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Taxes and Fees under the Affordable Care Act

The health care reform law, known as the Affordable Care Act (ACA), makes significant changes to the U.S. health care system, including new coverage requirements, patient protections and cost limitations. These changes affect health care providers, government programs, health insurance issuers, employers and plan sponsors, and individuals.

In order to fund many of these changes, the ACA imposes several new taxes and fees—many of which directly impact health plans and health plan sponsors. The following charts provide an overview of the ACA's new tax and fee provisions that affect health plans.

Please contact Clarke & Company Benefits, LLC for more information on these new taxes and fees.

TAX PROVISIONS

PROVISION	APPLIES TO	EFFECTIVE DATE	SUMMARY
Small Business Health Care Tax Credit	Small employers that: • Have fewer than 25 full-time equivalent employees (FTEs); • Pay average annual wages of less than $50,000 per FTE; and • Pay at least half of employee health insurance premiums (based on single coverage). Beginning in 2014, the tax credit is only available through a SHOP Exchange.	First Phase: Taxable years 2010-2013	Eligible small employers can receive a credit for contributions to purchase health insurance for employees. The credit is up to 35 percent of the employer's contribution to provide health insurance for employees. There is also up to a 25 percent credit for small tax-exempt organizations.
		Second Phase: Taxable years beginning in 2014	As of 2014, the maximum credit will increase to 50 percent for small business employers and 35 percent for small tax-exempt employers. The credit is gradually phased out for small employers with more than 10 FTEs and average annual wages in excess of $25,000. Also beginning in 2014, an employer may only claim the credit for two consecutive taxable years.
Increased Tax on HSA and Archer MSA Withdrawals	Withdrawals prior to age 65 that are not used for qualified medical expenses	Distributions after Dec. 31, 2010	The ACA increased the additional tax on HSA withdrawals prior to age 65 that are not used for qualified medical expenses from 10 to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses also increased from 15 to 20 percent.

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Additional Medicare Tax for High-wage Workers	Employees who earn wages in excess of $200,000 in a year	Taxable years beginning in 2013	The ACA increases the Medicare hospital insurance tax rate by 0.9 percentage points for high-income individuals. Employers must withhold the additional taxes on wages paid in excess of $200,000.
Individual Shared Responsibility (Individual Mandate)	All individuals who do not fall within a specific exemption (including children)	Jan. 1, 2014	The ACA requires most individuals to obtain acceptable health insurance coverage or pay a tax penalty. Individuals may be eligible for an exemption from the penalty in certain circumstances, including if they cannot obtain affordable coverage.
Individual Health Insurance Subsidies	Individuals who: • Have low income (between 100% and 400% of the federal poverty level); • Are not eligible for (or enrolled in) minimum essential coverage; and • Enroll in coverage through an Exchange.	Jan. 1, 2014	The ACA makes federal subsidies available through the Exchanges, in the form of premium tax credits and cost-sharing reductions, for low-income individuals who are not eligible for or offered other acceptable coverage.
Employer Shared Responsibility (Pay or Play Rules)	Large employers that employ, on average, at least 50 full-time employees, including FTEs, on business days during the preceding calendar year (including for-profit, nonprofit and government employers)	Jan. 1, 2015	Large employers may be subject to penalties if they do not provide health coverage to full-time employees (and dependents), or if the coverage they provide is not affordable or does not provide minimum value. A full-time employee is an employee who was employed on average at least 30 hours of service per week.
High Cost Plan Excise Tax (Cadillac Tax)	Coverage providers of high-cost group health coverage (which can be the insurer, the employer or a third-party administrator)	Jan. 1, 2018	A 40 percent excise tax is to be imposed on the excess benefit of high-cost employer-sponsored health insurance. The annual limit for purposes of calculating the excess benefits is $10,200 for individuals and $27,500 for other than individual coverage.

The ACA also establishes several other taxes that do not affect health plans, including the Indoor Tanning Services Tax and the Medical Devices Excise Tax.

