

**DESCRIPTION OF BUDGET RECONCILIATION
LEGISLATIVE RECOMMENDATIONS RELATING
TO REPEAL OF CERTAIN EXCISE TAXES ENACTED IN THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT**

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by the
HOUSE COMMITTEE ON WAYS AND MEANS
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INTRODUCTION

The House Committee on Ways and Means has scheduled a committee markup of Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Excise Taxes Enacted in the Patient Protection and Affordable Care Act on September 29, 2015. This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a description of the bill.

¹ This document may be cited as follows: Joint Committee on Taxation, *Description of Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Excise Taxes Enacted in the Patient Protection and Affordable Care Act* (JCX-127-15), September 28, 2015. This document can also be found on the Joint Committee on Taxation website at www.jct.gov.

A. Repeal of Individual Mandate

Present Law

Requirement to maintain coverage

Effective as of 2014, individuals must be covered by a health plan that provides at least minimum essential coverage or be subject to a tax for failure to maintain the coverage (commonly referred to as the “individual mandate”).² If an individual is a dependent³ of another taxpayer, the other taxpayer is liable for any tax for failure to maintain the required coverage with respect to the individual. The tax is imposed for any month that an individual does not have minimum essential coverage unless the individual qualifies for an exemption for the month as described below.

Minimum essential coverage

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. Certain individuals present or residing outside of the U.S.⁴ and bona fide residents of territories of the U.S.⁵ are deemed to maintain minimum essential coverage.

Minimum essential coverage does not include coverage that consists of only certain excepted benefits.⁶ Excepted benefits include: (1) coverage only for accident, or disability income insurance; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers’ compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage,

² Section 5000A which was added to the Code by section 1501 of the Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No 111-148, enacted March 23, 2010, as amended by section 10106 of PPACA and section 1002 of the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111-152, enacted March 30, 2010. PPACA and HCERA are collectively referred to as the Affordable Care Act (“ACA”). Except where otherwise stated, all references are to the Internal Revenue Code of 1986, as amended.

³ Sec. 152.

⁴ This rule applies to any month that occurs during a period described in section 911(d)(1)(A) or (B) which is applicable to an individual. Such periods include: (1) for a United States citizen, an uninterrupted period which includes an entire taxable year during which the individual is a bona fide resident of a foreign country or countries, and (2) for a United States citizen or resident, a period of 12 consecutive months during which the individual is present in a foreign country at least 330 full days.

⁵ Bona fide residence in a territory is determined under section 937(a). For this purpose, the territories include Puerto Rico, Guam, the Northern Mariana Islands, American Samoa, and United States Virgin Islands.

⁶ Sec. 2791(c)(1)-(4) of PHS (42 U.S.C. sec. 300gg-91(c)(1-4)). A parallel definition of excepted benefits is provided in section 9832(c)(1)-(4).

specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Other excepted benefits that do not constitute minimum essential coverage if offered under a separate policy, certificate or contract of insurance include long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance.

Tax on failure to maintain minimum essential coverage

The tax for failure to maintain minimum essential coverage for any calendar month is one-twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of the flat dollar amount or the excess income amount. The flat dollar amount is the lesser of the sum of the individual annual dollar amounts for the members of the taxpayer's family and 300 percent of the adult individual dollar amount. The excess income amount is a specified percentage of the excess of the taxpayer's household income for the taxable year over the threshold amount of income for required income tax return filing for that taxpayer.⁷ The total annual household payment may not exceed the national average annual premium for bronze level health plans offered through American Health Benefit Exchanges that year for the applicable family size. The individual adult annual dollar amount is phased in over the first three years as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016.⁸ For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount. The specified percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015.

Exemptions

Exemptions from the requirement to maintain minimum essential coverage are provided for the following: (1) an individual for whom coverage is unaffordable because the required contribution exceeds eight percent of household income, (2) an individual with household income below the income tax return filing threshold, (3) a member of an Indian tribe, (4) a member of certain recognized religious sects or a health sharing ministry, (5) an individual with a coverage gap for a continuous period of less than three months, and (6) an individual who is determined by the Secretary of Health and Human Services to have suffered a hardship with respect to the capability to obtain coverage.

Description of Proposal

The proposal repeals the individual mandate, so that it does not apply to any month beginning after December 31, 2014.⁹

⁷ Sec. 6012(a).

