to affordable healthcare—the very essence of the ACA. There are many factors, then, that are at play in determining the future landscape of healthcare in the United States.

The viability of options for obtaining health insurance will also be determined, in part, by how well the ACA’s mandates and its provision of benefits for qualifying individuals and small businesses are administered by the IRS. The agency has gotten off to a rocky start. At the outset, when the IRS’s role in overseeing compliance with the ACA was first unveiled, considerable doubt was being cast on the IRS’s ability to oversee an extensive overhaul of the health insurance marketplace. This was especially true given the high profile scandals that were causing the IRS’s integrity to come under bitter attack. The additional funding necessary to implement the ACA, and the short turn-around time that was required, were also real concerns for the agency.

And there are some indications that the rollouts have not been so smooth, including the Government Accountability Office’s findings regarding the potential for fraud,⁵ as well as a question, in more than one jurisdiction, about the allowance of a premium tax credit. Specifically, on July 22, 2014, the U.S. Court of Appeals for the D.C. Circuit held in *Halbig v. Burwell* that a premium tax credit was available only to taxpayers who purchase insurance through a state-run Exchange, as opposed to the federally-facilitated Exchange.⁶ On that same day, however, the Fourth Circuit Court of Appeals reached the opposite decision in *King v. Burwell*.⁷

The *Halbig* Court vacated its decision on September 3, 2014, and scheduled a rehearing en banc for December 17, 2014.⁸ A rehearing in the Court of Appeals is reserved for “exceptional cases” and is an indication that a majority of the judges who voted to grant the review did not agree with the original decision rendered in the case by a split three-judge panel.⁹ Meanwhile, the Supreme Court granted a petition for a writ

<http://www.forbes.com/sites/theapothecary/2014/02/26/obamacares-cadillac-tax-could-help-reduce-the-cost-of-health-care/>.

⁴ *King v. Burwell*, 2015 U.S. LEXIS 4248 (U.S. June 25, 2015).

⁵ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-14-705T, PATIENT PROTECTION AND AFFORDABLE CARE ACT: PRELIMINARY RESULTS OF UNDERCOVER TESTING OF ENROLLMENT CONTROLS FOR HEALTH CARE COVERAGE AND CONSUMER SUBSIDIES PROVIDED UNDER THE ACT (2014).

⁶ *Halbig v. Burwell*, 758 F.3d 390, 412 (D.C. Cir. 2014), vacated, rehearing, en banc, granted, 2014 U.S. App. LEXIS 17099 (D.C. Cir. 2014), held in abeyance, 2014 U.S. App. LEXIS 23434 (D.C. Cir., 2014).

⁷ *King v. Burwell*, 759 F.3d 358, 358 (4th Cir. 2014), cert. granted, 135 S. Ct. 475, aff’d, 2015 U.S. LEXIS 4248 (U.S. June 25, 2015).

⁸ *Halbig v. Burwell*, 2014 U.S. App. LEXIS 17099 (D.C. Cir. 2014), held in abeyance, 2014 U.S. App. LEXIS 23434 (D.C. Cir., 2014).

⁹ TIMOTHY JOST, *Implementing Health Reform: DC Circuit Vacates Halbig Judgement, Grants Rehearing*, HEALTH AFFAIRS BLOG (September 5, 2014),

of certiorari in *King v. Burwell* on November 7, 2014.¹⁰ This prompted the *Halbig* Court to issue yet another order, that same day, holding the case in abeyance pending the Supreme Court's decision.¹¹ Other Federal District Courts have been faced with similar cases, and the Supreme Court's involvement was therefore timely. For the IRS, there was a lot at stake and a lot of uncertainty. The same rings true, generally, for employers and individuals as they attempt to navigate the ins and outs of the new law.

In *Patient Protection and Affordable Care Act: Transition Relief for Employers and Individual Mandate*, the authors took a practical look at the ACA's new mandates for individuals and employers, including the transition rules for 2014 and 2015 and the various compliance options.¹² We also took a look at the small business health insurance credit.¹³ To understand fully the choices that employers and individuals will make, however, one must understand that there are many different aspects of the ACA at play—not only the individual and employer mandates and the small business health insurance credit, but also the premium tax credit and two additional costs of the ACA, the Health Insurance Tax and the Cadillac Tax. Each of these presents various issues that, in conjunction, will ultimately determine the success of the ACA in increasing access to affordable healthcare. We consider each of these in turn.

THE INDIVIDUAL MANDATE

The federal government aims to provide all individuals in the United States with affordable healthcare. The ACA, therefore, includes a mandate that every individual have “minimum essential” coverage. Thus, effective January 1, 2014, IRC §5000A(a)¹⁴ requires individuals to enroll in a qualifying plan or purchase a coverage option through an “Exchange” in the government regulated marketplace. Individuals who do purchase their healthcare coverage through an Exchange may qualify, based on household income, to receive a premium tax credit on their individual income tax return,¹⁵ providing them with a subsidy to help cover the cost of their healthcare plan.

<http://healthaffairs.org/blog/2014/09/05/implementing-health-reform-dc-circuit-vacates-halbig-judgement-grants-rehearing/>.

¹⁰ *King v. Burwell*, 135 S. Ct. 475 (2014).

¹¹ *Halbig v. Burwell*, 2014 U.S. App. LEXIS 23434 (D.C. Cir. 2014).

¹² Lynn Mucenski-Keck & Kari Smoker, *Patient Protection and Affordable Care Act: Transition Relief for Employers and Individual Mandate*, THE CPA JOURNAL Vol. 85, Issue 4 (April 2015).

¹³ *Id.*

¹⁴ 26 USC §5000A(a) (Supp. 2010). Unless indicated otherwise, all references to Title 26 of the United States Code are cited in the text as “IRC §...”, and all references to the Treasury Regulations promulgated under the Code are cited in the text as “Treas. Reg. §”.

¹⁵ 26 USC §36B (Supp. 2010).

The Premium Tax Credit

Healthcare coverage purchased by taxpayers through an Exchange— although paid for with after-tax dollars— affords them a potential tax credit on their individual income tax returns for the premiums they pay,¹⁶ providing them access to more “affordable” healthcare. In addition, a taxpayer may receive advance payments of the premium tax credit, which are paid directly to the taxpayer’s insurance carrier and thus lower the amount the taxpayer owes in monthly premiums.¹⁷

Generally, in order to qualify for the credit under IRC §36B, a taxpayer must be a U.S. citizen or be lawfully present in the U.S. and, if married, file a joint return.¹⁸ He or she cannot be claimed as a dependent of any other taxpayer, and the taxpayer’s family (including his or her spouse and dependents) must have modified adjusted gross income between 100% and 400% of the federal poverty line.¹⁹ The taxpayer must also buy coverage through an Exchange and be ineligible for other “minimum essential coverage,” such as Medicare, Medicaid, or an ESI plan that is deemed affordable and to provide minimum value.²⁰ Whether an ESI plan is deemed affordable and to provide minimum value is governed by IRC §36B(c)(2)(C)(i) and (ii),²¹ which are discussed in more detail below.²²

In an Exchange, taxpayers can choose from four different policy types that range from bronze to premium, with a bronze plan providing the least comprehensive coverage and requiring the taxpayer to contribute the most towards cost sharing, including higher deductibles and/or co-pays.²³ The calculation of the actual credit amount is somewhat complex and is based on the cost of the silver plan (the “benchmark plan”), the second lowest in cost that is available in the Exchange for each member of the taxpayer’s household.²⁴ It is also based on the household’s expected contribution towards coverage, which is determined on a sliding scale with those households having the lowest modified adjusted gross income contributing the least.²⁵ The amount of the credit is then equal to the lesser of i) the actual premiums paid for coverage; or ii) the household’s

¹⁶ *Id.*

¹⁷ *The Premium Tax Credit*, <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/The-Premium-Tax-Credit> (last visited June 30, 2015).

