

**DESCRIPTION OF BUDGET RECONCILIATION
LEGISLATIVE RECOMMENDATIONS RELATING TO
REPEAL AND REPLACE OF CERTAIN
HEALTH-RELATED TAX POLICY PROVISIONS**

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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 and Replace of Certain Health-Related Tax Policy Provisions on March 8, 2017. This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a description of the legislative recommendations.

¹ This document may be cited as follows: Joint Committee on Taxation, *Description of Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Certain Health-Related Tax Policy Provisions* (JCX-14-17), March 7, 2017. This document can be found also on the Joint Committee on Taxation website at www.jct.gov. All section references herein are to the Internal Revenue Code of 1986, as amended, unless otherwise stated. As used herein, the Affordable Care Act (or “ACA”) refers to the combination of the Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111-148, and the Healthcare and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111-152.

I. REPEAL AND REPLACE OF HEALTH-RELATED TAX POLICY

A. Modifications and Repeal of Premium Tax Credit

Present Law

In general

A refundable tax credit (the “premium assistance credit”) is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an American Health Benefit Exchange (“Exchange”), referred to as “qualified health plans.”² In general, advance payments with respect to the premium assistance credit are made during the year directly to the insurer, as discussed below. However, eligible individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

Qualified health plans generally must meet certain requirements.³ Special rules apply to certain qualified health plans, referred to as “catastrophic-only” qualified health plans, which are available only to individuals who are under age 30 or meet other specified requirements.⁴ The premium assistance credit is not available with respect to catastrophic-only qualified health plans.⁵ In addition, in the case of a qualified health plan that provides coverage for abortions for which Federal funds may not be used, no part of the premium assistance credit may be used for the portion of premiums attributable to that coverage.⁶

The premium assistance credit is generally available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for

² Sec. 36B. Under PPACA, an American Health Benefit Exchange is a source through which individuals can purchase health insurance coverage.

³ Secs. 1301 and 1302 of PPACA.

⁴ Sec. 1302(e) of PPACA.

⁵ Under the Public Health Service Act (“PHSA”) as amended by the ACA, health insurance must meet certain requirements. Section 1251 of PPACA excepts certain health plans sold at the time of enactment of PPACA from some of the PHSA requirements (referred to as “grandfathered” plans). In addition, under guidance provided by the Center for Consumer Information & Insurance Oversight (“CCIIO,” part of the Department of Health and Human Services), including a letter dated November 14, 2013, to the State Insurance Commissioners and subsequent extensions, certain health plans that were sold in the individual insurance market as of January 1, 2013, are permitted to be sold after January 1, 2014, despite not complying with ACA requirements (referred to as “grandmothered plans”). The premium assistance credit is not available with respect to a grandfathered plan or a grandmothered plan.

⁶ Sec. 1303(b)(2) of PPACA.

the family size involved.⁷ Household income is defined as the sum of: (1) the individual's modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining the individual's family size (but only if the other individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,⁸ (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the individual's social security benefits not included in gross income.⁹ To be eligible for the premium assistance credit, individuals who are married must file a joint return. Individuals who are listed as dependents on a return are not eligible for the premium assistance credit.

An individual who is eligible for minimum essential coverage from a source other than the individual insurance market generally is not eligible for the premium assistance credit.¹⁰ However, an individual who is offered minimum essential coverage under an employer-sponsored health plan may be eligible for the premium assistance credit if an employee's share of the premium for self-only coverage exceeds 9.69 percent (for 2017) of the employee's household income, or the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent of such costs (called "minimum value"), and the individual declines the employer-offered coverage. An individual who enrolls in an employer-sponsored health plan generally is ineligible for the premium assistance credit, even if the coverage is considered unaffordable or does not provide minimum value.

As part of the process of enrollment in a qualified health plan through an Exchange, an individual may apply and be approved for advance payments with respect to a premium assistance credit ("advance payments").¹¹ The individual must provide information on income, family size, changes in marital or family status or income, and citizenship or lawful presence status.¹² Eligibility for advance payments is generally based on the individual's income for the tax year ending two years prior to the enrollment period. The Exchange process includes a

⁷ Federal poverty level refers to the most recently published poverty guidelines determined by the Secretary of Health and Human Services ("HHS"). Levels for 2017 and previous years are available at <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>.

⁸ Sec. 911.

⁹ Under section 86, only a portion of an individual's social security benefits are included in gross income.

¹⁰ Minimum essential coverage is defined in section 5000A(f).

¹¹ Secs. 1411-1412 of PPACA. Under section 1402 of PPACA, certain individuals eligible for advance premium assistance payments are eligible also for a reduction in their share of medical costs, such as deductibles and copays, under the plan, referred to as reduced cost-sharing. Eligibility for reduced cost-sharing is also determined as part of the Exchange enrollment process. The Department of Health and Human Services ("HHS") is responsible for rules relating to Exchanges and the eligibility determination process.

¹² Under section 1312(f)(3) of PPACA, an individual may not enroll in a qualified health plan through an Exchange if the individual is not a citizen or national of United States or an alien lawfully present in the United States. Thus, such an individual is not eligible for the premium assistance credit.

system through which information provided by the individual is verified using information from the Internal Revenue Service (“IRS”) and certain other sources.¹³ If an individual is approved for advance payments, the Treasury pays the advance amount directly to the issuer of the health plan in which the individual is enrolled. The individual then pays to the issuer of the plan the difference between the advance payment amount and the total premium charged for the plan.

Amount of credit

The premium assistance credit amount is generally the lower of (1) the premium for the qualified health plan in which the individual or family enrolls and (2) the premium for the second lowest cost silver plan in the rating area where the individual resides, reduced by the individual’s or family’s share of premiums.¹⁴ As shown in Table 1 below, an individual’s or family’s share of premiums is a certain percentage of household income. For 2017, the percentage is 2.04 percent for household income up to 133 percent of FPL and is determined on a sliding scale in a linear manner up to 9.69 percent as household income rises from 133 percent of FPL to 400 percent of FPL.

**Table 1.—Individual’s Share of Premiums
(for 2017)¹⁵**

| <i>Household income (expressed as a percent of FPL)</i> | <i>Initial percentage of household income</i> | <i>Final percentage of household income</i> |
|---|---|---|
| 100% up to 133% | 2.04 | 2.04 |
| 133% up to 150% | 3.06 | 4.08 |
| 150% up to 200% | 4.08 | 6.43 |

¹³ Under section 6103, returns and return information are confidential and may not be disclosed, except as authorized by the Code, by the IRS, other Federal employees, State employees, and certain others having access to such information. Under section 6103(l)(21), upon written request of the Secretary of HHS, the IRS is permitted to disclose certain return information for use in determining an individual’s eligibility for advance premium assistance payments, reduced cost-sharing, or certain other State health subsidy programs, including a State Medicaid program under title XIX of the Social Security Act, a State’s Children’s Health Insurance Program under title XXI of the Social Security Act and a Basic Health Program under section 1331 of PPACA.

¹⁴ The premium assistance amount is determined on a monthly basis and the credit for a year is the sum of the monthly amounts.

¹⁵ Rev. Proc. 2016-24, 2016-18 I.R.B. 677. The percentages are indexed to the excess of premium growth over income growth for the preceding calendar year. After 2018, if the aggregate amount of premium assistance credits (and cost-sharing reductions under section 1402 of PPACA) exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year.

| <i>Household income (expressed as a percent of FPL)</i> | <i>Initial percentage of household income</i> | <i>Final percentage of household income</i> |
|---|---|---|
| 200% up to 250% | 6.43 | 8.21 |
| 250% up to 300% | 8.21 | 9.69 |
| 300% up to 400% | 9.69 | 9.69 |

Reconciliation of advance payment on return

An individual on whose behalf advance payments of the premium assistance credit for a taxable year are made is required to file an income tax return to reconcile the advance payments with the credit to which the individual is entitled for the taxable year.¹⁶

If the advance payments of the premium assistance credit exceed the amount of credit to which the individual is entitled, the excess (“excess advance payments”) is treated as an additional tax liability on the individual’s income tax return for the taxable year (referred to as “recapture”), subject to a limit on the amount of additional liability in some cases. For an individual with household income below 400 percent of FPL, liability for the excess advance payments for a taxable year is limited to a specific dollar amount (the “applicable dollar amount”) as shown in Table 2 below. One-half of the applicable dollar amount shown in Table 2 applies to an unmarried individual who is not a surviving spouse or filing as a head of household.

