HEALTHCARE

TAX INCENTIVES FOR INDIVIDUALS

Wolters Kluwer

HEALTH CARE: Tax Incentives For Individuals

Health care costs continue to outpace inflation and many Americans worry about how they will pay for not only health insurance but many related expenses. In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA). Both bills overhaul the nation's delivery of health insurance. Health care reform impacts everyone: working individuals, retirees, individuals with special needs, businesses, non-profits, and government employers. Many of the reforms take effect in 2014; others are subject to a gradual phase-in period. Additionally, many other provisions in the Tax Code can help individuals and businesses manage their health care expenses. The Tax Code includes a variety of incentives, credits and deductions to help make the cost of health care more affordable for individuals.

This guide highlights some of the key incentives for individuals and key provisions of the health care reform acts. You'll learn about:

- Deductible medical expenses;
- Health flexible spending arrangements (health FSAs);
- Health Savings Accounts;
- COBRA and COBRA continuation coverage;
- Health care reform and
- More.

DEDUCTING MEDICAL EXPENSES

The definition of "medical expense" for federal tax purposes is fairly broad. Generally, the expense must be to primarily alleviate or prevent a physical or mental defect or illness.

Deductible medical expenses include amounts paid for:

- The diagnosis, cure, mitigation, treatment, or prevention of disease; and
- The costs of treatments affecting any part or function of the body.

You can also include in medical expenses amounts paid for dental treatment, vision care, and, in many cases, mental health care.

Medical equipment and supplies

The costs of equipment, supplies and diagnostic services related to medical care generally qualify as a medical expense. Deductible expenses for medical equipment may include the use of special therapeutic devices, such as special controls on automobiles.

Equipment may also take the form of an addition to your home; for example, medical expense deductions have been allowed for installing elevators in the homes of persons suffering from heart disease. If the addition or improvement does not increase the value of the home, the entire cost of the addition or improvement is deductible as a medical expense. However, if the value of the home is increased, then the amount of the medical expense deduction is limited to the excess of the cost of the addition or improvement over the increase in the value of the home. Other qualified expenses may include removing structural barriers in a home to accommodate a physically-challenged person.

Costs for the blind and deaf

The costs of special items and equipment used by a blind or deaf taxpayer are deductible as medical expenses. This includes the costs of purchasing, training, and keeping a seeing-eye guide dog and other service animals as well as special telephone equipment for the hearing-impaired. The excess cost of braille books and magazines over the cost of the same printed material is deductible.

> ***Example.*** Amanda is vision-impaired. Amanda purchases a book that is printed in Braille at a cost of $35. The same book not printed in Braille costs $22. The $13 excess cost for the Braille book is deductible as a medical expense.

Nonqualifying expenses

Some common expenses do not qualify. These include expenditures to improve or preserve your general health, such as the costs of a vacation trip, non-prescription vitamins, or a gym membership. Funeral expenses are not medical expenses.

AGI limitations

While medical expenses may be deductible, there are two very important limitations. Medical expenses are deductible only to the extent they (1) are not compensated for (reimbursed) by insurance or otherwise, and (2) exceed 10 percent of your adjusted gross income (AGI).

> ***Caution.*** The PPACA raised the threshold from 7.5 percent of AGI to 10 percent of AGI for regular income tax purposes beginning in 2013. Individuals age 65 and older (and their spouses) are temporarily exempt from the increase.

If you are reimbursed more than your medical expenses, you may have to include the excess in income. If you are reimbursed in a later year for medical expenses you deducted in an earlier year, special rules apply.

Example. Debra and Paul are married. They file a joint federal tax return, on which they report an adjusted gross income of $42,000. During the year, they paid doctor and dental bills totaling $4,900, of which $1,000 was reimbursed by medical care insurance. They also spent $300 for prescribed medicines and drugs not compensated by insurance and paid after-tax medical care insurance premiums of $3,500 for the year.