¹⁸ 26 USC §36B(c)(1)(A)-(C) and (e) (Supp. 2010).

¹⁹ 26 USC §36B(c)(1)(A) and (D) (Supp. 2010).

²⁰ 26 USC §36B(b)(1) and (c)(2) (Supp. 2010).

²¹ 26 USC §36B(c)(2)(C)(i) and (ii) (Supp. 2010).

²² The Employer Mandate: Large Employers Must “Pay or Play,” *infra*.

²³ *Premium Tax Credits: Answers to Frequently Asked Questions*, CENTER ON BUDGET AND POLICY PRIORITIES, at page 2, available at <http://www.cbpp.org/files/QA-on-Premium-Credits.pdf> (last updated July 2013).

²⁴ 26 USC §36B(b)(2) and (3)(B)-(D) (Supp. 2010).

²⁵ 26 USC §36B(b)(2) and (3)(A) (Supp. 2010).

total cost of coverage for a benchmark plan less the household's expected contribution for coverage.²⁶

The premium tax credit is a refundable credit, meaning that the taxpayer can receive a refund as a result of the credit even if he or she has no tax liability.²⁷ Whether or not to receive it in advance in the form of premium assistance paid directly to the insurer is optional.²⁸ However, because changes in income or family size can have a significant effect on the amount of a taxpayer's premium tax credit, the IRS issued Health Care Tax Tip 2014-15, advising that taxpayers do "a mid-year checkup" to see if it is necessary to adjust the premium assistance they are receiving.²⁹ Otherwise, the agency warns, taxpayers may be getting too much of an advance of the premium tax credit, in which case they will either owe more in taxes in order to repay the advance credit or be entitled to a smaller refund when they file their tax returns.³⁰ Alternatively, they may be receiving too little of an advance to reduce the amount of their monthly premiums. In order to avoid these pitfalls, the IRS advises taxpayers to report changes such as marriage or divorce, the birth or adoption of a child, the start of a new job with health insurance, and either the gain or loss of eligibility for other health care coverage to their Exchange as soon as possible.³¹

Challenges in the Administration of the Premium Tax Credit

Are individuals who buy insurance from a federally-run Exchange eligible?

A split in the Circuits.

Each state has the ability to set up its own Exchange. However, there are currently 23 states that have completely opted out of building their own Exchanges and for whom the federal government, through the Department of Health and Human Services, is operating one instead.³²

²⁶ 26 USC §36B(b)(2) (Supp. 2010).

²⁷ *Premium Tax Credits: Answers to Frequently Asked Questions*, CENTER ON BUDGET AND POLICY PRIORITIES, at page 8, available at <http://www.cbpp.org/files/QA-on-Premium-Credits.pdf> (last updated July 2013).

²⁸ *Id.* at page 7.

²⁹ *IRS: Now is the Time for a Mid-Year Premium Tax Credit Checkup*, IRS Health Care Tax Tip 2014-15 (July 18, 2014), available at <http://www.irs.gov/uac/Newsroom/IRS-Now-is-the-Time-for-a-Mid-Year-Premium-Tax-Credit-Checkup>; and *Its Not Too Late to Report Changes in Circumstances that May Affect Your Premium Tax Credit*, IRS Health Care Tax Tip 2014-22 (Oct. 31, 2014), available at <http://www.irs.gov/uac/Newsroom/Its-Not-Too-Late-to-Report-Changes-in-Circumstances-that-May-Affect-Your-Premium-Tax-Credit>.

³⁰ *Id.* Notably, the amount of the excess that must be repaid is limited for taxpayers with household income that is less than 400% of the poverty line. 26 USC §36B(f)(2)(B) (Supp. 2010).

³¹ *Id.*

³² *State Actions to Address Health Insurance Exchanges*, THE NATIONAL CONFERENCE OF STATE LEGISLATURES, available at <http://www.ncsl.org/research/health/state-actions-to-implement-the-health-benefit.aspx>, published by (last updated June 25, 2015). In addition to those twenty-three states, Arkansas,

On July 22, 2014, the U.S. Court of Appeals for the D.C. Circuit held, in *Halbig v. Burwell*, that a premium tax credit is available only to those taxpayers who purchase insurance through state-run Exchanges,³³ thereby denying the credit to taxpayers who are forced to purchase insurance through a federally-facilitated Exchange because they reside in a state that has opted out of building its own. The Court based its decision on the plain language of IRC §36B(b)(2), which provides that the credit is available for coverage that is obtained through “an Exchange established by the State,”³⁴ and stated,

We reach this conclusion, frankly, with reluctance. At least until states that wish to can set up Exchanges, our ruling will likely have significant consequences both for the millions of individuals receiving tax credits through federal Exchanges and for health insurance markets more broadly. But, high as those stakes are, the principle of legislative supremacy that guides us is higher still....To hold otherwise would be to say that enacted legislation, on its own, does not command our respect—an utterly untenable proposition.³⁵

The Court vacated its decision, however, on September 4, 2014, in the wake of the Fourth Circuit’s decision in *King v. Burwell*³⁶ and scheduled a rehearing for December 17, 2014.³⁷

In *King v. Burwell*, the U.S. Court of Appeals for the Fourth Circuit held that the language of IRC §36B is ambiguous as to whether the credit is allowed for insurance purchased through a federally-run Exchange in the absence of one that is state-run.³⁸ Given the ambiguity, the Court further held that the IRS’s rules, which allow a tax credit for insurance purchased through the Federal Exchange, offer a reasonable interpretation of the statute, and the Court thus deferred to the IRS on the basis that it was granted agency-ruling authority for providing this interpretation.³⁹

The split in the Federal Circuits centers on whether the language of the statute is ambiguous and, in part, whether the legislature intended to

Delaware, Illinois, Iowa, Michigan, New Hampshire, and West Virginia are currently running state Exchanges in partnership with the Federal government. *Id.*

³³ *Halbig v. Burwell*, 758 F.3d 390, 412 (D.C. Cir. 2014), *vacated, rehearing, en banc, granted*, 2014 U.S. App. LEXIS 17099 (D.C. Cir. 2014), *held in abeyance*, 2014 U.S. App. LEXIS 23434 (D.C. Cir., 2014).

³⁴ 26 USC §36B(b)(2)(C) (Supp. 2010).