**Table 2.—Reconciliation Limit on Additional Tax Liability
(for 2017)¹⁷**

| <i>Household income (expressed as a percent of FPL)</i> | <i>Applicable dollar amount</i> |
|---|---------------------------------|
| Less than 200% | \$600 |
| At least 200% but less than 300% | \$1,500 |
| At least 300% but less than 400% | \$2,550 |

¹⁶ Under section 6055, health insurance issuers are required to report to the IRS and to an individual the months during a year for which the individual was covered by minimum essential coverage issued by the insurer in the individual market. In addition, under section 36B(f)(3), an Exchange is required to report to the IRS and to an individual the months during a year for which the individual was covered by a qualified health plan purchased through the Exchange, the premiums paid by the individual, and, if applicable, advance premium assistance payments made on behalf of the individual.

¹⁷ Rev. Proc. 2016-55, 2015-45 I.R.B. 707. The applicable dollar amounts are indexed to reflect cost-of-living increases, with the amount of any increase rounded down to the next lowest multiple of \$50.

If the advance payments of the premium assistance credit for a taxable year are less than the amount of the credit to which the individual is entitled, the additional credit amount is also reflected on the individual's income tax return for the year.

Description of Proposal

Overview

The proposal makes several modifications to the premium assistance credit for a transition period and repeals the premium assistance credit at the end of the transition period.

Recapture of excess advance payments

The proposal repeals the present-law provision under which, in the case of an individual with household income below 400 percent of FPL, the additional tax liability resulting from excess advance payments is limited to the applicable dollar amount. Thus, under the proposal, the full amount of excess advance payments is treated as an additional tax liability for the individual.

Application of credit to additional coverage

Under the proposal, the premium assistance credit is available with respect to catastrophic-only qualified health plans. In addition, the premium assistance credit is available with respect to health plans that otherwise meet the requirements relating to qualified health plans, except that they are not offered through an Exchange.¹⁸ Thus, an individual who purchases a qualified health plan in the individual market, but not through an Exchange, may be eligible for the premium assistance credit if the requirements for eligibility are otherwise met.¹⁹

Ineligibility of qualified health plans covering abortion

Under the proposal, the premium assistance credit is not available with respect to a qualified health plan that includes coverage for abortions, other than an abortion necessary to save the life of the mother or an abortion with respect to a pregnancy that is the result of an act of rape or incest.²⁰ For this purpose, the treatment of any infection, injury, disease, or disorder that

¹⁸ As under present law, the credit is not available with respect to a grandfathered plan or grandmothered plan. In addition, as under present law, an individual who is not a citizen or national of United States, or an alien lawfully present in the United States, is not eligible for the premium assistance credit.

¹⁹ Advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange. An individual who purchases such a plan must claim the premium assistance credit on his or her income tax return. The proposal amends the present-law reporting requirements under section 6055 so that additional information related to eligibility for the premium assistance credit is reported.

²⁰ Nothing in the proposal is to be construed as prohibiting any individual from purchasing separate coverage for abortions, or a health plan that includes those abortions, so long as no premium assistance credit is allowed with respect to the premiums for the coverage or plan. In addition, nothing in the proposal restricts any health insurance issuer from offering separate coverage for abortions, or a plan that includes abortions, so long as

has been caused by or exacerbated by the performance of an abortion is not considered an abortion.

Changes to individual share of premiums

The proposal revises the schedule under which an individual’s or family’s share of premiums is determined in applying the credit for taxable years beginning 2019. As revised, the schedule varies with household income and with the age of the individual or family members, as shown in Table 3 below, subject to adjustment as described below.²¹ Initial and final percentages refer to percentage of the taxpayer’s household income.

Table 3.—Individual’s Share of Premiums

| <i>Household income (expressed as a percent of FPL)</i> | <u>Up to Age 29</u> | | <u>Age 30-39</u> | | <u>Age 40-49</u> | | <u>Age 50-59</u> | | <u>Over Age 59</u> | |
|---|---------------------|---------|------------------|---------|------------------|---------|------------------|---------|--------------------|---------|
| | Initial % | Final % | Initial % | Final % | Initial % | Final % | Initial % | Final % | Initial % | Final % |
| <i>Up to 133%</i> | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| <i>133% – 150%</i> | 3 | 4 | 3 | 4 | 3 | 4 | 3 | 4 | 3 | 4 |
| <i>150% – 200%</i> | 4 | 4.3 | 4 | 5.3 | 4 | 6.3 | 4 | 7.3 | 4 | 8.3 |
| <i>200% – 250%</i> | 4.3 | 4.3 | 5.3 | 5.9 | 6.3 | 8.05 | 7.3 | 9 | 8.3 | 10.0 |
| <i>250% – 300%</i> | 4.3 | 4.3 | 5.9 | 5.9 | 8.05 | 8.35 | 9 | 10.5 | 10 | 11.5 |
| <i>300% – 400%</i> | 4.3 | 4.3 | 5.9 | 5.9 | 8.35 | 8.35 | 10.5 | 10.5 | 11.5 | 11.5 |

To determine the percentages applicable for taxable years beginning in calendar year 2019, the initial and final percentages may be subject to two adjustments. The first adjustment reflects the excess, if any, of (1) the rate of premium growth for the period beginning with calendar year 2013 and ending with calendar year 2018 over (2) the rate of income growth for

premiums for the separate coverage or plan are not paid for with any amount attributable to the premium assistance credit (or the amount of any advance payment of the credit under section 1412 of PPACA).

²¹ For purposes of the schedule, an individual’s age for a taxable year is the age the individual attains before the close of the taxable year, and, in the case of a joint return, the age of the older spouse is taken into account. As under present law, the applicable percentage is determined on a sliding scale in a linear manner as household income rises from 133 percent of FPL to 400 percent of FPL.

that period. The second adjustment reflects the excess, if any, of (1) the rate of premium growth for calendar year 2018 over (2) the rate of growth in the consumer price index for calendar year 2018. However, the second adjustment applies only if the aggregate amount of premium assistance credits and cost-sharing reductions for calendar year 2018 exceeds 0.504 percent of the gross domestic product for that year.

Repeal of premium assistance credit

The proposal terminates the premium assistance credit with respect to any coverage month beginning after December 31, 2019.²²

Effective Date

Repeal of the limit on additional tax liability resulting from excess advance payments is effective for taxable years beginning after December 31, 2017, and before January 1, 2020. The other transition modifications to the premium assistance credit are generally effective for taxable years beginning after December 31, 2017, except that the new schedule for determining an individual's or family's share of premiums is effective for taxable years beginning after December 31, 2018.²³ Repeal of the premium assistance credit is effective for months beginning after December 31, 2019, in taxable years ending after that date.²⁴

²² The proposal generally also repeals the provisions of sections 1411 and 1412 of PPACA relating to the determination of eligibility for advance premium assistance payments.

²³ The proposal specifying that advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange is effective on January 1, 2018. The proposal amending the present-law reporting requirements under section 6055 is effective for coverage provided for months beginning after December 31, 2017.

²⁴ Repeal of the provisions of sections 1411 and 1412 of PPACA relating to the determination of eligibility for advance premium assistance payments is effective January 1, 2020.

B. Small Business Tax Credit

Present Law

In general

Present law provides a tax credit for an eligible small employer for up to 50 percent of the employer's nonelective contributions to purchase health insurance for its employees.²⁵ An eligible small employer for this purpose generally is an employer with no more than 25 full-time equivalent employees ("FTEs") during the employer's taxable year, whose average annual wages (for 2017) do not exceed \$52,400.²⁶ The full amount of the credit is available only to an employer with 10 or fewer FTEs whose average annual wages do not exceed (for 2017) \$26,200 and is phased out based on the number of FTEs over 10 and average annual wages over \$26,200.