- Doctor and dental bills (not compensated by insurance): $3,900;
- Medical care insurance premiums: $3,500;
- Drug expenses (not compensated by insurance): $300;
- Total medical expenses subject to 10 percent limit: $7,700;
- Less: 10 percent of $42,000: $4,200;
- Allowable medical expense deduction: $ 3,500.

Reminder. The medical expense deduction can be claimed only as an itemized deduction on Schedule A, Form 1040. Some taxpayers may be better off taking the standard deduction.

Income phaseouts

Beginning in 2013, higher income individuals are subject to a phaseout of their itemized deductions but medical expenses are exempt from this phaseout. You may also be liable for the alternative minimum tax (AMT). In this case, medical expenses are deductible for AMT purposes to the extent that they exceed 10 percent of AGI.

Medical care insurance

The cost of medical care insurance, including supplementary medical insurance under Medicare, is deductible as a medical expense subject to the 10 percent AGI limitation, with the temporary exception for individuals age 65 and over. Special rules apply depending on the type of medical insurance involved. Special rules also apply to self-employed individuals.

Of course, any portion of insurance premiums either paid for by an employer

tax-free or by an employee pre-tax cannot also be deductible as a medical expense.

Generally, the premium cost of accident or health insurance is a deductible medical expense. However, you may be able only to deduct a portion if the premium is for multipurpose accident and health insurance. The deductible medical expense is limited to that portion of the premium paid for medical care expenses.

Premiums paid by an individual before age 65 for medical care insurance for himself, his spouse, or a dependent after he reaches age 65 are deductible in the year paid if the premiums are payable in equal yearly payments or more often.

Medicare. Medicare B payments are deductible as medical care insurance. However, the part of the Social Security tax that covers basic Medicare (Medicare A) is not deductible (with some very limited exceptions).

Medicines and drugs

Medicines and drugs must be prescribed by a physician or other professional to be deductible as a medical expense. If a physician recommends a medication but does not write a prescription, the medication is not a deductible medical expense. If a medication can be purchased over-the-counter without a prescription, it is not a deductible medical expense.

There is one important exception to the prescription-only rule: insulin. Additionally, the prescription requirement does not apply to items that are not medicines or drugs, so some non-prescription items are deductible. This would cover items such as crutches and bandages.

A medication must be obtained legally to be deductible and must be prescribed by a physician. The IRS treats many types of medical and mental health professionals as physicians, including doctors of medicine or osteopathy, dentists, and doctors of psychiatry.

> ***Comment.*** The rules for the medical expense deduction are similar to the rules for health FSAs and HSAs (discussed below) but there are some differences.

Travel expenses

Frequently, individuals must travel to meet with a health care specialist or undergo treatment at a particular hospital or clinic. Expenses for lodging away from home are deductible as a medical expense. No more than $50 per night per person may be counted as a medical expense. However, what you spend on food is not deductible as a medical expense.

Out-of-pocket expenses. Your out-of-pocket travel expenses for medical care are generally deductible medical expenses. These include the costs of transportation (for example, airline or train

tickets). If you use your vehicle for medical travel, you can deduct most operating expenses or deduct 24 cents per mile for 2013 (23.5 cents per mile for 2014), plus tolls and parking fees.

> ***Caution.*** Travel cannot be merely for the general improvement of your health or morale even if you make the trip on the advice of a doctor to be deductible as a medical expense.

Hospitals and other institutions

The cost of caring for a patient in a hospital, including the cost of meals and lodging, is a deductible medical expense. Generally, the cost of institutional care for the severely handicapped or disabled individual is deductible as a medical expense. However, there is no flat rule for determining the extent to which expenses for care in an institution other than a hospital are deductible as medical expenses. Each situation involving institutional care has to be considered separately.

Mentally/physically handicapped persons. The cost of maintaining a mentally or physically handicapped person at a special school, including tuition, meals, and lodging, has been held to be a deductible medical expense.