⁸ For years after 2016, the \$695 amount is indexed to CPI-U, rounded to the next lowest multiple of \$50.

⁹ The proposal also strikes section 1501(c) of PPACA, which added an entry for section 5000A to the Code's Table of Contents.

Effective Date

The proposal is effective for periods beginning after December 31, 2014.

B. Repeal of Employer Mandate

In general

Effective as of 2014, an applicable large employer, as defined below, may be subject to a tax, called an “assessable payment,” for a month if one or more of its full-time employees is certified to the employer as receiving for the month a premium assistance credit for health insurance purchased on an American Health Benefit Exchange or reduced cost-sharing for the employee’s share of expenses covered by such health insurance (commonly referred to as the “employer mandate”).¹⁰ As discussed below, the amount of the assessable payment depends on whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under a group health plan sponsored by the employer and, if it does, whether the coverage offered is affordable and provides minimum value.

Definitions of full-time employee and applicable large employer

For purposes of applying these rules, full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours of service per week. Hours of service are to be determined under regulations, rules, and guidance prescribed by the Secretary of the Treasury, in consultation with the Secretary of Labor, including rules for employees who are not compensated on an hourly basis.

Applicable large employer generally means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.¹¹ Solely for purposes of determining whether an employer is an applicable large employer (that is, whether the employer has at least 50 full-time employees), besides the number of full-time employees, the employer must include the number of its full-time equivalent employees for a month, determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. In addition, in determining whether an employer is an applicable large employer, members of the same controlled group, group under common control, and affiliated service group are treated as a

¹⁰ Sec. 4980H, added to the Code by section 1513 of PPACA and amended by 10106 of PPACA and section 1003 of HCERA. Premium assistance credits for health insurance purchased on an American Health Benefit Exchange are provided under section 36B. Reduced cost-sharing for an individual’s share of expenses covered by such health insurance is provided under section 1402 of PPACA.

Under the ACA, the requirement to offer minimum essential coverage is effective for months beginning after December 31, 2013. However, in Notice 2013-45, 2013-31 I.R.B. 116, Part III, Q&A-2, the Internal Revenue Service (“IRS”) announced that no assessable payments would be assessed for 2014. In addition, on February 10, 2014, the Department of the Treasury and the IRS issued final regulations on the employer shared responsibility requirement and announced that no assessable payments for 2015 will apply to applicable large employers that have fewer than 100 full-time employees and full-time equivalent employees and meet certain other requirements. Section XV.D.6 of the preamble to the final regulations, 79 Fed. Reg. 8544, 8574-8575, February 12, 2014.

¹¹ Additional rules apply, for example, in the case of an employer that was not in existence for the entire preceding calendar year.

single employer.¹² If the group is an applicable large employer under this test, each member of the group is an applicable large employer even if any member by itself would not be an applicable large employer.¹³

Assessable payments

If an applicable large employer does not offer its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is so certified to the employer, the employer may be subject to an assessable payment of \$2,000¹⁴ (divided by 12 and applied on a monthly basis) multiplied by the number of its full-time employees in excess of 30, regardless of the number of full-time employees so certified. For example, in 2016, Employer A fails to offer minimum essential coverage and has 100 full-time employees, 10 of whom receive premium assistance credits for the entire year. The employer's assessable payment is \$2,000 for each employee over the 30-employee threshold, for a total of \$140,000 (\$2,000 multiplied by 70, that is, 100-30).

Generally an employee who is offered minimum essential coverage under an employer-sponsored plan is not eligible for a premium assistance credit or reduced cost-sharing unless the coverage is unaffordable or fails to provide minimum value.¹⁵ However, if an employer offers its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is certified as receiving a premium assistance credit or reduced cost-sharing (because the coverage is unaffordable or fails to provide minimum value), the employer may be subject to an assessable payment of \$3,000 (divided by 12 and applied on a monthly basis) multiplied by the number of such full-time employees. However, the assessable payment in this case is capped at the amount that would apply if the employer failed to offer its full-time employees and their dependents minimum essential coverage. For example, in 2016, Employer B offers minimum essential coverage and has 100 full-time employees, 20 of whom receive premium assistance credits for the entire year. The employer's assessable payment before consideration of the cap is \$3,000 for each full-time employee receiving a credit, for a total of \$60,000. The cap on the assessable payment is the

¹² The rules for determining controlled group, group under common control, and affiliated service group under section 414(b), (c), (m) and (o) apply for this purpose.