³⁵ *Halbig v. Burwell*, 758 F.3d 390, 412 (D.C. Cir. 2014), *vacated, rehearing, en banc, granted*, 2014 U.S. App. LEXIS 17099 (D.C. Cir. 2014), *held in abeyance*, 2014 U.S. App. LEXIS 23434 (D.C. Cir., 2014).

³⁶ *King v. Burwell*, 759 F.3d 358, 358 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475, *aff’d*, 2015 U.S. LEXIS 4248 (U.S. June 25, 2015).

³⁷ *Halbig v. Burwell*, 2014 U.S. App. LEXIS 17099 (D.C. Cir. 2014), *held in abeyance*, 2014 U.S. App. LEXIS 23434 (D.C. Cir., 2014).

³⁸ *King v. Burwell*, 759 F.3d 358, 369 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475, *aff’d*, 2015 U.S. LEXIS 4248 (U.S. June 25, 2015).

³⁹ *Id.*, at 372-3.

limit the availability of the premium tax credit to those individuals who purchase insurance from a state-run Exchange. It is possible that the legislature intended to do so as an enticement for states to build their own Exchanges. In any event, nearly half the states have opted out of building their own,⁴⁰ which means there are many taxpayers who have purchased insurance from a federally-facilitated Exchange and for whom, on that basis, the credit could have been denied.

The United States Supreme Court settles the question.

On June 25, 2015, the Supreme Court upheld the Fourth Circuit Court's decision in *King v. Burwell*, holding that the premium tax credit is available to taxpayers purchasing insurance through a federally-facilitated Exchange. The Court first found—rather surprisingly—that although the statutory language in IRC §36B appears “plain” in its reference to an Exchange “established by the State”, the words must be read “in their context and with a view to their place in the overall statutory scheme” in order to determine whether the language is, in fact, plain.

The Court then determined that, when read in context and with a view to their place in the overall statutory scheme of the ACA, the phrase “established by the State” is ambiguous. It based its finding on the fact that, if a State opts out of building its own Exchange, the ACA directs the Secretary of Health and Human Services to build “such Exchange,” which implies incorrectly that the State Exchange and the federally-facilitated Exchange are interchangeable. It also reached this determination because it found it untenable that the ACA, the primary goal of which is to make healthcare more affordable, would do so only for State Exchanges.

Having determined that the language of IRC §36B is ambiguous, the Court then held that it must look more broadly at the ACA to determine whether there was a permissible meaning that ““produces a substantive effect that is compatible with the rest of the law.”⁴¹ It was based on its analysis of the overarching purpose of the ACA that the Court upheld the premium tax credit for taxpayers purchasing insurance through a federally-facilitated Exchange.

So why did the Supreme Court seemingly ignore the plain language of the statute and rule the way it did? Because to have held otherwise would have presented a considerable road-block for full implementation of the Affordable Care Act and its aim to make healthcare both affordable and accessible. Decisive legislative action would have been required to broaden the sweep of IRC §36B's provision of a premium tax credit⁴² to all qualifying taxpayers purchasing insurance through an

⁴⁰ FN 32 *supra*.

⁴¹ 2015 U.S. LEXIS 4248 (U.S. June 25, 2015) (citing *United Sav. Assn. of Tex. v. Timbers of Inwood Forest Associates, Ltd.*, 484 U. S. 365, 371).

⁴² 2015 U.S. LEXIS 4248 (U.S. June 25, 2015).

Exchange. Otherwise, the IRS would have been facing an administrative nightmare, determining which taxpayers are entitled to the credit—and recouping the advance tax credit from those who are not. The IRS was able to sidestep this particular road-block, but there are other challenges in its administration that lie ahead.

Is the IRS Making Proper Payments?

Another concern is whether the IRS is making proper payments of the advanced premium tax credit based on applications for coverage. This concern arises out of the amount of fraud, waste and abuse that has occurred in the administration of other existing programs and benefits, including the Earned Income Tax Credit, and the fact that the federal government “wastes tens of billions of dollars each year in improper payments.”⁴³ To address this concern, the House Ways and Means Oversight Committee held a hearing on July 25, 2014, to explore the integrity of the IRS’s Premium Tax Credit verification system and the program’s potential exposure to fraud, waste and abuse.⁴⁴ Seto J. Bagdoyan, the Acting Director of the Forensic Audits and Investigative Service with the United States Government Accountability Office (“GAO”), testified about initial undercover testing that has been done. Although the initial sample size was small, it was intended to be “illustrative.”⁴⁵ The preliminary findings are worrisome.

The IRS’s verification system is designed to ensure that payments are issued only to eligible taxpayers and in the correct amounts, and it does so by verifying, among other things, the taxpayer’s identity, Social Security Number, household income, and legal residency in the U.S.⁴⁶ While the IRS administers the Premium Tax Credit, the Department of Health and Human Services’ Centers for Medicare & Medicaid Services (CMS) is responsible for establishing the on-line federal Exchange, known as “HealthCare.gov,” that is operating in states that do not have state-run Exchanges.⁴⁷ CMS, in turn, has hired a number of contractors to develop, test and maintain the federal Exchange.⁴⁸ Obviously, the IRS’s verification system must be properly designed, and then properly utilized by CMS and its contractors, to make correct determinations regarding coverage and the

⁴³ MICHAEL COHN, *Congress Probes Legitimacy of ACA Premium Tax Credits*, BLOOMBERG BNA (July 18, 2014), http://www.accountingtoday.com/news/government_news/congress-probes-legitimacy-aca-premium-tax-credits-71398-1.html.

⁴⁴ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-14-705T, PATIENT PROTECTION AND AFFORDABLE CARE ACT: PRELIMINARY RESULTS OF UNDERCOVER TESTING OF ENROLLMENT CONTROLS FOR HEALTH CARE COVERAGE AND CONSUMER SUBSIDIES PROVIDED UNDER THE ACT (2014).

⁴⁵ *Id.*, at page 3.

⁴⁶ *Id.*, at page 2.

⁴⁷ *Id.*, at page 1-2.

⁴⁸ *Id.*, at page 2.

allowance of an advanced premium tax credit that reduces an individual's monthly insurance premiums.

In order to test the "front end" controls, if any, that are in place for verifying an applicant's identity or citizenship/immigration status, the GAO made 12 applications by phone or online for fictitious applicants, using invalid or missing social security numbers, or purporting to be noncitizens lawfully present in the U.S.⁴⁹ The applications were made at income levels that would qualify the individuals for advanced premium tax credits to lower their insurance premiums.⁵⁰ Alarming, 11 of those fictitious applicants were provided with subsidized coverage.⁵¹ The 12th applicant, however, was denied coverage because he or she refused to provide a social security number.⁵²

The 11 approved fictitious applicants were then required to submit supporting documents, such as proof of income or citizenship.⁵³ This step is consistent with the requirement that applicants provide supplementary documentation when the information they provide is inconsistent with government sources, in order that the inconsistencies can be resolved.⁵⁴ During this process, the ACA requires the marketplace to provide the applicant with continuing eligibility.⁵⁵ Here, the GAO found inconsistencies in the document submission and review process. As of July 2014, the GAO received notification that portions of the counterfeit documentation it submitted for two of the applicants had somehow been verified.⁵⁶ The GAO submitted no documentation at all for three of the applicants,⁵⁷ yet eligibility for all 11 fictitious applicants continued as of July 2014.⁵⁸

In addition to the 12 fictitious identities that were created to test "front end" controls, six more were created to test the extent to which, if any, those assisting applicants in-person would encourage them to misstate income in order to qualify for the premium tax credit.⁵⁹ However, for five of those applicants, the GAO was unsuccessful in its initial attempts to find someone who was willing or able to assist.⁶⁰ The one person that did offer fact-to-face assistance correctly advised the undercover investigator that his stated income would not qualify him for a premium tax credit.⁶¹

There is yet another concern that exposes the program to fraud, waste and abuse, and it is the CMS's inability to determine how much is

⁴⁹ *Id.*, at page 3-4.