Drug/alcohol abuse treatment. The cost of treatment, including meals and lodging, at an alcohol or drug

therapeutic center, has been held to be a deductible medical expense.

Nursing homes. Many of the costs of maintaining an individual at a nursing home for the aged may qualify if the availability of medical care is the principal reason for the person's presence in the nursing home. If the person is there for personal or family reasons, only the cost of medical care may qualify.

Spouses and dependents

You may deduct medical expenses paid on behalf of yourself, your spouse and dependents, such as your children. In determining dependency status for purposes of the medical expense deduction, the dependent must satisfy a relationship and support test. In some cases, an elderly parent may qualify as a dependent if you are also paying over half of their expenses, irrespective of where they are living.

A child of divorced or legally separated parents is normally the dependent of

the custodial parent, but, for purposes of the medical expense deduction, the child may be treated as the dependent of each parent. Therefore, the parent who pays a child's medical expenses can deduct the expenses without regard to whether the child is her dependent.

Cosmetic surgery

Cosmetic surgery is a complicated area. Generally, your expenses for cosmetic surgery or similar procedures are *not* deductible as a medical expense. This includes hair removal, hair transplants, liposuction, and face lift operations. However, they may be deductible if the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.

> ***Example.*** Clara had breast reconstruction surgery after having a mastectomy. The IRS has ruled that breast cancer is a disfiguring disease and the cost of breast reconstruction surgery after a mastectomy as a treatment for breast cancer is a deductible medical expense.

Weight loss programs

Weight loss programs may be deductible if you undertake the program to treat a specific disease (including obesity), which is diagnosed by a physician. However, the costs of weight loss programs are not deductible if you undertake the program merely to improve your appearance or general health.

Substantiation

Medical expenses must be substantiated or the IRS can deny your deduction. This means that if the IRS asks you to verify them, you must be able to. You must provide the name and address of each person/entity to whom payment for medical expenses was made, and the amount and date of the payment.

In addition, when substantiation is requested by the IRS, you must provide a statement or itemized invoice from the individual or entity to which payment for medical expenses was paid, showing the name of the person receiving the medical care, describing the nature of the services, the nature and purpose of any other expense, and the amount and date of payment, as well as any other information the IRS may deem necessary. The burden of proof is on you to show entitlement to a medical care deduction.

HEALTH FSAs

Many employers offer health flexible spending arrangements (also known as flexible spending accounts) (FSA). A health FSA allows employees to pay for eligible out-of-pocket health care and dependent care expenses with pre-tax dollars through a voluntary salary reduction agreement.

Neither federal income nor employment taxes are deducted from the contribution. The employer may also contribute.

However, there is a very important limitation. There is a tough "use or lose rule." Furthermore, the employer must take the incentive to act on a health FSA. Individual employees, by themselves, cannot set up a health FSA. Self-employed individuals also cannot create an FSA.

Medications. Taxpayers may use health FSA dollars for prescribed medicines (including prescribed OTC medicine) and insulin, but not for non-prescribed OTC medicines.

Comment. The OTC rules for health FSAs also apply to health savings accounts (HSAs) (discussed below) and Archer Medical Savings Accounts.

■ ***Planning Tip.*** When planning how much money to set aside for your 2014 health spending, individuals should take this change in treatment into account. Remember that health FSAs are subject to a strict "use-it-or-lose-it" rule (discussed below).

Caution. Don't confuse health FSAs with another form of FSAs: dependent care FSAs. A dependent care FSA can be used to pay for the costs of day care, summer day camp, and for the care of a physically or mentally incapacitated dependent of any age.

Employer-provided debit and credit cards

Health FSA reimbursements may be made through the use of employer-provided debit cards, credit cards, or other electronic media. The program ensures that reimbursements are for medical care.