¹³ In addition, in determining assessable payments (as discussed herein), only one 30-employee reduction in full-time employees applies to the group and is allocated among the members ratably based on the number of full-time employees employed by each member.

¹⁴ For calendar years after 2014, the \$2,000 dollar amount, and the \$3,000 dollar amount referenced herein, are increased by the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary of Health and Human Services ("HHS") no later than October 1 of the preceding calendar year) exceeds the average per capita premium for 2013 (as determined by the Secretary of HHS), rounded down to the next lowest multiple of \$10.

¹⁵ Under section 36B(c)(2)(C), coverage under an employer-sponsored plan is unaffordable if the employee's share of the premium for self-only coverage exceeds 9.5 percent of household income, and the coverage fails to provide minimum value if the plan's share of total allowed cost of provided benefits is less than 60 percent of such costs.

amount that would have applied if the employer failed to offer coverage, or \$140,000 (\$2,000 multiplied by 70, that is, 100-30). In this example, the cap therefore does not affect the amount of the assessable payment, which remains at \$60,000.

Description of Proposal

The proposal repeals the employer mandate, so that it does not apply to any month beginning after December 31, 2014.

Effective Date

The proposal is effective for periods beginning after December 31, 2014.

C. Repeal of Medical Device Excise Tax

Present Law

Effective for sales after December 31, 2012, a tax equal to 2.3 percent of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of such device.¹⁶ A taxable medical device is any device, as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act,¹⁷ intended for humans. Regulations further define a medical device as one that is listed by the Food and Drug Administration (“FDA”) under section 510(j) of the Federal Food, Drug, and Cosmetic Act and 21 C.F.R. Part 807, pursuant to FDA requirements.¹⁸

The excise tax does not apply to eyeglasses, contact lenses, hearing aids, or any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use (“retail exemption”). Regulations provide guidance on the types of devices that are exempt under the retail exemption. A device is exempt under these provisions if: (1) it is regularly available for purchase and use by individual consumers who are not medical professionals; and (2) the design of the device demonstrates that it is not primarily intended for use in a medical institution or office or by a medical professional.¹⁹ Additionally, the regulations provide certain safe harbors for devices eligible for the retail exemption.²⁰

The medical device excise tax is generally subject to the rules applicable to other manufacturers excise taxes. These rules include certain general manufacturers excise tax exemptions including the exemption for sales for use by the purchaser for further manufacture (or for resale to a second purchaser in further manufacture) or for export (or for resale to a second purchaser for export).²¹ If a medical device is sold free of tax for resale to a second

¹⁶ Sec. 4191, which was added to the Code by section 1405 of HCERA.

¹⁷ 21 U.S.C. sec. 321. Section 201(h) defines device as “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.”

¹⁸ Treas. Reg. sec. 48.4191-2(a). The regulations also include as devices items that should have been listed as a device with the FDA as of the date the FDA notifies the manufacturer or importer that corrective action with respect to listing is required.

¹⁹ Treas. Reg. sec. 48.4191-2(b)(2).

²⁰ Treas. Reg. sec. 48.4191-2(b)(2)(iii). The safe harbors include devices that are described as over-the-counter devices in relevant FDA classification headings as well as certain FDA device classifications listed in the regulations.

²¹ Sec. 4221(a). Other general manufacturers excise tax exemptions (*i.e.*, the exemption for sales to purchasers for use as supplies for vessels or aircraft, to a State or local government, to a nonprofit educational organization, or to a qualified blood collector organization) do not apply to the medical device excise tax.

purchaser for further manufacture or for export, the exemption does not apply unless, within the six-month period beginning on the date of sale by the manufacturer, the manufacturer receives proof that the medical device has been exported or resold for use in further manufacturing.²² In general, the exemption does not apply unless the manufacturer, the first purchaser, and the second purchaser are registered with the Secretary of the Treasury. Foreign purchasers of articles sold or resold for export are exempt from the registration requirement.