⁵⁰ *Id.*

⁵¹ *Id.*, at page 5-6.

⁵² *Id.*, at page 7.

⁵³ *Id.*, at page 8.

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*, at page 9.

⁵⁷ *Id.*

⁵⁸ *Id.*, at page 10.

⁵⁹ *Id.*, at page 13.

⁶⁰ *Id.*

⁶¹ *Id.*

owed to various insurance carriers in premium subsidies.⁶² CMS indicated, as of July 2014, that it did not yet have the capability to electronically identify enrollees who are paying premiums.⁶³ Therefore, it was unable to determine, independently, the amount it owed in subsidies to various insurance carriers because of advanced premium tax credits awarded to taxpayers that reduce their monthly premiums.⁶⁴ As a result, CMS was forced to rely on carriers to self-report their enrollment data, which was then used to determine the subsidy owed to them.⁶⁵ CMS indicated that, while it was working on developing and implementing an internal system, it did not have a timeline for doing so.⁶⁶

The “Individual Shared Responsibility Payment”

If individuals opt out of health care coverage, the government has the right to impose a penalty—the “individual shared responsibility payment”⁶⁷—for their failure to comply with the mandate.⁶⁸ Specifically, if the taxpayer or any of his dependents does not have minimum essential coverage for any month, then the monthly penalty for transition year 2014 was generally 1/12 of the greater of⁶⁹ i) \$95 for each such adult and \$47.50 for each child under age 18,⁷⁰ subject to a maximum amount of \$285 per family;⁷¹ or ii) 1% of applicable household income.⁷² The amounts increased for transition year 2015, such that the monthly penalty amount is generally 1/12 of the greater of⁷³ i) \$325 for each such adult and \$162.50 for each child under age 18,⁷⁴ subject to a maximum amount of \$975 per family;⁷⁵ or ii) 2% of applicable household income.⁷⁶ The amounts increase once again for 2016. For 2016, the monthly penalty amount is generally 1/12 the greater of⁷⁷ i) \$695 for each such adult and \$347.50 for each child under age 18,⁷⁸ subject to a maximum amount of \$2,085 per family;⁷⁹ or ii) 2.5% of applicable household income.⁸⁰ The 2016 amounts are adjusted for inflation for subsequent years.⁸¹ The

⁶² *Id.*, at page 17.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ 26 USC §5000A(b) (Supp. 2010).

⁶⁸ 26 USC §5000A(b)(1) (Supp. 2010).

⁶⁹ 26 USC §5000A(c)(2) (Supp. 2010).

⁷⁰ 26 USC §5000A(c)(2)(A)(i) and (3)(B)-(C) (Supp. 2010).

⁷¹ 26 USC §5000A(c)(2)(A), (A)(ii), and (3)(B) (Supp. 2010).

⁷² 26 USC §5000A(c)(2)(B)(i) (Supp. 2010).

⁷³ 26 USC §5000A(c)(2) (Supp. 2010).

⁷⁴ 26 USC §5000A(c)(2)(A)(i) and (3)(B)-(C) (Supp. 2010).

⁷⁵ 26 USC §5000A(c)(2)(A), (A)(ii), and (3)(B) (Supp. 2010).

⁷⁶ 26 USC §5000A(c)(2)(B)(ii) (Supp. 2010).

⁷⁷ 26 USC §5000A(c)(2) (Supp. 2010).

⁷⁸ 26 USC §5000A(c)(2)(A)(i), (3)(A), and (C) (Supp. 2010).

⁷⁹ 26 USC §5000A(c)(2)(A), (A)(ii), and (3)(B) (Supp. 2010).

⁸⁰ 26 USC §5000A(c)(2)(B)(iii) (Supp. 2010).

⁸¹ 26 USC §5000A(c)(3)(D) (Supp. 2010).

taxpayer's shared responsibility payment for the year is the total penalty amount for all months of non-coverage, subject to certain exemptions, and is capped at the national average premium for a bronze level health plan available through the Exchanges.⁸² See Exhibit 1.

THE EMPLOYER MANDATE: LARGE EMPLOYERS MUST "PAY OR PLAY"

Large employers can also be assessed a penalty if they do not provide certain health care coverage to their employees.⁸³ This is often referred to as the "shared responsibility" or the "pay or play" requirement. The rules for large employers are rather complex. Generally, if a large employer has at least one full-time employee whose household income is between 100% and 400% of the federal poverty level and who receives a premium tax credit for Exchange coverage, the employer must offer coverage to its full-time employees that is deemed affordable and provides minimum value.⁸⁴ Otherwise, an excise tax, or penalty, may be assessed.⁸⁵ Exhibit 2 provides a summary of the rules for determining large employer status. For a more detailed discussion, as well as examples for determining large employer status, see Patient Protection and Affordable Care Act: Transition Relief for Employers and Individual Mandate.⁸⁶ Note that special rules apply for members of a controlled group.⁸⁷

The Excise Tax

Enforcement of the ACA's excise tax on employers was delayed until January 1, 2015, to allow employers additional time to provide input on the information reporting rules being implemented for them under IRC §6056.⁸⁸ The transition relief also allowed them additional time to adapt their health coverage and reporting systems.⁸⁹ This means there was no excise tax for 2014.⁹⁰

Beginning in 2015, however, if a large employer does not offer coverage, or if it offers coverage to less than 95% of its full-time employees and their dependents for any month (70% for transition year

⁸² 26 USC §5000(A)(c)(1) and (1)(B) (Supp. 2010).

⁸³ 26 USC §4980H (Supp. 2010).

⁸⁴ 26 USC IRC §4980H(a) and (b) (Supp. 2010).

⁸⁵ *Id.*

⁸⁶ Lynn Mucenski-Keck & Kari Smoker, *Patient Protection and Affordable Care Act: Transition Relief for Employers and Individual Mandate*, THE CPA JOURNAL Vol. 85, Issue 4 (April 2015).

⁸⁷ 26 USC §4980H(c)(2)(C) (Supp. 2010).

⁸⁸ IRS Notice 2013-45, 2013-31 I.R.B. 116.