Use-it-or-lose-it rule

A health FSA may not defer compensation. Consequently, no contribution or benefit from an FSA may be carried over to any subsequent plan year or period of coverage. Unused benefits or contributions remaining at the end of the plan year (or at the end of a grace period, if applicable), are forfeited. This is known as the "use-it-or-lose-it" rule.

Example. Barry elects coverage under a health FSA providing coverage of up to $2,000 in eligible expenses during 2014. Through a salary reduction agreement, Barry has a specified amount per month taken out of his paycheck. If, during the course of 2014, Barry has only $1,900 in eligible health expenses, he must generally

forfeit $100 in unused benefits. Barry cannot receive the $100 in the form of cash or any other taxable or non-taxable benefit.

Grace period or carryover. There is a limited exception to the use-it-or-lose-it rule. A plan that establishes the FSA may allow for a grace period of up to 2 1/2 months following the end of each plan year before amounts are forfeited. Expenses an employee incurs during the grace period may be paid or reimbursed from benefits or contributions that remain unused at the end of the immediately preceding plan year. Alternatively, a play may allow up to $500 of unused amounts remaining at the end of the plan year to be paid or reimbursed for expenses incurred during the following plan year. A plan may allow either the grace period or a carryover, but not both.

Contribution limitations. Annual contributions to a health FSA are limited to a maximum of $2,500. This amount is adjusted for inflation after 2013, but remains at $2,500 for 2014.

HEALTH SAVINGS ACCOUNTS

Many individuals mistakenly believe that a health savings account (HSA) is something they purchase, like health insurance. It is not. It is a savings account set up by the individual's employer or created through a bank, credit union or insurance company. Unlike a savings account that an individual opens at a bank, an HSA is generally only available to individuals who are covered by a high deductible health plan (HDHP). HSAs allow qualified individuals to save to cover medical expenses on a tax-free basis.

HDHPs. Individuals generally must be enrolled in a high deductible health plan (HDHP) to be eligible for an HSA. Eligibility for an HSA is determined on a monthly basis. An eligible taxpayer is generally any individual who, on the first day of the month, is covered under an HDHP. If taxpayers who are married both have family coverage under separate plans, they are both treated as having family coverage. If only one spouse has family coverage, both spouses are treated as having the family coverage.

Many HDHPs cost less than traditional health insurance plans. Typically, an HDHP will not pay for the first several thousand dollars of health care expenses but will cover costs after that threshold is met. Because HDHPs cost less than traditional plans, individuals can use their cost savings to fund an HSA.

Minimum deductibles. For 2013 and 2014, an individual's HDHP minimum deductible must be $1,250 for self-coverage only or $2,500 for family coverage. The annual out-of-pocket (including deductibles and co-pays) for 2013 cannot exceed $6,250 for self-only

coverage ($6,350 for 2014) or $12,500 for family coverage ($12,700 for 2014).

Contributions. Contributions to an HSA may be made by the covered individual, his or her employer, or both. If the individual's employer offers a cafeteria plan, the contributions may be made on a pre-tax basis. In other cases, contributions may be made on an after-tax basis and the employee can take an above-the-line deduction.

> ***Comment.*** Contributions from persons other than the individual's employer are deductible by the individual but they may be subject to gift tax. No deduction is allowed to an individual who can be claimed as a taxpayer's dependent. Additionally, contributions cannot be made by or for an individual who is eligible for Medicare.

For 2013, the maximum annual HSA contribution for an eligible individual with self-only coverage is $3,250 ($3,300 for 2014). For family coverage, the maximum annual HSA contribution is $6,450 ($6,550 for 2014).

Individuals age 55 and older can make "catch-up" contributions. The catch-up amount is $1,000 on top of the regular contribution amount. An individual who is entitled to Medicare cannot make a catch-up contribution.