For purposes of the credit, the employer is determined by applying the aggregation rules for controlled groups, groups under common control, and affiliated service groups.²⁷ In addition, for purposes of the credit, the term "employee" includes a leased employee, that is, an individual who is not an employee of the employer, who provides services to the employer pursuant to an agreement between the employer and another person (a "leasing organization") and under the primary direction or control of the employer, and who has performed such services on a substantially full-time basis for at least one year.²⁸

Self-employed individuals (including partners and sole proprietors),²⁹ two-percent shareholders of an S Corporation,³⁰ and five-percent owners of the employer³¹ are not employees for purposes of the credit with the result that they are disregarded in determining number of FTEs, average annual wages, and nonelective contributions for employees' health insurance.

²⁵ Sec. 45R.

²⁶ Wages for this purpose is defined as under the Federal Insurance Contributions Act ("FICA"), sections 3101-3128, without regard to the dollar limit on FICA wages under section 3121(a). The wage amounts relevant for purposes of the credit are indexed to the Consumer Price Index for Urban Consumers ("CPI-U") for years beginning after 2013.

²⁷ Section 414(b) provides that, for specified employee benefit purposes, employees of corporations that are members of a controlled group of corporations are treated as employed by a single employer. Similarly, employees of trades or businesses (whether or not incorporated) under common control as provided in regulations under section 414(c), and employees of members of an affiliated service group as defined under section 414(m), are treated as employed by a single employer for specified employee benefit purposes. Section 414(o) authorizes the Secretary of the Treasury to issue regulations to prevent avoidance of the purposes specified in section 414(m).

²⁸ Sec. 414(n)(2).

²⁹ Sec. 401(c).

³⁰ Sec. 1372(b).

³¹ Five-percent owner is defined as for purposes of the qualified retirement plan top-heavy rules under section 416(i)(1)(B)(i).

Family members of these individuals and any member of the individual's household who is a dependent for tax purposes are also not employees for purposes of the credit. In addition, the hours of service worked by and wages paid to a seasonal worker of an employer are not taken into account in determining number of FTEs and average annual wages unless the worker works for the employer on more than 120 days during the taxable year.

The employer contributions must be provided under an arrangement that requires the eligible small employer to make, on behalf of each employee who enrolls in qualifying health insurance offered by the employer, a nonelective contribution equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualifying health insurance.³² The credit is available only for nonelective contributions for premiums for insurance purchased through a Small Business Health Options ("SHOP") Exchange and is available for a maximum credit period of two consecutive taxable years beginning with the first taxable year in which the employer (or any predecessor) offers coverage to its employees through a SHOP Exchange.³³

The credit is available only to offset actual tax liability (that is, it is not a refundable credit) and is claimed on the employer's tax return. The credit is a general business credit and generally can be carried back for one year and carried forward for 20 years. The credit is available for tax liability under the alternative minimum tax. The dollar amount of the credit reduces the amount of employer contributions the employer may deduct as a business expense.

Tax-exempt organizations

A tax-exempt organization³⁴ that otherwise qualifies as an eligible small employer is eligible to receive the credit. For tax-exempt organizations, the applicable credit percentage is limited to 35 percent. In addition, for tax-exempt organizations, instead of being a general business credit, the credit is a refundable credit limited to the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins. For this purpose, "payroll taxes" means: (1) the amount of income tax required to be withheld from its employees' wages; (2) the amount of hospital insurance tax required to be withheld from its employees' wages; and (3) the amount of the hospital insurance tax imposed on the employer.³⁵

³² A nonelective contribution is an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

³³ The maximum two-year credit period does not take into account any taxable years beginning before 2014.

³⁴ A tax-exempt organization is an organization described in section 501(c) that is exempt from tax under section 501(a).

³⁵ Secs. 3402, 3101(b) and 3102, 3111(b).

Description of Proposal

Ineligibility of qualified health plans covering abortion

Under the proposal, the small employer health insurance credit is not available with respect to a qualified health plan that includes coverage for abortions, other than an abortion necessary to save the life of the mother or an abortion with respect to a pregnancy that is the result of an act of rape or incest.³⁶ For this purpose, the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion is not considered an abortion.

Repeal of the credit

The proposal repeals the small employer health insurance credit.

Effective Date

The proposal disallowing the credit with respect to a qualified health plan that provides coverage with respect to abortions is effective for taxable years beginning after December 31, 2017. The proposal repealing the small employer health insurance credit is effective for taxable years beginning after December 31, 2019.

³⁶ Nothing in the proposal is to be construed as prohibiting an employer from purchasing for its employees separate coverage for abortions, or a health plan that includes abortions, so long as no small employer health insurance credit is allowed with respect to the employer contributions for the coverage or plan. In addition, nothing in the proposal restricts any health insurance issuer from offering separate coverage for abortions, or a plan that includes abortions, so long as the separate coverage or plan is not paid for with any employer contribution eligible for the credit.

C. Repeal of Individual Mandate Penalty

Present Law

Individuals must be covered by a health plan that provides at least minimum essential coverage or be subject to a tax (also referred to as a penalty) for failure to maintain the coverage (commonly referred to as the “individual mandate”).³⁷ 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 Health and Human Services (“HHS”) in coordination with the Secretary of the Treasury.³⁸ 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.

The tax for any calendar month is one-twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of a flat dollar amount or an excess income amount. The flat dollar amount is the lesser of (1) the sum of the individual annual dollar amounts for the members of the taxpayer’s family and (2) 300 percent of the adult individual dollar amount. The individual adult annual dollar amount is \$695 for 2017.³⁹ For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount. The excess income amount is 2.5 percent of the excess of the taxpayer’s household income for the taxable year over the threshold amount of income for requiring the taxpayer to file an income tax return.⁴⁰ The total annual household payment may not exceed the national average annual premium for bronze level health plans for the applicable family size offered through Exchanges that year.

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 HHS to have suffered a hardship with respect to the capability to obtain coverage.⁴¹

³⁷ Section 5000A. If an individual is a dependent, as defined in section 152, of another taxpayer, the other taxpayer is liable for any tax for failure to maintain the required coverage with respect to the individual.

³⁸ Minimum essential coverage does not include coverage that consists of only certain excepted benefits, such as limited scope dental and vision benefits or long-term care insurance offered under a separate policy, certificate or contract.

³⁹ For years after 2016, the \$695 amount is indexed to CPI-U, rounded to the next lowest multiple of \$50.

⁴⁰ Sec. 6012(a).

⁴¹ In addition, certain individuals present or residing outside of the United States and bona fide residents of United States territories are deemed to maintain minimum essential coverage.

Description of Proposal

Under the proposal, the amount of the tax for failure to maintain minimum essential coverage is zero. Thus, the proposal effectively repeals the individual mandate.

Effective Date

The proposal is effective for months beginning after December 31, 2015.

D. Repeal of Employer Mandate Penalty

Present Law

In general

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 with respect to health insurance purchased through an Exchange (commonly referred to as the “employer mandate”).⁴² 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

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. For purposes of 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. 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 single employer.⁴³ 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.

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 (for 2017) of \$2,260 (divided by 12 and applied on a monthly basis) multiplied by the

⁴² Sec. 4980H. As discussed in Part A, premium assistance credits under section 36B apply with respect to health insurance purchased through an Exchange. An employer may also be subject to an assessable payment if an employee received reduced cost-sharing with respect to coverage purchased through an Exchange as discussed in Part A.

⁴³ 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.

number of its full-time employees in excess of 30, regardless of the number of full-time employees so certified.

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.⁴⁴ 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 (for 2017) of \$3,390 (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.

Description of Proposal

Under the proposal, the amount of the assessable penalties under the employer mandate is zero. Thus, the proposal effectively repeals the employer mandate.