⁸⁹ *Id.*

⁹⁰ *Id.*

2015), then an excise tax may be assessed if at least one full-time employee is receiving a premium tax credit.⁹¹ Even if the employer offers coverage to the minimum number of employees required by law, an excise tax may be assessed if the coverage is either unaffordable for certain full-time employees or does not provide “minimum value.”⁹² Exhibit 3 provides a summary of the rules for calculating the penalty for offering non-compliant coverage, as well as the penalty for failing to offer coverage to the required minimum number of employees. Notably, the excise tax is comprised of both penalties, and the calculation of one penalty is distinctly different from that of the other.⁹³

Whether coverage is deemed affordable or to provide minimum value is governed by IRC §36B(c)(2)(C)(i) and (ii).⁹⁴ Coverage is deemed affordable to a full-time employee if he or she is required to contribute no more than 9.5% of his or her annual household income to purchase, for the year, the lowest cost, minimum value, self-only coverage offered by the employer.⁹⁵ Because most employers do not know their employees’ household income, there are three affordability safe harbor tests that employers may rely upon to avoid the excise tax.⁹⁶ See Exhibit 4.

In addition, proposed regulations have been issued that provide guidance for determining whether minimum value coverage is met.⁹⁷ Under IRC §36B(c)(2)(C)(ii), coverage provides minimum value if payments under the health plan cover at least 60% of the total allowed cost of benefits that are expected to be incurred.⁹⁸ The IRS and the Department of Health and Human Services have made a minimum value calculator available to determine whether coverage meets this requirement.⁹⁹ However, in November 2014, the IRS announced that even if an employer achieves a minimum value determination using the calculator, a coverage plan will not be deemed to provide minimum value if it does not offer “substantial” coverage of inpatient hospital and physician services.¹⁰⁰

⁹¹ 26 USC §4980H(a) (Supp. 2010); and *Employers Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> (last updated May 20, 2015).

⁹² 26 USC §4980H(b) (Supp. 2010).

⁹³ Compare 26 USC §4980H(a) (Supp. 2010) and 26 USC §4980H(b) (Supp. 2010).

⁹⁴ 26 USC §36B(c)(2)(C)(i) and (ii) (Supp. 2010).

⁹⁵ 26 USC §36B(c)(2)(C)(i) (Supp. 2010).

⁹⁶ 26 CFR §54.4980H-5(e)(2) (2014); and *Employers Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, at question 19, <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> (last updated May 20, 2015).

⁹⁷ 78 Fed. Reg. 86 (2013) (to be codified at 26 C.F.R. pt 1, §1.36B-6); and *Employers Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, at question 20, <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> (last updated May 20, 2015).

⁹⁸ 26 USC §36B(c)(2)(C)(ii) (Supp. 2010).

⁹⁹ 78 Fed. Reg. 86 (2013) (to be codified at 26 C.F.R. pt 1, §1.36B-6); and *Employers Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, at question 19, <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> (last updated May 20, 2015).

¹⁰⁰ IRS Notice 2014-69, 2014-48 I.R.B. 903.

Accordingly, the Department of Health and Human Services issued final regulations in February 2015, adopting this rule effective April 28, 2015.¹⁰¹ It is still unclear how “substantial” will be defined. Also, certain plans may be deemed, automatically, to meet the minimum value coverage requirement under the safe harbor rules.¹⁰²

To summarize, if a large employer fails to offer coverage to a minimum number of employees that is deemed to be affordable and to provide minimum value, and if at least one employee receives a premium tax credit, the employer is subject to the excise tax under IRC §4980H(a) and (b).¹⁰³ If, however, the employer offers coverage that is deemed to be affordable and to provide minimum value, the employee will be ineligible to receive a premium tax credit as a means of subsidizing coverage,¹⁰⁴ and the employer will successfully avoid the excise tax under the ‘pay or play’ rules in effect for large employers. But at what cost does the employer avoid the tax?

Tax avoidance under the “pay or play rules”: a cost/benefit analysis

In “Patient Protection and Affordable Care Act: Transition Relief for Employers and Individual Mandate,” we explore the compliance options for large employers under the “pay or play rules” and provide examples for calculating the penalties for non-compliance.¹⁰⁵ The examples emphasize the importance of tracking, each year, the number of full-time employees an employer will be deemed to have and also estimating the number of full-time employees who will not receive compliant coverage and will likely receive a premium tax credit through the Exchange. If a large employer does not offer coverage to the appropriate percentage of full-time employees, and one full-time employee receives the premium tax credit, the employer opens itself up to a penalty for each full-time employee less a designated excludable number (30 employees for 2016 going forward). However, the employer must weigh the potential tax assessment against the additional cost of providing appropriate coverage.

For example, the employer may find that it is better for the organization's bottom line—at least in the short run—to offer some type of coverage to 95% of full time employees that is deemed unaffordable or

¹⁰¹ 80 Fed. Reg. 39 (2015), amending 45 C.F.R. §156.145(a); and *Employers Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, at question 20, <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> (last updated May 20, 2015).

¹⁰² 78 Fed. Reg. 86 (2013) (to be codified at 26 C.F.R. pt 1, §1.36B-6); and *Employers Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act*, at question 20, <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act> (last updated May 20, 2015).

¹⁰³ 26 USC §4980H(a) and (b) (Supp. 2010).

¹⁰⁴ 26 USC §36B(c)(2)(B) and (C) (Supp. 2010).

¹⁰⁵ Lynn Mucenski-Keck & Kari Smoker, *Patient Protection and Affordable Care Act: Transition Relief for Employers and Individual Mandate*, THE CPA JOURNAL Vol. 85, Issue 4 (April 2015).

does not provide minimum coverage for the employee (70% under the 2015 transition rules). In that case, an organization will only be assessed a penalty on the number of full time employees who utilize the Exchange and receive a premium tax credit. The employer must compare this cost with the amount the employer has saved in ESI premiums. Likewise, it may find that it is better for its bottom line—again, in the short run—to offer some employees coverage that does not provide minimum value.

Some employers may ultimately decide that the simplest solution, when dealing with ESI, is to decrease the healthcare benefits they provide to their employees and encourage them to utilize the Exchange. However, others may conclude they need to continue to provide ESI coverage to retain and attract talented employees. Which brings us to the long term.

In a 2013 survey conducted by the International Foundation of Employee Benefit Plans, approximately 94% of the single employer plans surveyed stated they would definitely or very likely continue providing coverage, when the Exchanges opened in 2014, in order to retain and attract talented employees.¹⁰⁶ This underscores the importance, when conducting a cost/benefit analysis, of weighing not only the short-term cost in tax assessments against the short-term savings in ESI premiums, but also the long-term cost to organizational culture and the employer's ability to retain and attract talent as a result of a cut in employee benefits. The employer may decide that it is much too high a price to pay.

SMALL EMPLOYERS: TAX RELIEF TO HELP AFFORD THE COST OF HEALTHCARE

While large employers are subject to the “pay or play” requirements, small employers may qualify for the Small Business Health Care Credit to help them afford the cost of providing an ESI plan.¹⁰⁷ It is specifically designed to encourage them to sponsor an ESI plan for the first time or maintain one that they already have in place.¹⁰⁸

For tax years 2010 through 2013, the maximum credit was 35% of the premiums they contributed for an ESI plan.¹⁰⁹ Beginning in 2014, the maximum credit increased to 50%.¹¹⁰ The amount of the actual credit the business can claim is determined using a sliding scale and is reduced if the

¹⁰⁶ *2013 Employer-Sponsored Healthcare: ACA's Impact*, INTERNATIONAL FOUNDATION OF EMPLOYEE BENEFIT PLANS, at page 3, available at <https://www.ifebp.org/Resources/research/Pages/empsponsoredhcimpact13.aspx>, (follow “Survey Result”) (last visited June 30, 2015).