The lease of a medical device is generally considered to be a sale of such device.²³ Special rules apply for the imposition of tax to each lease payment. The use of a medical device subject to tax by manufacturers, producers, or importers of such device, is treated as a sale for the purpose of imposition of excise taxes.²⁴

There are also rules for determining the price of a medical device on which the excise tax is imposed.²⁵ These rules provide for (1) the inclusion of containers, packaging, and certain transportation charges in the price, (2) determining a constructive sales price if a medical device is sold for less than the fair market price, and (3) determining the tax due in the case of partial payments or installment sales.

Description of Proposal

The proposal repeals the medical device excise tax.

Effective Date

The proposal applies to sales in calendar quarters beginning after the date of enactment.

²² Sec. 4221(b).

²³ Sec. 4217(a).

²⁴ Sec. 4218.

²⁵ Sec. 4216.

D. Repeal of the Excise Tax on Employee Health Insurance Premiums and Health Plan Benefits and Related Reporting Requirements

Excise tax on high cost employer-sponsored health coverage

In general

Effective as of 2018, an excise tax is imposed on the provider of applicable employer-sponsored health coverage (the “coverage provider”) if the aggregate cost of the coverage for an employee (including a former employee, surviving spouse, or any other primary insured individual) exceeds a threshold amount (referred to as “high cost health coverage”).²⁶ The tax is 40 percent of the amount by which aggregate cost exceeds the threshold amount (the “excess benefit”).

The annual threshold amount for 2018 is \$10,200 for self-only coverage and \$27,500 for other coverage (such as family coverage), multiplied by a one-time health cost adjustment percentage.²⁷ This threshold is then adjusted annually (including for 2018) by an age and gender adjusted excess premium amount.²⁸ The age and gender adjusted excess premium amount is the excess, if any, of (1) the premium cost of standard FEHBP coverage for the type of coverage provided to an individual if priced for the age and gender characteristics of all employees of the employer, over (2) the premium cost of standard FEHBP coverage if priced for the age and gender characteristics of the national workforce. For this purpose, standard FEHBP coverage means the per employee cost of Blue Cross/Blue Shield standard benefit coverage under the Federal Employees Health Benefit Program.

The excise tax is determined on a monthly basis, by reference to the monthly aggregate cost of applicable employer-sponsored coverage for the month and 1/12 of the annual threshold amount. The excise tax is not deductible.²⁹

²⁶ Sec. 4980I, which was added to the Code by section 9001 of PPACA and amended by section 10901 of PPACA and section 1401 of HCERA.

²⁷ The health cost adjustment percentage is 100 percent plus the excess, if any, of (1) the percentage by which the cost of standard FEHBP coverage for 2018 (determined according to specified criteria) exceeds the cost of standard FEHBP coverage for 2010, over (2) 55 percent.

²⁸ Under section 4980I, the 2018 threshold amounts are increased by \$1,650 for self-only coverage or \$3,450 for other coverage in the case of certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines. For years after 2018, the threshold amounts (after application of the health cost adjustment percentage), and the increases for certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines, are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) (CPI-U increased by one percentage point for 2019 only), rounded to the nearest \$50.

²⁹ Sec. 275(a)(6), referring to taxes imposed by chapter 43.

Applicable employer-sponsored coverage and determination of cost

Subject to certain exceptions, applicable employer-sponsored coverage is coverage under any group health plan offered to an employee by an employer that is excludible from the employee's gross income or that would be excludible if it were employer-sponsored coverage.³⁰ Thus, applicable employer-sponsored coverage includes coverage for which an employee pays on an after-tax basis. Applicable employer-sponsored coverage includes coverage under any group health plan established and maintained primarily for its civilian employees by the Federal government or any Federal agency or instrumentality, or the government of any State or political subdivision thereof or any agency or instrumentality of a State or political subdivision.

Applicable employer-sponsored coverage includes both insured and self-insured health coverage, including coverage in the form of reimbursements under a health flexible spending account ("health FSA") or a health reimbursement arrangement and contributions to a health savings account ("HSA") or Archer medical savings account ("Archer MSA").³¹ In the case of a self-employed individual, coverage is treated as applicable employer-sponsored coverage if the self-employed individual is allowed a deduction for all or any portion of the cost of coverage.³²

For purposes of the excise tax, the cost of applicable employer-sponsored coverage is generally determined under rules similar to the rules for determining the applicable premium for purposes of COBRA continuation coverage,³³ except that any portion of the cost of coverage attributable to the excise tax is not taken into account. Cost is determined separately for self-only coverage and other coverage. Special valuation rules apply to retiree coverage, certain health FSAs, and contributions to HSAs and Archer MSAs.