Effective Date

The proposal is effective for months beginning after December 31, 2015.

⁴⁴ 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.

E. Repeal of Tax on Employee Health Insurance Premiums and Health Plan Benefits

Present Law

In general

Effective for taxable years beginning after December 31, 2019, 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”).⁴⁵ 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.⁴⁶ This threshold is then adjusted annually by an age and gender adjusted excess premium amount.⁴⁷ 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.

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

⁴⁵ Sec. 4980I.

⁴⁶ 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.

⁴⁷ 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.

employee's gross income or that would be excludible if it were employer-sponsored coverage.⁴⁸ 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").⁴⁹ 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.⁵⁰

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,⁵¹ 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 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

⁴⁸ Section 106 provides an exclusion for employer-provided coverage.

⁴⁹ 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.

⁵⁰ Section 162(l) allows a deduction to a self-employed individual for the cost of health insurance.

⁵¹ Sec. 4980B(f)(4).

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.⁵²

The excise tax is imposed on the coverage provider.⁵³ 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.⁵⁴

Description of Proposal

Under the proposal, the excise tax on high cost employer-sponsored health coverage will not apply for any taxable period beginning after December 31, 2019, and before January 1, 2025. Thus, the tax will apply only for taxable periods beginning after December 31, 2024.

Effective Date

The proposal is effective upon enactment.

⁵² 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.

⁵³ 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.

⁵⁴ 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.

F. Repeal of Tax on Over-the-Counter Medications

Present Law

Exclusion for employer-provided health benefits

Employees may exclude from gross income the value of employer-provided health coverage under an accident or health plan.⁵⁵ In addition, any reimbursements under an employer-provided accident or health plan for medical care expenses for employees, their spouses, their dependents, and adult children under age 27 generally are excludible from gross income.⁵⁶

An employer may agree to reimburse expenses for medical care of its employees (and their spouses, dependents, and adult children under age 27), not covered by a health insurance plan, through a flexible spending arrangement (“FSA”) which allows reimbursement not in excess of a specified dollar amount, provided the amount is only available for reimbursement for medical care.⁵⁷ The amount available for reimbursement is either elected by an employee under a cafeteria plan (“health FSA”) or otherwise specified by the employer under a health reimbursement arrangement (“HRA”). Reimbursements under these arrangements are also excludible from gross income as reimbursements for medical care under an employer-provided accident or health plan.

Health savings accounts

An individual with a high deductible health plan (and no other health plan other than a plan that provides certain permitted insurance or permitted coverage) may establish a health savings account (“HSA”).⁵⁸ Subject to limits, contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excludible from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize deductions. Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and generally are subject to an additional tax of 20 percent. Similar rules apply for another type of medical savings arrangement called an Archer medical savings account (“Archer MSA”).⁵⁹

⁵⁵ Secs. 106.

⁵⁶ Sec. 105(b).

⁵⁷ Sec. 106(c)(1).

⁵⁸ Sec. 223.

⁵⁹ Sec. 220.

Medical care for excludible reimbursements

For purposes of the exclusion for reimbursements under employer-provided accident and health plans (including under health FSAs and HRAs), and for distributions from HSAs and Archer MSAs used for qualified medical expenses, the definition of medical care is generally the same as the definition that applies for the itemized deduction for the cost of medical care and includes prescription medicine or drugs and insulin.⁶⁰ However, the definition of medical care for purposes of the exclusion for reimbursements for medical care under employer-provided accident and health plans and for distributions from HSAs and Archer MSAs used for qualified medical expenses includes an over-the-counter medicine but only if prescribed by a physician.⁶¹ Thus, under present law, excludible treatment under a health FSA or an HRA is available on reimbursements for the cost of over-the-counter medicine only if the medicine is prescribed by a physician, and distributions from an HSA or an Archer MSA used to purchase over-the-counter medicine are not a qualified medical expense unless the medicine is prescribed by a physician.

Description of Proposal

The proposal changes the definition of qualified medical care for purposes of the exclusions for reimbursements for medical care under employer-provided accident and health plans (including health FSAs and HRAs) and for distributions from HSAs or Archer MSAs used for qualified medical expenses to include over-the-counter medicine that is not prescribed by a physician. Thus, for example, amounts paid from a health FSA or HRA, or funds distributed from an HSA or an Archer MSA, to reimburse a taxpayer for over-the-counter medicine, such as nonprescription aspirin, allergy medicine, antacids, or pain relievers, will be excluded from income in accordance with the general rules associated with those health-related savings and reimbursement vehicles.

Effective Date

The proposal is effective (1) in the case of HSAs and MSAs, amounts paid with respect to taxable years beginning after December 31, 2017, and (2) in the case of health FSAs and HRAs, expenses incurred with respect to taxable years beginning after December 31, 2017.

⁶⁰ Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.

⁶¹ The prescription requirement does not apply to insulin.

G. Repeal of Increase in Tax on Health Savings Accounts

Present Law

Subject to limits, an individual with a high deductible health plan generally may make deductible contributions to a health savings account (“HSA”) or an Archer MSA (or “medical savings account”), which is a tax-exempt trust or custodial account.⁶² Employer contributions to Archer MSAs and HSAs on behalf of employees are excluded from income and wages, including Archer MSA and HSA contributions made with salary reduction contributions through a cafeteria plan.⁶³ Thus, contributions to an HSA or Archer MSA are made on a pretax basis.

Distributions from an HSA or Archer MSA that are used for qualified medical expenses are excludible from gross income. Distributions that are not used for qualified medical expenses are includible in income and are generally subject to an additional tax. Before 2011, the additional tax on HSA distributions not used for qualified medical expenses was 10 percent of the distributed amount, and the additional tax on Archer MSA distributions not used for qualified medical expenses was 15 percent of the distributed amount. Effective for distributions made after December 31, 2010, the additional tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses is 20 percent of the distributed amount.

Description of Proposal

Under the proposal, the additional tax on HSA distributions not used for qualified medical expenses is 10 percent of the distributed amount, and the additional tax on Archer MSA distributions not used for qualified medical expenses is 15 percent of the distributed amount.

Effective Date

The proposal is effective for distributions made after December 31, 2017.

⁶² Secs. 223 and 220.

⁶³ Sec. 106(b) and (d). Employer contributions are subject to the same limits as individual contributions and reduce the amount of contributions that the individual can make.

H. Repeal of Limitations on Contributions to Flexible Spending Accounts

Present Law

A health flexible spending arrangement (“health FSA”) is an arrangement under which medical care expenses of an employee (and family members, if applicable) that are not covered by insurance may be paid or reimbursed.⁶⁴ The funds available to an employee through a health FSA generally consist of the employee’s salary reduction contributions under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses.⁶⁵ In order for a health FSA to be a qualified benefit under a cafeteria plan, an employee’s salary reduction contributions cannot exceed a dollar limit (\$2,600 for 2017).⁶⁶

Description of Proposal

The proposal repeals the limitation on health FSA salary reduction contributions.

Effective Date

The proposal applies to taxable years beginning after December 31, 2017.

⁶⁴ Sec. 106(c)(2).

⁶⁵ Health FSAs may also include funds provided by the employer (often called “flex credits”).

⁶⁶ Sec. 125(i). The dollar limit is indexed to CPI-U, with any increase that is not a multiple of \$50 rounded to the next lowest multiple of \$50.

J. Repeal of Medical Device Excise Tax

Present Law

Effective for sales after December 31, 2012, excluding sales during the period beginning on January 1, 2016 and ending on December 31, 2017, 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.⁶⁷ A taxable medical device is any device, as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act,⁶⁸ 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.⁶⁹

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.⁷⁰ Additionally, the regulations provide certain safe harbors for devices eligible for the retail exemption.⁷¹

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

⁶⁷ Sec. 4191. Section 4191(c) provides a moratorium under which the medical device excise tax does not apply to sales during the period beginning on January 1, 2016, and ending on December 31, 2017.

⁶⁸ 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.”

⁶⁹ 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.