Contributions to an HSA must be made in cash; they cannot be made in stock

or property. Contributions may be invested to earn tax-free income. Funds in an HSA may be invested in investments approved for IRAs (such as certificates of deposit, stocks, mutual funds, or bonds). HSAs may not invest in life insurance contracts or in collectibles (such as works of art). HSAs may, however, invest in certain types of bullion or coins. The HSA trustee or custodian may also restrict investments to certain types of permissible investments.

Distributions. Distributions are excluded from gross income if they are used to pay the qualified medical expenses of the account beneficiary or the beneficiary's spouse or dependents. On the other hand, distributions not used for qualified medical expenses are included in gross income and are generally subject to an additional penalty.

> ***Comment.*** One popular way to access funds in an HSA is through a debit card. The card must restrict payments and reimbursements to health care.

Qualified medical expenses. Qualified medical expenses are generally amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease. The cost of treating any structure or function of the body is also a qualified medical expense, as is the cost of insulin and any medicine prescribed by a health care professional. HSA expenses are qualified medical expenses only to the extent they are not paid for by insurance or otherwise.

Generally, funds in an HSA cannot be used to pay premiums for any insurance. There are some exceptions, including COBRA continuation coverage.

Employer responsibilities

Employers who contribute to an employee's HSA are responsible for determining if the employee is covered under an HDHP. Employers must also comply with a comparability rule. If the employer makes any HSA contributions, it must make available comparable contributions on behalf of all employees with comparable coverage during the same period.

Additional tax. There is an additional tax of 20 percent on HSA distributions that are not made for qualified medical expenses.

COBRA

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) providing certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. The continuation coverage must be identical to the coverage provided to similarly situated beneficiaries. However, the continuation coverage is only available when coverage is lost due to specific events, such as job loss.

The upside of COBRA is that continuation of group coverage is generally less expensive than individual coverage. The downside is that the individual pays the entire premium for coverage.

Qualifying events. Qualifying events are certain events that cause an individual to lose health coverage. The type of qualifying event determines who the qualified beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.

For COBRA continuation coverage, termination of employment includes voluntary resignations and retirements, as well as firings if the employee was not fired for gross misconduct. A strike, a lockout or a layoff may also be a qualifying event.

Employers and plans required to provide COBRA continuation coverage and that fail to do so risk incurring an excise tax. The excise tax is generally $100 per day for each qualified beneficiary for whom there has been a failure to extend coverage. The IRS will not impose a tax if the failure to provide continuation coverage is due to reasonable cause and is corrected within 30 days.

Small employers. COBRA generally does not apply to small-employer plans, church plans, and government plans. A small employer is one with fewer than 20 employees. However, so-called state "mini-COBRAs" may require small employers to offer COBRA continuation coverage.

Duration. Generally, COBRA continuation coverage is available for 18 months. Disability can extend the period of coverage. COBRA coverage may end earlier if:

- Premiums are not paid on a timely basis;
- The employer no longer has a group health plan;
- Coverage is obtained through another employer group health plan; or
- A beneficiary becomes eligible for Medicare.

> ***Comment.*** Some individuals eligible for COBRA coverage may also be eligible for a Health Coverage Tax Credit (HCTC) (discussed below).

HEALTH COVERAGE TAX CREDIT

Congress created the refundable Health Coverage Tax Credit (HCTC) as part of the Trade Adjustment Act of 2002 (TAA) to help trade-displaced workers continue health care coverage. Individuals age 55 to 64 receiving benefits from the Pension Benefit Guaranty Corporation (PBGC) may also be eligible for the HCTC. Additionally, individuals must be enrolled in a qualified health plan.

Individuals can receive the HCTC either monthly as their premium becomes due or yearly as a credit on their federal tax return. Individuals electing a monthly credit receive an invoice from the IRS each month.

The legislation that authorized the HCTC has expired. The credit is not available for tax years after 2013.

HEALTH CARE REFORM

Congress enacted comprehensive health care reform in early 2010. The PPACA and the HCERA implement health care reform over a period of years. Many provisions go into effect in 2013 and 2014.

