

# ALERT

## House of Representatives passes landmark health reform legislation

Late on March 21, the House of Representatives passed two pieces of legislation that, together, would reform the U.S. health system and impact most employers, virtually all taxpayers, and all segments of the health care industry. First, the House by a vote of 219-212 approved H.R. 3590, the Patient Protection and Affordable Care Act as passed the Senate in December of 2008. Thus, this bill was cleared for signature by the President which subsequently occurred on March 23. Second, the House by a vote of 220 to 211 approved the "Health Care and Education Reconciliation Act of 2010," i.e., the "Amendment in the Nature of a Substitute to H.R. 4872, as amended." The Amendment in the Nature of a Substitute amended the health reform bill that the Senate passed in December to make it more palatable to House members. Assuming this second, "follow-on" bill passes the Senate (only a simple majority is needed under the reconciliation rules), it too will be cleared for the President's signature, thus completing a massive overhaul of the U.S. health care system.

Here are highlights of the House-passed health reform measure based on information released by the House Rules Committee, the House Ways & Means Committee, and the Joint Committee on Taxation.

### Tax Changes Relating to Universal Health Coverage Mandate

***Penalty for remaining uninsured.*** Effective for tax years beginning after Dec. 31, 2013, non-exempt U.S. citizens and legal residents would have to maintain minimum essential coverage, or pay a penalty. Those failing to maintain minimum essential coverage in 2016 would be subject to a penalty equal to the greater of: (1) 2.5% of household income over the threshold amount of income required for income tax return filing, or (2) \$695 per uninsured adult in the household. The fee for an uninsured individual under age 18 would be one-half of the fee for an adult. The total household penalty wouldn't exceed 300% of the per adult penalty (\$2,085), nor exceed



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the national average annual premium for the “bronze level” health plan offered through the Insurance Exchange that year for the household size.

The per adult annual penalty would be phased in as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016. For years after 2016, the \$695 amount would be indexed to CPI-U, rounded to the next lowest \$50. The percentage of income would be phased in as follows: 1% for 2014; 2% in 2015; and 2.5% beginning after 2015. If a taxpayer files a joint return, the individual and spouse would be jointly liable for any penalty payment. The penalty, which would apply to any period the individual does not maintain minimum essential coverage (determined monthly) would be assessed through the Code.

Among those individuals who would be exempted from the penalty: Individuals who cannot afford coverage because their required contribution for employer sponsored coverage or the lowest cost “bronze plan” in the local Insurance Exchange exceeds 8% of household income; those who are exempted for religious reasons; and those residing outside of the U.S.

***Low-income tax credits for participating in health exchanges.*** For tax years ending after 2013, tax credits would be available for individuals and families with incomes up to 400% of the federal poverty level (\$43,420 for an individual or \$88,200 for a family of four) that are not eligible for Medicaid, employer sponsored insurance, or other acceptable coverage. These individuals and families would have to obtain health care coverage in newly established Insurance Exchanges in order to obtain credits. Additionally, effective on the enactment date, a “cost-sharing subsidy” would be provided to low income individuals to help with health insurance costs.

***Employer responsibilities.*** Effective for months beginning after Dec. 31, 2013, an “applicable large employer” (generally, one that employed an average of at least 50 full-time employees during the preceding calendar year) not offering coverage for all its full-time employees, offering minimum essential coverage that is unaffordable, or offering minimum essential coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%, would have to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee. The penalty for any month would be an excise tax equal to the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees



are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of \$2,000.

Also, an applicable large employer that offers, for any month, its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer sponsored plan would be subject to a penalty if any full-time employee is certified to the employer as having enrolled in health insurance coverage purchased through a State exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees.

*“Free choice vouchers.”* After 2013, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage would have to provide qualified employees with a voucher whose value could be applied to purchase of a health plan through the Insurance Exchange. Qualified employees would be those employees: who do not participate in the employer's health plan; whose required contribution for employer sponsored minimum essential coverage exceeds 8%, but does not exceed 9.5% of household income; and whose total household income does not exceed 400% of the poverty line for the family. The value of the voucher would be equal to the dollar value of the employer contribution to the employer offered health plan.

*Tax credits for small employers offering health coverage.* Effective for tax years beginning after 2009, a qualified small employer would be given a tax credit for non-elective contributions to purchase health insurance for its employees. A qualified small business employer for this purpose generally would be an employer with no more than 25 full-time equivalent employees (FTEs) employed during the employer's tax year, and whose employees have annual full-time equivalent wages that average no more than \$50,000. However, the full amount of the credit would be available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than \$25,000. These wage limits would be indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) for years beginning in 2014.