⁷⁰ Treas. Reg. sec. 48.4191-2(b)(2).

⁷¹ 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.

second purchaser for export).⁷² If a medical device is sold free of tax for resale to a second 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.⁷³ 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.⁷⁴ 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.⁷⁵

There are also rules for determining the price of a medical device on which the excise tax is imposed.⁷⁶ 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

Under the proposal, the medical device excise tax applies only to sales before January 1, 2016. Thus, the medical device excise tax will not resume for sales in calendar years beginning after December 31, 2017.

Effective Date

The proposal is effective upon enactment.

⁷² 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.

⁷³ Sec. 4221(b).

⁷⁴ Sec. 4217(a).

⁷⁵ Sec. 4218.

⁷⁶ Sec. 4216.

K. Repeal of Elimination of Deduction for Expenses Allocable To Medicare Part D Subsidy

Present Law

Sponsors of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of HHS with respect to a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").⁷⁷ A qualified retiree prescription drug plan is employment-based retiree health coverage that has an actuarial value at least as great as the Medicare Part D standard plan for the risk pool and that meets certain other disclosure and recordkeeping requirements. These qualified retiree prescription drug plan subsidies are excludible from the plan sponsor's gross income.⁷⁸

In general, no deduction is allowed under any provision of the Code for any expense or amount that would otherwise be allowable as a deduction if the expense or amount is allocable to a class or classes of exempt income.⁷⁹ Thus, expenses incurred with respect to the subsidies excluded from income would generally not be deductible. For years before 2013, the exclusion for the qualified retiree prescription drug plan subsidy included a provision under which the exclusion was not taken into account in determining deductions with respect to the retiree prescription drug costs for which subsidy payments were received, thus allowing a deduction for costs subsidized by HHS payments. The ACA eliminated that provision and, as a result, the amount otherwise allowable as a deduction for retiree prescription drug costs is reduced by the amount of excludable subsidy payments received.

Description of Proposal

Under the proposal, the exclusion for qualified retiree prescription drug plan subsidy payments is not taken into account in determining whether a deduction is allowed with respect to retiree prescription drug costs taken into account in determining the subsidy payments from HHS. Therefore, a taxpayer may claim a deduction for covered retiree prescription drug expenses notwithstanding that the taxpayer excludes from income qualified retiree prescription drug plan subsidies received from HHS with respect to the expenses.

Effective Date

The proposal is effective for taxable years beginning after December 31, 2017.

⁷⁷ Sec. 1860D-22 of the Social Security Act (SSA), 42 U.S.C. sec. 1395w-132.

⁷⁸ Sec. 139A.

⁷⁹ Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

L. Repeal of Increase in Income Threshold for Medical Expense Deduction

Present Law

Individuals may claim an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 10 percent of adjusted gross income.⁸⁰ For taxable years beginning before January 1, 2017, the 10-percent threshold is reduced to 7.5 percent in the case of taxpayers who have attained the age of 65 before the close of the taxable year.⁸¹ For these taxpayers, during these years, the threshold is 10 percent for AMT purposes.

Description of Proposal

The proposal extends the reduced 7.5-percent threshold for taxpayers who have attained the age of 65 before the close of the taxable year to taxable years beginning before January 1, 2018 (10 percent for AMT purposes). Thus, the 7.5-percent threshold applies for taxable years beginning in 2017. The proposal also permanently lowers the adjusted gross income threshold from 10 percent to 7.5 percent for all taxpayers, including for AMT purposes, regardless of age.

Effective Date

The proposal extending the reduced 7.5-percent threshold for taxpayers who have attained the age of 65 before the close of the taxable year is effective for taxable years beginning after December 31, 2016. The proposal lowering the adjusted gross income threshold from 10 percent to 7.5 percent for all taxpayers is effective for taxable years beginning after December 31, 2017.

⁸⁰ Sec. 213. For taxable years beginning before January 1, 2013, the threshold was 7.5 percent and 10 percent for alternative minimum tax (“AMT”) purposes.

⁸¹ In the case of married taxpayers, the 7.5 percent threshold applies if either spouse has obtained the age of 65 before the close of the taxable year.

M. Repeal of Medicare Tax Increase

Present Law

Social Security and Medicare taxes - in general

The Federal Insurance Contributions Act (“FICA”) imposes tax on employers and employees based on the amount of wages (as defined for FICA purposes) paid to an employee during the year.⁸² The tax imposed on the employer and on the employee is each composed of two parts: (1) the social security or old age, survivors, and disability insurance (“OASDI”) tax equal to 6.2 percent of covered wages up to the taxable wage base (\$127,200 for 2017); and (2) the Medicare or hospital insurance (“HI”) tax equal to 1.45 percent of all covered wages. The employee portion of the FICA tax generally must be withheld and remitted to the Federal government by the employer. If the employer fails to withhold the employee portion, the employer is generally liable for the amount that should have been withheld.

Instead of FICA taxes, railroad employers and employees are subject, under the Railroad Retirement Tax Act (“RRTA”), to taxes equivalent to the OASDI and Medicare taxes under FICA with respect to compensation as defined for RRTA purposes (“RRTA compensation”).⁸³ The employee portion of RRTA taxes generally must be withheld from an employee’s RRTA compensation and remitted to the Federal government by the employer.

As a parallel to FICA and RRTA taxes, the Self-Employment Contributions Act (“SECA”) imposes tax on the self-employment income of self-employed individuals.⁸⁴ The rate of the OASDI portion of SECA tax is equal to the combined employee and employer OASDI FICA tax rates (12.4 percent) and applies to self-employment income up to the FICA taxable wage base (reduced by FICA wages, if any). Similarly, the rate of the Medicare portion of SECA tax is the same as the combined employer and employee Medicare rates (2.9 percent) and applies to all self-employment income.

Additional Medicare tax

An additional Medicare tax of 0.9 percent is imposed on employees and self-employed individuals with FICA wages, RRTA compensation or self-employment income exceeding a threshold amount.

Under FICA and RRTA, the employee portion of the Medicare tax (not the employer portion) is increased by an additional tax of 0.9 percent on wages received in excess of the threshold amount. The threshold amount is \$250,000 in the case of a joint return, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case. Thus, in

⁸² Secs. 3101-3128.

⁸³ Secs. 3201-3233.

⁸⁴ Secs. 1401-1403.

the case of a joint return, the additional Medicare tax is based on the combined wages of an employee and the employee's spouse.

An employer is required to withhold the additional Medicare tax from an employee's wages and RRTA compensation only to the extent wages or compensation paid to the employee by the employer exceeds \$200,000. The employer's withholding obligation does not depend on the amount of the employee's ultimate liability for the additional Medicare tax, if any. That is, the amount required to be withheld may be more or less than the employee's ultimate liability. If the employee's liability is more than the amount withheld, the employee must pay the additional amount. If the employee's liability is less than the amount withheld, the employee may claim a refund.

The additional Medicare tax applies also to self-employment income in excess of the threshold amount. As in the case of the additional Medicare tax for employees, the threshold amount for the additional SECA Medicare tax is \$250,000 in the case of a joint return, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case. The threshold amount is reduced (but not below zero) by the amount of wages taken into account in determining the individual's additional FICA Medicare tax, if any. Thus, only a single threshold amount applies for an individual (or individual and spouse) with both FICA wages and self-employment income.

Description of Proposal

The proposal repeals the additional 0.9 percent Medicare tax.

Effective Date

The proposal is effective with respect to remuneration received after, and taxable years beginning after, December 31, 2017.