Calculation of excess benefit and imposition of excise tax

In determining the excess benefit with respect to an employee (*i.e.*, the amount by which the cost of applicable employer-sponsored coverage for the employee exceeds the threshold amount), the aggregate cost of all applicable employer-sponsored coverage of the employee is

³⁰ Section 106 provides an exclusion for employer-provided coverage.

³¹ Some types of coverage are not included in applicable employer-sponsored coverage, such as long-term care coverage, separate insurance coverage substantially all the benefits of which are for treatment of the mouth (including any organ or structure within the mouth) or of the eye, and certain excepted benefits. Excepted benefits for this purpose include (whether through insurance or otherwise) coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; and other similar insurance coverage (as specified in regulations), under which benefits for medical care are secondary or incidental to other insurance benefits. Applicable employer-sponsored coverage does not include coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance if the cost of the coverage is not excludible from an employee's income or deductible by a self-employed individual.

³² Section 162(l) allows a deduction to a self-employed individual for the cost of health insurance.

³³ Sec. 4980B(f)(4).

taken into account. The threshold amount for self-only coverage generally applies to an employee. The threshold amount for other coverage applies to an employee only if the employee and at least one other beneficiary are enrolled in coverage other than self-only coverage under a group health plan that provides minimum essential coverage and under which the benefits provided do not vary based on whether the covered individual is the employee or other beneficiary. For purposes of the threshold amount, any coverage provided under a multiemployer plan is treated as coverage other than self-only coverage.³⁴

The excise tax is imposed on the coverage provider.³⁵ In the case of insured coverage (*i.e.*, coverage under a policy, certificate, or contract issued by an insurance company), the health insurance issuer is liable for the excise tax. In the case of self-insured coverage, the person that administers the plan benefits (“plan administrator”) is generally liable for the excise tax. However, in the case of employer contributions to an HSA or an Archer MSA, the employer is liable for the excise tax.

The employer is generally responsible for calculating the amount of excess benefit allocable to each coverage provider and notifying each coverage provider (and the IRS) of the coverage provider’s allocable share. In the case of applicable employer-sponsored coverage under a multiemployer plan, the plan sponsor is responsible for the calculation and notification.³⁶

Reporting of cost of employer-sponsored health coverage on Form W-2

Every employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. The statement, made on the Form W-2, must be provided to each employee by January 31 of the succeeding year.

Effective as of 2010, the ACA added the cost of employer-sponsored health coverage as an item of information required to be reported on each employee’s annual Form W-2.³⁷ For this reporting requirement, the definition of applicable employer-sponsored coverage for purposes of the excise tax on high cost health coverage applies. If an employee enrolls in applicable

³⁴ As defined in section 414(f), a multiemployer plan is generally a plan to which more than one employer is required to contribute and that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

³⁵ The excise tax is allocated pro rata among the coverage providers, with each responsible for the excise tax on an amount equal to the total excess benefit multiplied by a fraction, the numerator of which is the cost of the applicable employer-sponsored coverage of that coverage provider and the denominator of which is the aggregate cost of all applicable employer-sponsored coverage of the employee.

³⁶ The employer or multiemployer plan sponsor may be liable for a penalty if the total excise tax due exceeds the tax on the excess benefit calculated and allocated among coverage providers by the employer or plan sponsor.

³⁷ Sec. 6051(a)(14), which was added to the Code by section 9002 of PPACA.

employer-sponsored coverage under multiple plans, the employer must disclose the aggregate cost of all such health coverage (excluding any salary reduction contributions to a health FSA).

Description of Proposal

The proposal repeals both the excise tax on high cost health coverage and the requirement to report the cost of employer-sponsored health coverage on each employee's annual Form W-2.

Effective Date

The proposal to repeal the excise tax on high cost health coverage is effective for taxable years beginning after December 31, 2017. The proposal to repeal the requirement to report the cost of employer-sponsored health coverage on each employee's Form W-2 is effective for calendar years beginning after December 31, 2014.