¹⁰⁷ 26 USC §45R (Supp. 2010).

¹⁰⁸ *Affordable Care Act Tax Provisions*, <http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions> (last updated June 26, 2015).

¹⁰⁹ 26 USC IRC §45R(b) and (g)(2)(A) (Supp. 2010).

¹¹⁰ 26 USC §45R(b) (Supp. 2010).

business has more than ten full-time equivalent employees and/or pays an average wage of more than \$25,000, which is adjusted for inflation beginning in 2014,¹¹¹ so that the credit begins to phase out for tax year 2014 when the average wage exceeds \$25,400, and for tax year 2015 when the average wage exceeds \$25,800.¹¹² Also, effective 2014, employers can claim the credit for only two consecutive tax years, beginning in 2014 or after.¹¹³ The credit can be carried back or carried forward to other tax years, and a business expense deduction can be taken for the amount of premiums paid in excess of the credit.¹¹⁴

In order to qualify for the credit, the business cannot employ more than 25 full-time equivalent employees.¹¹⁵ In addition, employees must earn an average wage of less than \$50,000, an amount that is adjusted for inflation beginning in 2014.¹¹⁶ Thus, the credit is completely phased out for 2014 when average wages exceed \$50,800.¹¹⁷ Finally, the small business must purchase a health insurance plan for its employees through the Small Business Health Options Program (SHOP) Marketplace, unless an exception applies, and cover at least half the cost of an individual policy for each employee.¹¹⁸

THE HIDDEN COSTS OF THE ACA

Employers are generally entitled to a tax deduction for the premiums they pay for ESI plans and—although the employer’s contribution is a tremendous benefit for employees—employees are not required to include the premiums as income on their individual tax returns.¹¹⁹ However, the ACA does require employers to now report on their employees’ W-2s (in Box 12, using Code DD) the cost of coverage being provided under an employer-sponsored health plan in order that employees know the value of the health care benefits they are receiving tax free.¹²⁰

¹¹¹ 26 USC §45R(c) and (d)(3)(B) (Supp. 2010).

¹¹² *In 2015, Various Tax Benefits Increase Due to Inflation Adjustments*, (October 30, 2014), <http://www.irs.gov/uac/Newsroom/In-2015,-Various-Tax-Benefits-Increase-Due-to-Inflation-Adjustments>.

¹¹³ 26 USC §45R(e)(2) and (g)(1) (Supp. 2010).

¹¹⁴ 26 USC §§38 and 39 (Supp. 2010). See also *Affordable Care Act Tax Provisions*, <http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions> (last updated June 26, 2015).

¹¹⁵ 26 USC §45R(d)(1)(A) (Supp. 2010).

¹¹⁶ 26 USC §45R(d)(1)(B) and (3)(B) (Supp. 2010).

¹¹⁷ *Changes to Small Business Health Care Tax Credit*, IRS Health Care Tax Tip 2015-13 (February 26, 2015), <http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Changes-to-Small-Business-Health-Care-Tax-Credit>.

¹¹⁸ 26 USC §45R(d)(1)(C) and (4) (Supp. 2010). See also <http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>.

¹¹⁹ 26 USC §§162 and 106 (Supp. 2010).

¹²⁰ 26 USC §6051(a) (Supp. 2010). See also *Affordable Care Act Tax Provisions*, <http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions> (last updated June 26, 2015).

The employer's deduction, in tandem with the employee's exclusion of income, means that there is no matching of taxable income against the deduction and leads to an implicit and substantial governmental subsidy towards healthcare costs. For 2013, this "ESI tax subsidy" created approximately \$260 billion in tax expenditures for the U.S. government.¹²¹ In response to this issue, the ACA calls for the implementation of four new taxes in order to raise revenues. They include the Health Insurance Tax and the Cadillac Tax, and each tax is assessed on the health insurance industry for different reasons.

The Health Insurance Tax is assessed on insurers presumably because they can pay the tax with the additional premiums generated from an increase in enrollments mandated under the ACA.¹²² The Cadillac Tax, on the other hand, is being assessed as a penalty on the high cost plans that are underwritten. The rationale for the Cadillac Tax is that the ESI tax subsidy benefits only the half of Americans with employer-sponsored health insurance and "encourages the misappropriation of fund[s] towards bloated health plans" instead of compensating middle-class workers with higher wages; it is also being instituted to cut back on the incentive for employees to overuse the health services afforded by "Cadillac" plans.¹²³ Whatever the rationale for instituting these new taxes, they are both highly controversial because of concerns that they will ultimately increase the cost of healthcare coverage.

The Health Insurance Tax

The ACA assesses a tax (or the "Health Insurance Provider Fee") on the entire health insurance industry for all coverage underwritten except for certain exempt plans, which include self-insured plans.¹²⁴ The annual fee is allocated to each insurer based on that insurer's proportionate share of premiums in the market.¹²⁵ The total amount of the industry-wide tax is assessed annually by the Treasury in order to raise a specified sum of revenue and was assessed at \$8 billion for 2014, increasing significantly to \$11.3 billion for 2015 and 2016, \$13.9 billion for 2017, and \$14.3 billion for 2018.¹²⁶

¹²¹ *The Distribution of Major Tax Expenditures in the Individual Income Tax System*, THE CONGRESSIONAL BUDGET OFFICE (May 29, 2013), at page 15, <http://www.cbo.gov/publication/43768> (follow hyperlink to view pdf document).

¹²² ROBERT BOOK, *The Strange Effects Of The Health Insurance 'Annual Fee' Tax*, FORBES BLOG (February 20, 2014, 2:22 PM), <http://www.forbes.com/sites/theapothecary/2014/02/20/the-strange-effects-of-the-health-insurance-annual-fee-tax/>.

¹²³ WILLIAM H. FRIST, M.D., *Obamacare's "Cadillac Tax" Could Help Reduce the Cost of Healthcare*, FORBES BLOG (February 26, 2014, 7:37 AM), <http://www.forbes.com/sites/theapothecary/2014/02/26/obamacares-cadillac-tax-could-help-reduce-the-cost-of-health-care/>.

¹²⁴ See <http://www.heritage.org/research/reports/2013/10/obamacare-s-health-insurance-tax-targets-consumers-and-small-businesses>.