N. Refundable Tax Credit for Health Insurance Coverage

Present Law

Premium assistance credit

In general

A refundable tax credit (the “premium assistance credit”) is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an Exchange, referred to as “qualified health plans.”⁸⁵ The premium assistance credit is generally available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved. An individual who is eligible for minimum essential coverage from a source other than the individual insurance market, such as employer-provided coverage, generally is not eligible for the premium assistance credit.⁸⁶ In general, advance payments with respect to the premium assistance credit are made during the year directly to the insurer, as discussed below. However, eligible individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

As part of the process of enrollment in a qualified health plan through an Exchange, an individual may apply and be approved advance payments with respect to a premium assistance credit (“advance payments”).⁸⁷ The individual must provide information on income, family size,

⁸⁵ Sec. 36B. Under the Public Health Service Act (“PHSA”) as amended by the ACA, health insurance must meet certain requirements. Section 1251 of PPACA excepts certain health plans sold at the time of enactment of PPACA from some of the PHSA requirements (referred to as “grandfathered” plans). In addition, under guidance provided by the Center for Consumer Information & Insurance Oversight (“CCIIO,” part of the Department of Health and Human Services), including a letter dated November 14, 2013, to the State Insurance Commissioners and subsequent extensions, certain health plans that were sold in the individual insurance market as of January 1, 2013, are permitted to be sold after January 1, 2014, despite not complying with ACA requirements (referred to as “grandmothered plans”). The premium assistance credit is not available with respect to a grandfathered plan or a grandmothered plan. Another proposal in the bill repeals the premium assistance credit.

⁸⁶ Minimum essential coverage is defined in section 5000A(f). An individual covered by a qualified small employer health reimbursement arrangement (“QSEHRA”) as defined in section 9831(d) may be eligible for the premium assistance credit. In that case, the amount of the credit is reduced by the benefit amount available to an individual under the QSEHRA. Under section 162(l), a self-employed individual may take a deduction in determining adjusted gross income (“AGI”), that is, an “above-the line” deduction, for the cost of health insurance for the individual and the individual’s spouse, dependents and, under the ACA, children up to age 26. Under section 213, an individual may take an itemized deduction for medical expenses, including health insurance premiums, that exceed 10 percent of AGI. If an individual receives a premium assistance credit, the amount of premiums taken into account in determining a deduction under section 162(l) or 213 is reduced by the amount of the credit.

⁸⁷ Secs. 1411-1412 of PPACA. Under section 1402 of PPACA, certain individuals eligible for advance premium assistance payments are eligible also for a reduction in their share of medical costs, such as deductibles and copays, under the plan, referred to as reduced cost-sharing. Eligibility for reduced cost-sharing is also determined as part of the Exchange enrollment process. The Department of Health and Human Services (“HHS”) is responsible for rules relating to Exchanges and the eligibility determination process.

changes in marital or family status or income, and citizenship or lawful presence status.⁸⁸ Eligibility for advance payments is generally based on the individual's income for the tax year ending two years prior to the enrollment period. The Exchange process includes a system through which information provided by the individual is verified using information from the IRS and certain other sources.⁸⁹ If an individual is approved for advance premium assistance payments, the Treasury pays the advance amount directly to the issuer of the health plan in which the individual is enrolled. The individual then pays to the issuer of the plan the difference between the advance payment amount and the total premium charged for the plan.

Amount of credit and reconciliation of advance payment on return

The premium assistance credit amount is generally the lower of (1) the premium for the qualified health plan in which the individual or family enrolls and (2) the premium for the second lowest cost silver plan in the rating area where the individual resides, reduced by the individual's or family's share of premiums, determined as a specified percentage of household income.⁹⁰ Household income is defined as the sum of: (1) the individual's modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining the individual's family size (but only if the other individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,⁹¹ (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the individual's social security benefits not included in gross income.⁹²

An individual on whose behalf advance payments of the premium assistance credit for a taxable year are made is required to file an income tax return to reconcile the advance payments with the credit to which the individual is entitled for the taxable year. If the advance payments of the premium assistance credit exceed the amount of credit to which the individual is entitled, the excess ("excess advance payments") is treated as an additional tax liability on the individual's income tax return for the taxable year (referred to as "recapture"), subject to a limit

⁸⁸ Under section 1312(f)(3) of PPACA, an individual may not enroll in a qualified health plan through an Exchange if the individual is not a citizen or national of the United States or an alien lawfully present in the United States. Thus, such an individual is not eligible for the premium assistance credit.

⁸⁹ Under section 6103, returns and return information are confidential and may not be disclosed, except as authorized by the Code, by the IRS, other Federal employees, State employees, and certain others having access to such information. Under section 6103(l)(21), upon written request of the Secretary of HHS, the IRS is permitted to disclose certain return information for use in determining an individual's eligibility for advance premium assistance payments, reduced cost-sharing, or certain other State health subsidy programs, including a State Medicaid program under title XIX of the Social Security Act, a State's Children's Health Insurance Program under title XXI of the Social Security Act and a Basic Health Program under section 1331 of PPACA.

⁹⁰ The premium assistance amount is determined on a monthly basis and the credit for a year is the sum of the monthly amounts.

⁹¹ Sec. 911.

⁹² Under section 86, only a portion of an individual's social security benefits are included in gross income.

on the amount of additional liability in the case of an individual with household income below 400 percent of FPL. If the advance payments of the premium assistance credit for a taxable year are less than the amount of the credit to which the individual is entitled, the additional credit amount is also reflected on the individual's income tax return for the year.

Health coverage tax credit

Another refundable tax credit (the "health coverage tax credit" or "HCTC") is available to certain individuals for months beginning before January 1, 2020, generally based on eligibility relating to the Trade Adjustment Assistance ("TAA") program or the receipt of pension benefits from the Pension Benefit Guaranty Corporation.⁹³ The credit amount is 72.5 percent of the individual's premiums for qualified health insurance of the individual and qualifying family members for each eligible coverage month beginning in the taxable year. The credit is available on an advance payment basis through a program established by the IRS.⁹⁴ In the case of an individual on whose behalf advance HCTC payments are made, the individual's income tax liability is increased by the amount of the advance payment, but then offset by the amount of the HCTC allowed to the individual.⁹⁵

Health Savings Accounts

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage) may establish a health savings account ("HSA").⁹⁶ Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an "above-the-line" deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.⁹⁷ Distributions from an HSA for qualified medical expenses are not includible in gross income. An individual may roll funds over from one HSA to another on a nontaxable basis. In that case, the amount of the rollover is not taken into account in applying the HSA contribution limits.

Reporting relating to health insurance and employer-provided health coverage

A health insurance issuer is required to report to the IRS and to an individual the months during a year for which the individual was covered by minimum essential coverage issued by the

⁹³ Sec. 35.

⁹⁴ Sec. 7527.

⁹⁵ Rules to coordinate eligibility for the HCTC and the premium assistance credit apply in the case of an individual who is eligible for both.

⁹⁶ Sec. 223.

⁹⁷ Secs. 106(d), 125, 3121(a)(2), 3231(e)(1), 3306(b)(2), 3401(a)(22).

insurer in the individual market.⁹⁸ In addition, an Exchange is required to report to the IRS and to an individual the months during a year for which the individual was covered by a qualified health plan purchased through the Exchange, the premiums paid by the individual, and, if applicable, advance premium assistance payments made on behalf of the individual.⁹⁹ An employer generally is required to report the cost of health coverage provided to an employee on Form W-2.¹⁰⁰

Penalty for claim of excess credit

Present law imposes a penalty of 20 percent on the amount by which a claim for refund or credit exceeds the amount allowable unless it is shown that the claim has reasonable cause.¹⁰¹

Description of Proposal

In general

The proposal establishes a refundable tax credit with respect to eligible health insurance for individuals and their qualifying family members for eligible coverage months. Qualifying family members are the individual's spouse in the case of a joint return, a dependent, and a child who has not attained age 27 as of the end of the taxable year and is covered for the month by the same health insurance plan as the individual or the individual's spouse.¹⁰²

The total credit for a taxable year is the lesser of (1) the sum of the monthly credit amounts described below for the year, subject to reduction based on modified adjusted gross income, as described below, and (2) the amount paid for eligible health insurance for the individual and qualifying family members for eligible coverage months beginning during the year.¹⁰³ Advance payments with respect to the credit may be made during the year directly to the insurer, as discussed below. Alternatively, individuals may choose to pay their total health

⁹⁸ Sec. 6055.

⁹⁹ Sec. 36B(f)(3).