For tax years beginning in 2010 through 2013, the credit would be 35% for small employers with fewer than 25 employees and average annual wages of less than \$50,000 who offer health insurance coverage to their employees. In 2014 and later, eligible small employers who purchase coverage through the Insurance Exchange would be eligible for a tax credit for two years of up to 50% of their contribution.



***Dependent coverage in employer health plans.*** Effective on the enactment date, the health reform measure would extend the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan to any child of an employee who has not attained age 27 as of the end of the tax year. This change would also be intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child. A parallel change would be made for VEBA's and 401(h) accounts. Also, self-employed individuals would be permitted to take a deduction for any child of the taxpayer who has not attained age 27 as of the end of the tax year.

## Health-Related Revenue Raisers

***Excise tax on high-cost employer-sponsored health coverage.*** For tax years beginning after Dec. 31, 2017, the bill would place a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan to the extent that the annual premium exceeds \$10,200 for single coverage and \$27,500 for family coverage. An additional threshold amount of \$1,650 for single coverage and \$3,450 for family coverage would apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions.

The tax would apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). Stand-alone dental and vision plans would be disregarded in applying the tax. The dollar amount thresholds would be automatically increased if the inflation rate for group medical premiums between 2010 and 2018 is higher than the Congressional Budget Office (CBO) estimates in 2010.

Employers with age and gender demographics that result in higher premiums could value the coverage provided to employees using the rates that would apply using a national risk pool.

The excise tax would be levied at the insurer level. Employers would be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

***New employer reporting responsibilities.*** For tax years beginning after Dec. 31, 2010, employers would have to disclose the value of the benefit provided by them for each employee's health insurance coverage on the employee's annual Form W-2.



***Additional Hospital Insurance Tax (HI) for high wage workers.*** For tax years beginning after Dec. 31, 2012, the HI tax rate would be increased by 0.9 percentage points on an individual taxpayer earning over \$200,000 (\$250,000 for married couples filing jointly); these figures are not indexed.

***Surtax on unearned income.*** For tax years beginning after Dec. 31, 2012, a 3.8% surtax called the Unearned Income Medicare Contribution would be placed on net investment income of a taxpayer earning over \$200,000 (\$250,000 for a joint return). Net investment income would be interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income would be reduced by properly allocable deductions to such income.

***New limit on health FSA contributions.*** The amount of contributions to health flexible spending accounts (FSAs) would be limited to \$2,500 per year, effective for tax years beginning after Dec. 31, 2012. The dollar amount would be inflation indexed after 2013.

***Restricted definition of medical expenses for employer provided coverage.*** For purposes of employer provided health coverage (including health reimbursement accounts (HRAs) and health flexible savings accounts (FSAs), health savings accounts (HSAs), and Archer medical savings accounts (MSAs)), the definition of medicine expenses deductible as a medical expense would generally be conformed to the definition for purposes of the itemized deduction for medical expenses. But this change would not apply to doctor prescribed over-the-counter medicine. Thus, the cost of over-the-counter medicine (other than insulin or doctor prescribed medicine) could not be reimbursed through a health FSA or HRA. In addition, the cost of over-the-counter medicines (other than insulin or doctor prescribed medicine) could not be reimbursed on a tax-free basis through an HSA or Archer MSA. These changes would be effective for tax years beginning after Dec. 31, 2010.

***Increased tax on non-qualifying HSA or Archer MSA distributions.*** The additional tax for HSA withdrawals before age 65 that are used for purposes other than qualified medical expenses would be increased from 10% to 20%, and the additional tax for Archer MSA withdrawals that are used for purposes other than qualified medical expenses would be increased from 15% to 20%, both effective for distributions made after Dec. 31, 2010.



**Modified threshold for claiming medical expense deductions.** For tax years beginning after Dec. 31, 2012, the adjusted gross income (AGI) threshold for claiming the itemized deduction for medical expenses would be increased from 7.5% to 10%. However, the 7.5%-of-AGI threshold would continue to apply through 2016 to individuals age 65 and older (and their spouses).

**Deduction for employer Part D would be eliminated.** The deduction for the subsidy for employers who maintain prescription drug plans for their Medicare Part D eligible retirees would be eliminated, for tax years beginning after Dec. 31, 2012.