Comment. The U.S. Treasury Department along with the U.S. Departments of Health and Human Services (HHS) and Labor (DOL) are the primary federal agencies responsible for implementing health care reform. In many cases, the three departments issue joint rules. The IRS also has an important role to play in the implementation, administration and enforcement of the tax provisions in the PPACA and the HCERA.

INDIVIDUAL RESPONSIBILITY

Beginning in 2014, individuals who do not carry minimum essential health coverage will be subject to a penalty. Generally, individuals covered by their employers will be deemed to have minimum essential coverage. Additionally, individuals covered by Medicare, Medicaid, and other government programs will not be liable for the penalty. The PPACA also exempts individuals who cannot afford coverage and individuals who do not carry health insurance because of religious reasons.

Comment. The amount of the penalty is calculated under a complex formula. Taken into account are a flat dollar amount and the individual's income. The penalty is also capped at certain amounts.

Comment. The United States Supreme Court upheld the individual mandate in *NFIB v. Sebelius*, June 28, 2012. In a 5-4 decision, the Supreme Court found that the individual mandate is a valid exercise of Congress' taxing power.

Employers. The PPACA does not mandate that employers provide health insurance coverage to their employees. However, employers that do not offer minimum essential coverage (measured against a government benchmark) may be subject to a penalty after 2013. The penalty provisions have been delayed for certain employers and transition rules apply. The PPACA provides a special tax credit to encourage small employers to offer health insurance and also will allow small employers to purchase insurance through state insurance exchanges.

Tax credit. To help individuals obtain coverage, the PPACA provides for a health insurance premium assistance tax credit. The credit will be available after 2013 to qualified individuals who obtain coverage through a state-based health insurance exchange and in limited other circumstances. Eligibility for the credit will depend on an individual's income, family size and other factors.

HEALTH INSURANCE EXCHANGES

The PPACA requires states to create insurance exchanges by January 1, 2014. The exchanges will make available insurance to individuals and qualified employers (generally small employers).

Grandfathered plans

Generally, health insurance plans in existence on the date of enactment of the PPACA (March 23, 2010) are exempt from many requirements of the new law. They are known as "grandfathered plans." However, the PPACA does place some restrictions on grandfathered plans. If they violate these rules, they risk losing their grandfathered status. Grandfathered plans cannot:

- Significantly cut or reduce benefits
- Raise co-insurance charges
- Raise co-payment charges; and
- Take certain other impermissible actions.

CHILDREN

Insurance coverage. The PPACA requires plans and issuers that offer insurance coverage to children on their parents' plans to make the coverage available until the adult child reaches the age of 26.

Until 2014, "grandfathered" group plans do not have to offer dependent coverage up to age 26 if the young adult is eligible for group coverage outside of his or her parent's plan. Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her job).

Tax treatment. Under the PPACA, the value of any employer-provided health coverage for an employee's child is excluded from the employee's income through the end of the tax year in which the child turns 26. It is no longer necessary that the child of the employee be a dependent of the employee to qualify for the exclusion. If a child is age 26 or less at the end of the tax year, the exclusion applies even if the child does not live with the employee or provides more than one-half of his or own support. This new rule also applies to

self-employed individuals who qualify for the self-employed health insurance deduction on their federal income tax return.

- A "child" for purposes of this new treatment is:
- Son, daughter, stepson, stepdaughter of the taxpayer; and
- A foster child or legally adopted child (including child placed with taxpayer pending adoption).

Example. Anita is employed by ABC Co, which provides health care coverage for its employees and their spouses and dependents and for any employee's child who has not attained age 27 as of the end of the tax year. For the 2014 tax year, ABC provides health care coverage to Anita and her son, Emilio, who will not attain age 27 until after the end of the 2014 tax year. Because Emilio will not attain age 27 during the 2014 tax year, the health care coverage and reimbursements for Emilio under ABC's plan are excludible from Anita's gross income.