¹⁰⁰ Sec. 6051(a)(14).

¹⁰¹ Sec. 6676. This penalty does not apply to the portion of any claim to which accuracy-related and fraud penalties apply.

¹⁰² In order to claim the credit, married individuals must file a joint return. A dependent, or a child described above, may not claim the credit with respect to the same period for which a credit is claimed by the individual. If a health insurance plan covers a person other than the individual and qualifying family members, rules similar to the rules of section 213(d)(6) apply in allocating the amount paid for the coverage.

¹⁰³ Amounts paid for eligible health insurance may not be taken into account in determining a deduction under section 162(l) or 213 except to the extent they exceed the amount of the credit (plus the amount deposited into an HSA as described below, if applicable). In the case of an individual covered by a QSEHRA, the amount of the credit is reduced by the benefit amount available to an individual under the QSEHRA. The proposal includes rules to coordinate eligibility for the HCTC and the new credit in the case of an individual who is eligible for both.

insurance premiums without advance payments and claim the credit at the end of the taxable year.

Definitions

Eligible coverage month

For purposes of the credit, a month is an eligible coverage month with respect to an individual if, as of the first day of the month, the individual--

- is covered by eligible health insurance,
- is not eligible for other specified coverage,
- is a citizen or national of the United States or a qualified alien,¹⁰⁴ and
- is not incarcerated, other than incarceration pending the disposition of charges.

Eligible health insurance

Eligible health insurance is health insurance coverage¹⁰⁵--

- that is offered in the individual market within a State or is unsubsidized COBRA continuation coverage,¹⁰⁶
- substantially all of such coverage is not of excepted benefits,¹⁰⁷
- that does not include coverage relating to abortions, other than an abortion necessary to save the life of the mother or an abortion with respect to a pregnancy that is the result of an act of rape or incest,¹⁰⁸ and

¹⁰⁴ Qualified alien is defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641).

¹⁰⁵ Health insurance coverage is defined in section 9832(b).

¹⁰⁶ Individual health insurance market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. COBRA continuation coverage generally means continuation coverage provided under section 4980B, sections 601-608 of the Employee Retirement Income Security Act of 1974, or Title XXII of the PHS Act, temporary continuation coverage under the Federal Employees Health Benefit Program, or coverage under a State program that provides comparable continuation coverage. It does not include coverage under a health flexible spending arrangement. Unsubsidized COBRA continuation coverage' means COBRA continuation coverage no portion of the premiums for which are subsidized by the employer.

¹⁰⁷ Excepted benefits is defined in section 9832(b).

¹⁰⁸ For purposes of this restriction, the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion is not considered an abortion. In addition, nothing in the proposal is to be construed as prohibiting any individual from purchasing separate coverage for abortions, or a health plan that includes those abortions, so long as no credit under the proposal is allowed with respect to the premiums for the coverage or plan. In addition, nothing in the proposal restricts any health insurance issuer offering a health plan from offering separate coverage for abortions, or a plan that includes those abortions, so long as

- the State in which the insurance is offered (or, in the case of unsubsidized COBRA continuation coverage under a group health plan, the plan administrator) certifies that the coverage meets the preceding requirements.¹⁰⁹

Other specified coverage

Other specified coverage is (1) coverage under a group health plan,¹¹⁰ other than COBRA continuation coverage or coverage under a plan substantially all of the coverage of which is of excepted benefits, (2) Part A Medicare coverage, (3) Medicaid coverage, (4) coverage under the Children’s Health Insurance Plan (“CHIP”), (5) military-related medical coverage, including coverage under the TRICARE program, (6) coverage under a veterans health care program, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury,¹¹¹ (7) coverage under a health plan for Peace Corps volunteers, or (8) coverage under the Nonappropriated Fund Health Benefits Program of the Department of Defense.

Credit amount

The monthly credit amount applicable with respect to an individual is 1/12 of an annual amount that varies with the age of the individual as follows:

| Age of individual¹ | Under age 30 | Has attained age 30 but under age 40 | Has attained age 40 but under age 50 | Has attained age 50 but under age 60 | Has attained age 60 (and is not eligible for Medicare) |
|--------------------------------------|---------------------|---|---|---|---|
| Annual credit amount | \$2,000 | \$2,500 | \$3,000 | \$3,500 | \$4,000 |

¹ Age for this purpose is determined as of the beginning of the taxable year.

In general, the monthly credit amount for a family is the sum of the monthly credit amounts applicable with respect to the five oldest family members with respect to whom monthly credit amounts are available. The maximum credit amount with respect to a family for

premiums for the separate coverage or plan are not paid for with any amount attributable to the credit under the proposal.

¹⁰⁹ A State certification will not be taken into account for this purpose unless the certification is made available to the public and meets such other requirements as the Secretary may provide. A certification relating to COBRA coverage must meet requirements provided by the Secretary.

¹¹⁰ Group health plan is defined in section 5000(b)(1).

¹¹¹ An individual is not treated as eligible for this coverage unless enrolled in the coverage.

a taxable year is \$14,000.¹¹² In addition, the credit amount otherwise determined for a taxable year under this rule is reduced (but not below zero) by 10 percent of the excess (if any) of (1) the individual's modified adjusted gross income for the taxable year, over (2) \$75,000 (twice this amount in the case of a joint return).¹¹³ For this purpose, modified adjusted gross income means adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad, (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the individual's social security benefits not included in gross income.

The total credit for a taxable year cannot exceed the amount paid for eligible health insurance for the individual and qualifying family members eligible for coverage months beginning during the year. If the amount paid for the insurance is less than the maximum credit amount described above and the individual or a qualifying family member is eligible to contribute to a health savings account ("HSA") for the year, at the request of the individual, the Secretary may deposit the excess into the HSA (or among one or more HSAs) of the individual or a qualifying family member as designated by the individual.¹¹⁴ The deposit is generally treated as a rollover, and the amount deposited is not taken into account for purposes of the limits on HSA contributions.

Advance payments and reconciliation

The proposal directs the Secretary, in consultation with the Secretary of HHS, the Secretary of Homeland Security, and the Commissioner of Social Security, to establish a program not later than January 1, 2020, for making payments to providers of eligible health insurance on behalf of individuals eligible for the credit (an "advance payment" program). The aggregate advance payments made with respect to any individual, determined as of any time during any calendar year, must not exceed the monthly credit amounts determined with respect to the individual under the proposal for completed months during the year.

The program established for making advance payments is, to the greatest extent practicable, to use the methods and procedures used to administer the programs created under the rules relating to advance payments of the present-law premium assistance credit (as in effect before repeal by another proposal), and each entity required to take any actions under those programs is, at the request of the Secretary, to take those actions to the extent necessary to carry out the advance payment program under the proposal. Except as otherwise provided by the

¹¹² For years after 2020, the monthly and maximum credit amounts are increased to reflect increases in cost-of-living based on the consumer price index ("CPI") plus one percentage point, with the result rounded to the nearest multiple of \$50.

¹¹³ For years after 2020, the modified adjusted gross income amount is increased to reflect increases in cost-of-living based on the consumer price index ("CPI") plus one percentage point, with the result rounded to the nearest multiple of \$50.

¹¹⁴ If the individual (or, in the case of a joint return, either spouse) has a seriously delinquent tax debt, as defined in section 7345(b), that has not been fully satisfied, the Secretary will not make any HSA deposit, and if the beneficiary of the designated HSA has a seriously delinquent tax debt, the Secretary will not make a deposit to that HSA.