¹²⁵ *Id.*

¹²⁶ *Id.*

The proposed rationale for the annual fee is that insurers will be in a position to pay it because of increased enrollments under the ACA.¹²⁷ There are concerns, however, that insurers will need to pass the cost of the annual fee on to policyholders through higher premiums, or a reduction in benefits, because of state and federal insurance regulations that govern pricing and also in order for the insurance companies to just stay afloat.¹²⁸ Cigna Corp., for instance, spent a larger share of its second-quarter premiums in 2014 on medical expenses compared to the prior year and attributed the increase in expenses to “costlier-than-expected” individuals that are newly enrolled and seeking surgeries at higher rates.¹²⁹ Many of them may be seeking services that they delayed because they were previously uninsured.¹³⁰ Cigna Corp.’s CEO indicated, based on its enrollment as of July 2014, that “the public exchanges are ‘not a sustainable model’”, although “Cigna expects the enrollment to change, with more people and a healthier mix.”¹³¹ It may take a number of years before the market stabilizes and the spike in medical expenses slows down.¹³²

There may also be several unintended consequences of the Health Insurance Tax.¹³³ At least initially, if insurers do pass the cost of the health insurance tax on to policyholders, it is estimated that the tax will increase insurance premiums to almost as much as the individual mandate penalty.¹³⁴ For a larger lower-income family for whom the individual mandate penalty is capped, the increased premiums could even exceed the penalty and ultimately encourage families to pay the penalty rather than obtain the higher cost health insurance.¹³⁵ In addition, if policyholders are strapped with the extra cost, it is possible in certain instances that the government will essentially be paying the tax to itself, due to the premium tax credit allowed to certain individuals who utilize the Exchange.¹³⁶

Meanwhile, those individuals who receive coverage through an ESI plan, or through the Exchange but without a subsidy, will bear the full burden of the Health Insurance Tax. And the cost to the insurer—which is assumed to be passed on to the consumer—is further compounded in so

¹²⁷ ROBERT BOOK, *The Strange Effects Of The Health Insurance 'Annual Fee' Tax*, FORBES BLOG (February 20, 2014, 2:22 PM), <http://www.forbes.com/sites/theapothecary/2014/02/20/the-strange-effects-of-the-health-insurance-annual-fee-tax/>.

¹²⁸ *Id.*

¹²⁹ CHRISTOPHER WEAVER, *Hospitals Cash In on the Newly Insured*, THE WALL STREET JOURNAL (August 4, 2014, 7:57 PM), <http://www.wsj.com/articles/hospitals-cash-in-on-the-newly-insured-1407196639>.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ ROBERT BOOK, *The Strange Effects Of The Health Insurance 'Annual Fee' Tax*, FORBES BLOG (February 20, 2014, 2:22 PM), <http://www.forbes.com/sites/theapothecary/2014/02/20/the-strange-effects-of-the-health-insurance-annual-fee-tax/>.

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

much as the annual fee, unlike other fees and taxes, is *not* generally deductible to the insurer on its federal income tax return.¹³⁷

One of the many concerns about the Health Insurance Tax is that it is a “hidden” cost that will be ultimately passed on to small businesses and self-employed individuals; 88% of small business owners purchase fully-insured plans, which are not exempt from the Health Insurance Tax.¹³⁸ Meanwhile, large businesses most often self-insure and are therefore shielded from the tax.¹³⁹ The irony, then, is that small businesses and self-insured individuals will bear the brunt of the tax even though they are not as well positioned to face the rising costs of healthcare and, in fact, had hoped that controlling the costs would have been a primary aim of healthcare reform.¹⁴⁰

The anticipated increase in premiums is significant, estimated to be between 2% and 3%, or about \$500 per family.¹⁴¹ And according to one study, this increased cost will have a significant effect on the job market, reducing private-sector employment by as many as 146,000 to 262,000 jobs in 2022.¹⁴² Meanwhile, providers are making money. On average, there were 11.4 million fewer Americans uninsured between January and September 2014 than the average in 2010,¹⁴³ and these newly insured individuals began seeking more health services, including back surgeries, maternity care, and emergency services.¹⁴⁴ This meant, for instance, a 4% increase in 2014 in Tenet Healthcare Corp.’s second-quarter patient volumes compared to the prior year, and a 37% increase in earnings (before interest, tax, depreciation, and amortization).¹⁴⁵ It also meant an 8% increase in its emergency room visits, despite efforts to encourage new enrollees to utilize care at urgent care clinics and doctors’ offices where appropriate care can be given at lower cost.¹⁴⁶

The Cadillac Tax

Another tax, on the horizon for 2018, is the Cadillac Tax.¹⁴⁷ It is another revenue generator that will be assessed on insurers (and employers that are self-insured) but this time on the high cost plans that they

¹³⁷ 26 USC §§213 and 162(l) (Supp. 2010).

¹³⁸ <http://www.stopthehit.com/hit/background> (last visited June 30, 2015).

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² DAVID R. BURTON, *Obamacare’s Health Insurance Tax Targets Consumers and Small Businesses*, THE HERITAGE FOUNDATION (October 31, 2013), <http://www.heritage.org/research/reports/2013/10/obamacare-s-health-insurance-tax-targets-consumers-and-small-businesses>.

¹⁴³ THE ASSOCIATED PRESS, *CDC: Uninsured Drop by 11M Since Passage of Obama’s Law*, THE NEW YORK TIMES (March 24, 2015, 12:20 AM), <http://www.nytimes.com/aponline/2015/03/24/us/politics/ap-us-health-overhaul-uninsured.html>.

¹⁴⁴ CHRISTOPHER WEAVER, *Hospitals Cash In on the Newly Insured*, THE WALL STREET JOURNAL (August 4, 2014, 7:57 PM), <http://www.wsj.com/articles/hospitals-cash-in-on-the-newly-insured-1407196639>.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ 26 USC §4980I (Supp. 2010).

underwrite. It is a 40% tax on the amount of the benefit offered by a plan for which the premiums paid by the employer and employee, and including contributions to HSAs and FSAs, exceed a threshold amount (subject to certain health cost, age, gender, and cost of living adjustments) of either \$10,200 for single coverage or \$27,500 for family coverage.¹⁴⁸ This additional cost, like the Health Insurance Tax, will likely be passed onto employers in the premiums they pay.

Like the Health Insurance Tax, the Cadillac Tax is fraught with controversy about the ultimate effects it will have on healthcare plans because of the choices that both employers and employees will have to make. Some of the controversy stems from the fact that, although only 16% of employer-sponsored plans may be affected in 2018, more and more plans—perhaps as many as 75% by 2029—will be subject to the Cadillac Tax as the growth in healthcare spending causes premiums to exceed certain threshold amounts.¹⁴⁹ One issue of notable concern is that a plan could be subject to the Cadillac Tax because it covers a higher-risk/higher-cost population that includes the elderly, chronically ill, or women in need of obstetrical care, and therefore qualifies as a high cost plan.¹⁵⁰ If employers cut back on their contributions to these high-cost plans in order to avoid the Cadillac tax, it may result in increased costs, such as high deductibles and co-pays, to workers who wish to continue coverage, thus making the plan unaffordable and providing them with an incentive to go to the Exchange.¹⁵¹ As the number of high-risk employees going to the Exchange increases, premiums in the Exchange may also increase as it is faced with covering a growing higher-risk/higher-cost population.¹⁵²

Based on at least one recent survey, this is a legitimate concern. A 2013 survey conducted by the International Foundation of Employee Benefit Plans found that, while approximately 94% of the single employer plans surveyed stated they would definitely or very likely continue to provide coverage in 2014, employers were still analyzing how they would handle the increased cost associated with the ACA.¹⁵³ Approximately 64% of the participants had analyzed the ACA's cost impact on their health insurance coverage, and the majority estimated a 3-4% or greater increase in cost in 2013.¹⁵⁴ The most common strategy to cover the increased cost is to pass it onto employees, including increasing their share of premium

¹⁴⁸ 26 USC §4980I(a) and (b) (Supp. 2010).