Comment. Some employers may decide to continue coverage beyond the child's 26th birthday. In such a case, the PPACA provides that the value of the employer-provided health coverage is excluded from the employee's income for the entire taxable year in which the child turns 26. Thus, if a child turns 26 in March but stays on the plan through December 31 (the end of most people's tax year), all health benefits provided that year are excluded for income tax purposes.

HIGH-COST PLANS

After 2017, the PPACA imposes a 40 percent excise tax on high-cost health insurance plans (so called "Cadillac" plans). The tax is imposed to the extent that the aggregate value of employer-provided health insurance exceeds a threshold amount. The threshold amounts are $10,200 for self-only coverage and $27,500 for family coverage. The coverage provider is responsible for paying the tax.

Comment. The threshold amounts will be adjusted for inflation and age/gender and other factors using a complex formula.

Comment. The thresholds will be higher for senior citizens and individuals in certain high-risk occupations, such as law enforcement.

MEDICARE TAX CHANGES

The PPACA makes two changes to Medicare (HI) tax that affects higher-income individuals. The PPACA imposes an additional 0.9 percent additional Medicare tax on single individuals who receive wages in respect to employment in excess of $200,000 ($250,000 for a married couple filing a joint return). The PPACA also imposes a 3.8 percent surtax on the lesser of an individual's net investment income for the tax year or any excess of modified AGI in excess of $200,0000 for an individual

($250,000 for a married couple filing a joint return).

Comment. The employee's portion of Medicare tax is 1.45 percent and the employer's portion of Medicare (HI) is 1.45 percent for a total of 2.9 percent.

Comment. The additional 0.9 percent Medicare tax, unlike the general 1.45 percent Medicare tax, is on the combined wages of the employee and the employee's spouse in the case of a joint return. Additionally, the employee is personally liable for the additional 0.9 percent Medicare tax if it is not withheld by the employer. This contrasts with the employee portion of the Medicare tax of 1.45 percent of wages for which the employee generally has no direct liability.

REPORTING EMPLOYER-PROVIDED HEALTH COVERAGE

The PPACA requires employers to report the cost of coverage under an employer-sponsored group health plan. All employers except small employers (generally employers filing fewer than 250 W-2s) are required to satisfy the reporting requirement. Reporting is for informational purposes only.

PREVENTIVE SERVICES

The PPACA requires new plans and issuers to cover certain preventive services without any cost-sharing when delivered by in-network providers. Some examples of preventive services are:

- Screenings for diabetes, high cholesterol and high blood pressure;
- Tobacco cessation counseling;
- Womens' health services; and
- Routine childhood immunizations and other preventive services for children.

Comment. Grandfathered plans are generally exempt from the new rules for preventive services.

APPEALS

The PPACA enhances the ability of individuals to appeal denials and recissions of coverage. Individuals may appeal decisions made by their health plan through the plan's internal process. Additionally, the PPACA provides for an outside, independent appeal.

MORE PROVISIONS

The PPACA also:

- Prohibits lifetime limits on coverage
- Restricts annual dollar limits on coverage;
- Requires plans to provide "plain English" summaries of benefits;
- Bars pre-existing condition exclusions for children; and
- Bans certain rescissions of coverage.

Comment. Some of these provisions do not apply immediately to grandfathered plans and there are other limitations.

CONCLUSION

Health care costs consume a large portion of many families' budgets. The tax incentives we have discussed can help you save current health care dollars and also plan for future health care costs. Some the savings are significant, especially where children are involved.

Looking ahead, individuals also need to plan for the many changes already implemented or soon to be put in place by health care reform legislation. Individuals covered by grandfathered plans are not expected to see many changes but individuals who change jobs or have other life events, such as childbirth or divorce, may encounter new rules put in place by the health care reform package. Careful planning is all the more important today.