**Industry-specific revenue raisers.** The following revenue raising changes would be imposed on health related industries:

- A new deduction limit on executive compensation would apply to insurance providers. If at least 25% of the insurance provider's gross premium income is derived from health insurance plans that meet the minimum essential coverage requirements in the bill ("covered health insurance provider"), an annual \$500,000 per tax year compensation deduction limit would apply for all officers, employees, directors, and other workers or service providers performing services for or on behalf of a covered health insurance provider. The limit would apply for remuneration paid in tax years beginning after 2012, with respect to services performed after 2009.
- Pharmaceutical manufacturers and importers would have to pay an annual flat fee beginning in 2011 allocated across the industry according to market share. The schedule for the flat fee would be: 2011, \$2.5 billion; 2012 to 2016, \$3 billion; 2017, \$4 billion; 2018, \$4.1 billion; 2019 and later, \$2.8 billion. The fee would not apply to companies with sales of branded pharmaceuticals of \$5 million or less.
- Manufacturers or importers of medical devices would have to pay a 2.3% of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of the device. A taxable medical device would be any device, defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act, intended for humans. The excise tax would not apply to eyeglasses, contact lenses, hearing aids, and any other medical device determined by IRS to be of a type that is generally purchased by the general public at retail for individual use.



- Health insurance providers would face an annual flat fee on the health insurance sector effective for calendar years beginning after Dec. 31, 2013. The fee would be allocated based on market share of net premiums written for a U.S. health risk for calendar years beginning after Dec. 31, 2012. The schedule for the flat fee would be: 2014, \$8 billion; 2015 and 2016, \$11.5 billion; 2017, \$13.5 billion; 2018, \$14.3 billion and indexed to medical inflation for later years. The fee would not apply to companies whose net premiums written are \$25 million or less.
- The indoor tanning industry would be hit with a 10% excise tax on indoor tanning services, effective for services provided on or after July 1, 2010.
- Non-profit Blue Cross Blue Shield organizations would have to maintain a medical loss ratio of 85% or higher in order to take advantage of the special tax benefits provided to them, including the deduction for 25% of claims and expenses and the 100% deduction for unearned premium reserves. The provision is effective in 2010.

### Non-Health Related Revenue Raisers

*Corporate information reporting.* Businesses that pay any amount greater than \$600 during the year to corporate providers of property and services would have to file an information report with each provider and with IRS, effective for payments made after Dec. 31, 2011.

*Codification of economic substance doctrine and imposition of penalties.* The economic substance doctrine is a judicial doctrine that has been used by the courts to deny tax benefits when the transaction generating these tax benefits lacks economic substance. The courts have not applied the economic substance doctrine uniformly. The manner in which the economic substance doctrine should be applied by the courts would be clarified and a penalty would be imposed on understatements attributable to a transaction lacking economic substance. These changes would be effective for transactions entered into after the enactment date.

*Elimination of credit for "black liquor."* A \$1.01 per gallon tax credit applies for the production of biofuel from cellulosic feedstocks in order to encourage the development of new production capacity for biofuels that are not derived from food source materials. Congress is aware that some taxpayers are seeking to claim the cellulosic biofuel tax credit for unprocessed fuels, such as "black liquor." For fuel



sold or used after Dec. 31, 2009, eligibility for the tax credit would be limited to processed fuels (i.e., fuels that could be used in a car engine or in a home heating application).

***Estimated taxes for large corporations.*** The required corporate estimated tax payments factor for corporations with assets of at least \$1 million would be increased by 15.75 percentage points for payments due in July, August, and September of 2014.

## Other Tax Changes

***Simple cafeteria plans for small businesses.*** For tax years beginning after 2010, a new employee benefit cafeteria plan to be known as a Simple Cafeteria Plan would be established. This plan would be subject to eased participation restrictions so that small businesses could provide tax-free benefits to their employees; it would include self-employed individuals as qualified employees.

***Liberalized adoption credit and adoption assistance rules.*** For tax years beginning after Dec. 31, 2009, the adoption tax credit would be increased by \$1,000, made refundable, and extended through 2011. The adoption assistance exclusion also would be increased by \$1,000.

***New credit for new therapies.*** Effective for expenses paid or incurred after Dec. 31, 2008, in tax years beginning after that date, a two-year temporary credit would be created, subject to an overall cap of \$1 billion, to encourage investments in new therapies to prevent, diagnose, and treat acute and chronic diseases.

***New exclusion for certain health professionals.*** Payments made under any State loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas would be excluded from gross income, effective for amounts received by an individual in tax years beginning after Dec. 31, 2008. (A separate provision would exclude from gross income the value of specified Indian tribal health benefits, effective for benefits and coverage provided after the enactment date.)

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