¹⁴⁹ WILLIAM H. FRIST, M.D., *Obamacare's "Cadillac Tax" Could Help Reduce the Cost of Healthcare*, FORBES BLOG (February 26, 2014, 7:37 AM), <http://www.forbes.com/sites/theapothecary/2014/02/26/obamacares-cadillac-tax-could-help-reduce-the-cost-of-health-care/>.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *2013 Employer-Sponsored Healthcare: ACA's Impact*, at page 3, available at <https://www.ifebp.org/Resources/research/Pages/empsponsoredhcimpact13.aspx>.

¹⁵⁴ *Id.*

costs, the employee portion of dependent care coverage costs, in-network deductibles, and out-of-pocket limits.¹⁵⁵

THE EXCHANGES: WHAT WILL THEY LOOK LIKE IN YEARS TO COME?

What does all of this mean for the future of healthcare in the United States? There are obviously many different factors that will ultimately determine which options, if any, prove viable for providing, and obtaining, affordable coverage. Whether the provisions of the ACA will increase access to affordable healthcare remains to be seen. One certainty is that the difference in opinions that are thrown about, regarding the effectiveness and ineffectiveness of the ACA, is baffling and, often, politically driven.

The Supreme Court's decision in *King v. Burwell*¹⁵⁶ on June 25, 2015, upholding the availability of the premium tax credit for individuals purchasing insurance through a federally-facilitated Exchange, is touted as having saved Obamacare.¹⁵⁷ It certainly puts to rest a great deal of uncertainty for the IRS, as it looks ahead to its administration of the new law and other challenges that lie ahead.

If the cost of healthcare continues to skyrocket, then— despite the fact that the focus of the ACA is to help control these costs—small businesses and self-employed individuals will likely see a significant hike in premiums. If employers, both large and small, choose to cut back on their employee benefit plans, employees might seek coverage through an Exchange as an alternative. And if higher-risk/higher-cost populations turn to them for coverage, the Exchanges may ultimately see a hike in premiums. These are a lot of ifs, but all distinctly possible.

In any event, individuals will need to learn the new requirements implemented by the ACA that affect them directly—and also the requirements imposed on employers and insurers—in order to understand the full impact of the ACA and make an informed decision.

¹⁵⁵ *Id.*

¹⁵⁶ *King v. Burwell*, 2015 U.S. LEXIS 4248 (U.S. June 25, 2015).

¹⁵⁷ *The Supreme Court Saves Obamacare, Again*, THE NEW YORK TIMES (June 25, 2015), found at <http://www.nytimes.com/2015/06/26/opinion/the-supreme-court-saves-obamacare-again.html> (last visited June 30, 2015).

Exhibit 1: The Individual Shared Responsibility Payment under IRC §5000A

	<p>"Individual Shared Responsibility Payment" for each month taxpayer and/or a dependent is uninsured. IRC §5000A(c)(1)(A) and (2)</p>	<p>Capped at national average premium for bronze level health plan available through the Exchanges each year. IRC §5000A(c)(1) and (1)(B)</p>
<p>2014 Transition Year</p>	<p><u>The annual amount is the greater of:</u> 1% of (taxpayer's household income - tax return filing threshold based on filing status), <u>or</u> Flat dollar amount: \$95 per adult and \$47.50 per child (under 18), limited to a family maximum of \$285.</p> <p><u>Divide this amount by 12 for monthly penalty.</u></p>	<p>\$204/month per individual, subject to a \$1,020/month maximum for a family with five or more members (Rev. Proc. 2014-46)</p>
<p>2015 Transition Year</p>	<p><u>The annual amount is the greater of:</u> 2% of (taxpayer's household income - tax return filing threshold based on filing status), <u>or</u> Flat dollar amount: \$325 per adult and \$162.50 per child (under 18), limited to a family maximum of \$975.</p> <p><u>Divide this amount by 12 for monthly penalty.</u></p>	<p>TBD</p>
<p>2016 and forward</p>	<p><u>The annual amount is the greater of:</u> 2.5% of (taxpayer's household income - tax return filing threshold based on filing status), <u>or</u> Flat dollar amount: \$695 per adult and \$347.50 per child (under 18), limited to a family maximum of \$2,085.</p> <p><u>Divide this amount by 12 for monthly penalty.</u></p> <p>Figures are subject to inflation after 2016.</p>	<p>TBD</p>
<p>Household income is the taxpayer's adjusted gross income plus any excludible foreign earned income and tax-exempt interest received during the taxable year, and also includes the incomes of all of the taxpayer's dependents who are required to file tax returns. (http://www.irs.gov/uac/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment)</p>		

Exhibit 2: Large Employer Classification under IRC §4980H

	Large Employer	Full-time Employees	Testing Period
Transition Year 2015	At least 100 or more full-time employees	Individuals who work 30 hours or more per week (IRC §4980H(c)(4)) and full-time equivalents (total number of hours worked in a month by part-time individuals/120) (IRC §4980H(c)(2)(E)).	May adopt a measurement period of less than 12 consecutive months (but not less than 6 consecutive months) during the 2014 calendar year. (Treasury Decision 9655, 02/13/2014.)
2016 and forward	At least 50 or more full-time employees	Disregard any fraction that arises. (Treas. Reg. 54.4980H-2(b)(1))	Prior calendar year.
<p><u>Seasonal Exception:</u> If workforce exceeds 50 full-time employees (or full-time equivalent employees) for 120 days or less, and the employees in excess of 50 are considered seasonal workers, then the employer will not be considered a large employer (IRC §4980H(c)(2)).</p>			

Exhibit 3: Penalties for Large Employers under §4980H

Large Employer		
<i>Does not offer coverage to the required minimum number of full-time employees</i>	<i>Offers coverage to the required minimum number of full-time employees that is not affordable or is not minimum coverage</i>	<i>Offers coverage to substantially all full-time employees that is affordable and provides minimum coverage</i>
Penalty applies if one or more full-time employees receives a premium tax credit for the Exchange		No Penalty
Amount of penalty is:		
(Number of full-time employees - 30) x \$2,000	Lesser of: (Number of full-time employees - 30) x \$2,000 Or (Number of full-time employees who receive a premium tax credit for Exchange coverage) x \$3,000	

Exhibit 4: Affordability Safe Harbor Tests under 26 CFR 54.4980H-5(e)(2)

	Affordability Safe Harbor Tests
W-2 Wages Safe Harbor	Lowest self-only coverage does not exceed 9.5% of the employee's W-2, Box 1 wages
Rate of Pay Safe Harbor	Lowest self-only coverage does not exceed 9.5% of 130 hours x employee hourly rate
Federal Poverty Line Safe Harbor	Lowest self-only coverage is not greater than 9.5% of FPL for a single individual