Secretary, in making advance payments with respect to eligible health insurance that is not enrolled in through an Exchange, the rules relating to advance payments of the present-law premium assistance credit are to be applied by treating references to an Exchange as references to the provider of the eligible health insurance (or, as the Secretary determines appropriate, to the licensed agent or broker with respect to the insurance).¹¹⁵

The advance payment program is to provide that any individual applying to have payments made on their behalf under the program must, if the individual (or any qualifying family member taken into account in determining the amount of the credit) is employed, submit a written statement from each employer of the individual or qualifying family member stating whether the individual or qualifying family member (as the case may be) is eligible for other specified coverage in connection with the employment. An employer must, at the request of any employee, provide such a statement at the time, and in the form and manner, as the Secretary may provide.¹¹⁶

If an individual receives advance payments under the proposal for a taxable year, the credit amount for which the individual would otherwise be eligible is reduced (but not below zero) by the aggregate amount of the advance payments for months beginning in the taxable year. If the aggregate amount of the individual's advance payments for months beginning in the taxable year exceed the credit amount for which the individual is eligible (before the previously described reduction), the individual's tax liability for the year is increased by the excess.

Reporting

Provider of eligible health insurance

Under the proposal, any person who provides eligible health insurance for any month of any calendar year with respect to any individual is required to report certain information to the IRS, generally at the time prescribed by the Secretary. However, in the case of an individual with respect to whom payments are made under the advance payment program, the reports to the IRS must be made on a monthly basis. The required reporting is to be in the form prescribed by the Secretary and must include the following information with respect to each policy of eligible health insurance:

- the name, address, and tax identification number of each individual covered under the policy,
- the premiums paid with respect to the policy,
- the amount of advance payments made on behalf of the individual,

¹¹⁵ As under present law, the proposal includes authority for the IRS to disclose a limited amount of return information for purposes of determining eligibility for the new credit and certain State health subsidy programs. In addition, for insurance not purchased from an Exchange, the proposal would permit the disclosure to the provider of the insurance, the amount of any advance payment for which the taxpayer may be eligible.

¹¹⁶ An employer may be subject to a reporting penalty if failing to provide the statement as required.

- the months during which the health insurance is provided to the individual,
- whether the policy constitutes a high deductible health plan, and
- any other information prescribed by the Secretary.

The same information must be provided to the individual, on or before January 31 of the year following the calendar year to which it relates, and must also include the name and address of the person required to report and the phone number of the information contact for that person.

Employer

Under the proposal, an employer is required to report on the Form W-2 of an employee each month with respect to which the employee is eligible for other specified coverage in connection with employment by the employer.

Penalty for claim of excess credit

The proposal increases the penalty imposed on claims for refund or credit in excess of the amount allowable to 25 percent in the case of a claim relating to the refundable tax credit for health insurance coverage.

Effective Date

The proposal is effective for months beginning after December 31, 2019, in taxable years ending after that date.

O. Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-Pocket Limitation

Present Law

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage) may establish a health savings account (“HSA”).¹¹⁷ Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an “above-the-line” deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.¹¹⁸ Distributions from an HSA for qualified medical expenses are not includible in gross income.

HSA contributions for a year are subject to basic dollar limits that are adjusted annually as needed to reflect annual cost-of-living increases. For 2017, the basic limit on contributions that can be made to an HSA for a year is \$3,400 in the case of self-only coverage and \$6,750 in the case of family coverage.¹¹⁹ The basic contribution limits are increased by \$1,000 for an eligible individual who has attained age 55 by the end of the taxable year (referred to as “catch-up contributions”).¹²⁰ All HSA contributions are aggregated for purposes of the contribution limits.¹²¹ The annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (that is, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual’s status and health plan coverage as of the first day of the month.¹²²

A minimum annual deductible amount and a maximum on the sum of the annual deductible and out-of-pocket expenses (such as co-pays) apply to high deductible health plans, which are adjusted annually as needed to reflect cost-of-living increases. For 2017, the minimum deductible is \$1,300 in the case of self-only coverage and \$2,600 in the case of family coverage. In addition, for 2017, the sum of the deductible and out-of-pocket expenses must be

¹¹⁷ Sec. 223.

¹¹⁸ Secs. 106(d), 125, 3121(a)(2), 3231(e)(1), 3306(b)(2), 3401(a)(22).

¹¹⁹ Under section 4973, an excise tax applies to contributions in excess of the maximum contribution amount for the HSA. The excise tax generally is equal to six percent of the cumulative amount of excess contributions that are not distributed from the HSA.

¹²⁰ Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

¹²¹ In addition, contributions to Archer MSAs under section 220 reduce the annual HSA contribution limit.

¹²² Under a special rule, an individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual for every month in the taxable year for purposes of computing the annual limit. Thus, the individual may contribute the maximum annual amount. However, if the individual ceases to be an eligible individual within a certain period, contributions that could not otherwise have been made are generally includible in income and are subject to a 10-percent additional tax.

no more than \$6,550 in the case of self-only coverage and no more than \$13,100 in the case of family coverage.

Description of Proposal

The proposal increases the basic limit on aggregate HSA contributions for a year to equal the maximum on the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan, which are, for 2017, \$6,550 in the case of self-only coverage and \$13,100 in the case of family coverage. As under present law, basic contribution limits are increased by \$1,000 for an eligible individual who has attained age 55 by the end of the taxable year. In addition, as under present law, the annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (that is, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month.

Effective Date

The proposal applies for taxable years beginning after December 31, 2017.

P. Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account

Present Law

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage) may establish an HSA. HSA contributions for a year are subject to basic dollar limits that are adjusted annually as needed to reflect annual cost-of-living increases. The basic contribution limits are increased by \$1,000 for an eligible individual who has attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). If eligible individuals are married to each other and either spouse has family coverage, both spouses are treated as having only family coverage, so that the contribution limit for family coverage applies. The contribution limit (without regard to any catch-up contribution amounts) is divided equally between the spouses unless they agree on a different division.

If both spouses of a married couple are eligible individuals, each may contribute to an HSA, but they cannot have a joint HSA.¹²³ Under the rule described above, however, the spouses may divide their basic contribution limit for the year by allocating the entire amount to one spouse to be contributed to that spouse’s HSA.¹²⁴ This rule does not apply to catch-up contribution amounts. Thus, if both spouses are at least age 55 and eligible to make catch-up contributions, each must make the catch-up contribution to his or her own HSA.¹²⁵

Description of Proposal

Under the proposal, if both spouses of a married couple are eligible for catch-up contributions and either has family coverage, the annual contribution limit that can be divided between them includes catch-up contribution amounts of both spouses. Thus, for example, the spouses can agree that their combined basic and catch-up contribution amounts are allocated to one spouse to be contributed to that spouse’s HSA. In other cases, as under present law, a spouse’s catch-up contribution amount is not eligible for division between the spouses; the catch-up contribution must be made to the HSA of that spouse.

Effective Date

The proposal applies for taxable years beginning after December 31, 2017.

¹²³ Notice 2004-50, 2004-2 C.B. 196, Q&A-63.

¹²⁴ Notice 2004-50, Q&A-32. Funds from that HSA can be used to pay qualified medical expenses for either spouse on a tax-free basis. Notice 2004-50, Q&A-36.

¹²⁵ Notice 2008-59, 2008-2 C.B. 123, Q&A-22.

Q. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account

Present Law

Distributions from an HSA for qualified medical expenses are not includible in gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 20 percent. The 20-percent additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (that is, age 65).

In order for a distribution from an HSA to be excludible as a payment for a qualified medical expense, the medical expense must be incurred on or after the date that the HSA is established.¹²⁶ Thus, a distribution from an HSA is not excludible as a payment for a qualified medical expense if the medical expense is incurred after a taxpayer enrolls in a high deductible health plan but before the taxpayer establishes an HSA.

Description of Proposal

Under the proposal, if an HSA is established during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins, then the HSA is treated as having been established on the date coverage under the high deductible health plan begins for purposes of determining if an expense incurred is a qualified medical expense. Thus, if a taxpayer establishes an HSA within 60 days of the date that the taxpayer's coverage under a high deductible health plan begins, any distribution from an HSA used as a payment for a medical expense incurred during that 60-day period after the high deductible health plan coverage began is excludible from gross income as a payment for a qualified medical expense even though the expense was incurred before the date that the HSA was established.

Effective Date

The proposal applies with respect to coverage beginning after December 31, 2017.

¹²⁶ Notice 2004-2, 2004-1 C.B. 269, Q&A-26.