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FEES

PROVISION	APPLIES TO	EFFECTIVE DATE	SUMMARY
Patient-centered Outcomes Research Institute (PCORI) Fee	Health insurance issuers and sponsors of self-insured health plans	Plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. The first possible payments were due July 31, 2013.	The ACA imposes new fees to fund health care research through the Patient-centered Outcomes Research Institute. The initial fee is $1 per covered life, increasing to $2 per covered life for 2013 (and adjusted annually for later plan years).
Reinsurance Fee	Health insurance issuers and sponsors of self-insured group health plans	Calendar years 2014-2016	Health insurance issuers and self-funded group health plans will be required to make contributions to fund the transitional reinsurance program based on a federal contribution rate established by HHS. For 2014, HHS announced a national contribution rate of $5.25 per month ($63 per year) per covered life. For 2015, the national contribution rate will be about $3.67 per month ($44 per year) per covered life. States may collect additional contributions on top of the federal contribution rate.
Health Insurance Providers Fee	Any entity that provides health insurance for any U.S. health risk, including: • Health insurers • HMOs • MEWAs • Providers of Medicare Advantage, Medicare Part D prescription drug coverage or Medicaid coverage The fee does not apply to companies whose net premiums written are $25 million or less.	Paid by Sept. 30 of each calendar year, beginning in 2014	The health care reform law imposes an annual, non-deductible fee on the health insurance sector, allocated across the industry according to market share. The fee will be assessed on health insurers' premium revenue with respect to health insurance above $25 million. The aggregate annual fee for all covered entities is expected to be: • $8 billion in 2014; • $11.3 billion in 2015 and 2016; • $13.9 billion in 2017; and • $14.3 billion in 2018. Beginning in 2019, the cost of the fee will increase based on the rate of premium growth.

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Paying PCORI/Reinsurance Fees Using Plan Assets

Depending on the type of fee, it may be able to be paid using plan assets. The DOL generally considers all amounts that a participant pays to or has withheld by an employer for purposes of obtaining benefits under a plan as plan assets. If an employer holds plan assets, plan fiduciaries are obligated under ERISA to treat those assets as any other assets of the plan, which includes ensuring compliance with applicable trust and reporting and disclosure requirements of ERISA. The DOL has provided a safe harbor from being considered to hold plan assets (and a related exemption from the associated trust and reporting requirements) for insured employer plans where employee contributions are forwarded to a carrier for purposes of paying premiums.

PROVISION	CAN THE FEE BE PAID USING PLAN ASSETS?	CAN THE FEE BE PASSED ALONG TO PARTICIPANTS?
Patient-centered Outcomes Research Institute (PCORI) Fee	**Single-employer plan**: The PCORI fee generally may not be paid with plan assets. This fee is a tax assessed against the plan sponsor itself. **Multiemployer plan**: In an FAQ (Q8), the Departments created a special exception for multiemployer plans. Multiemployer plan assets may be used to pay the PCORI fees since the plan sponsor liable for a multiemployer plan's fee is generally an independent joint board of trustees with no source of funding other than plan assets. The Departments also said that there may be rare circumstances where sponsors of employee benefit plans that are not multiemployer plans would also be able to use plan assets to pay the PCORI fee, such as a VEBA that provides retiree-only health benefits where the sponsor is a trustee or board of trustees that exists solely for the purpose of sponsoring and administering the plan and that has no source of funding independent of plan assets. However, other plan sponsors required to pay the PCORI fee may not use plan assets to pay the fee even if the plan uses a VEBA trust to pay benefits under the plan.	**By issuer**: Nothing in the Internal Revenue Code or regulations prevents an issuer from recovering the PCORI fee through increases in premiums. **By self-funded plan**: In cases where the PCORI fee cannot be paid from plan assets, it may still be possible to pass the fee along to participants, but such repayment would need to be properly structured. If the plan is subject to ERISA, it will need to use caution to avoid paying the fee using plan assets (for example, salary reduction contributions).
Reinsurance Fee	Plan assets may be used to pay the reinsurance fee because it is assessed against the plan. However, the plan would need to have plan assets and comply with all applicable plan asset requirements.	Nothing in the ACA or regulations prevents an issuer or plan sponsor from recovering the reinsurance fee through increases in premiums or increases in participant contributions. The reinsurance fee final regulations note that commentators asked for guidance regarding whether the fee can be passed along to participants, but the final regulations do not address this issue.

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