

Senate approves comprehensive health care bill with \$398 billion tax package

Deloitte Tax Policy Group - December 28, 2009

The Senate voted 60-39 along party lines December 24 to approve comprehensive health care reform legislation financed with a \$398.1 billion revenue package that includes an excise tax on so-called “Cadillac” health plans offered by insurance companies, a payroll tax increase for high-income individuals, and a limit on executive compensation for health insurance providers. The Patient Protection and Affordable Care Act also includes a corporate information reporting provision, about \$10 billion a year in new fees targeting health-related industries, and new requirements for nonprofit hospitals.

Passage of the bill comes after weeks of intense negotiations and wrangling over amendments – often during weekend and late-night sessions – as Majority Leader Harry Reid, D-Nev., worked to hold together the Democratic caucus and secure the 60 votes needed to overcome a series of Republican filibuster threats along the way. Disagreements among Democrats centered primarily over nontax issues, although a manager’s amendment that Reid unveiled December 19 included minor tweaks to the tax title of the legislation he introduced in November.

With passage of the bill, the Senate has completed legislative work for the year, and is scheduled to return to Washington for business on January 19.

Excise tax on high-cost insurance

The bill’s key revenue raiser generally would impose a nondeductible 40 percent excise tax on employer-provided health coverage with an aggregate value that exceeds \$8,500 a year for individuals or \$23,000 for families, for tax years beginning after December 31, 2012. These threshold amounts would be indexed to the Consumer Price Index for Urban Consumers (CPI-U) plus 1 percent beginning in 2014.

Who pays – The excise tax would be imposed on the issuer of the insurance. The plan administrator would pay the tax in the case of a self-insured group health plan, a health flexible spending arrangement (FSA), or a health reimbursement arrangement (HRA). The employer would pay the excise tax when it acts as plan administrator for the same benefit arrangements and with respect to employer contributions to a health savings account (HSA).

Calculation and reporting – The amount subject to the excise tax is the sum of the premiums for health insurance coverage, the amount of salary deductions for health FSAs for the taxable year, and the amount of employer contributions to HSAs, minus the threshold amount. Health insurance coverage includes the premiums for medical, dental, vision, and other supplementary health insurance coverage. The premium for health coverage provided through an HRA is also included in the aggregate amount. The amount subject to the high-premium excise tax does not include fixed indemnity health coverage that is purchased by an employee with after-tax dollars. The provision requires that the employer calculate and report the amount subject to excise tax to each insurer and plan administrator and to the Treasury Secretary. The insurer or plan administrator is then responsible for calculating, reporting, and paying the excise tax. Employers would be penalized for undervaluing the insurance cost subject to the excise tax. The penalty would equal the amount of any additional excise tax that the insurer or administrator would have owed if the employer had reported correctly, plus interest to be accrued from the date the tax otherwise would have been paid to the date the penalty is paid.

Exceptions – The excise tax would phase in for the 17 “highest cost” states. In these states, the excise tax threshold would be increased by 20 percent in the first year, then reduced by half each

year thereafter until the additional premium is eliminated for taxable years beginning after December 31, 2015.

For retired individuals over the age of 55 and for plans that cover employees engaged in high-risk professions, the threshold amount is increased by \$1,350 for individual coverage and \$3,000 for family coverage. High-risk professions include law enforcement officers, firefighters, members of a rescue squad or ambulance crew, longshoremen, and individuals engaged in the construction, mining, agriculture (but not food processing), forestry, or fishing industries. The bill also would exempt plans providing certain excepted benefits under section 9832(c) – for example, coverage only for accident and disability income.

Under the provision, the threshold amount cannot be increased by more than \$1,350 for individual coverage or \$3,000 for family coverage, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high-risk profession.

Effective date – The excise tax would be effective for tax years beginning after December 31, 2012. The Joint Committee on Taxation (JCT) staff estimates that the provision would raise \$148.9 billion over 10 years. Because of the delayed effective date, the provision would raise revenue for only seven of the ten budget years covered under the bill.

Medicare tax hike for high-income individuals

The bill calls for a 0.9 percentage point increase – from 1.45 percent to 2.35 percent – in the Medicare wage tax on employees (but not the portion on employers). The increase would apply to income in excess of \$200,000 for singles and \$250,000 for married couples. These thresholds would not be indexed for inflation. This increase would raise an estimated \$86.8 billion over 10 years, and would apply to wages or self-employment income received, and taxable years beginning, after December 31, 2012.

Under the provision, employers would collect the new liability for wages paid to an employee in excess of \$200,000. The employer would disregard the amount of wages received by an employee's spouse.

If the employer failed to collect the tax, the employee would be liable for the tax. However, the employer would remain liable for penalties or other additions.

In the case of an employee, there would be no matching liability representing the employer's share owed. Similarly, a self-employed individual would only owe the 0.9 percentage point increase. Self-employed individuals would not be permitted to deduct any portion of this increase.

New fees on health-related industries

The bill would impose annual fees on health insurance providers and medical device manufacturers beginning in 2011 and on pharmaceutical manufacturers beginning in 2010. The fees are estimated to raise approximately \$101 billion over 10 years.

- For medical device manufacturers, the annual fee would be \$2 billion for the years 2011 through 2017 and \$3 billion for years after 2017.
- For pharmaceutical manufacturers, an annual fee of \$2.3 billion would be imposed beginning in 2010.
- For health insurance providers, the annual fee would be \$2 billion for 2011, \$4 billion for 2012, \$7 billion for 2013, \$9 billion for 2014 through 2016, and \$10 billion for years

after 2016. The bill would provide a limited exemption from the fee for certain nonprofit insurers with a medical loss ratio of 90 percent or more. Additionally, the bill would exempt third-party administration agreement fees from the allocation of the fee to health insurance providers.

The fees for pharmaceutical and medical device manufacturers would be allocated by prior-year domestic market share, and determined by the Secretary of Treasury on the basis of information provided by the covered businesses. Fees for health insurance providers would be apportioned among the providers based on relative market share, described as a provider's net premiums written with respect to health insurance as a percentage of the total reported net premiums written with respect to health insurance for all U.S. health insurance providers. The fee calculated and assessed by the Secretary of Treasury would be determined by the provider's market share in the preceding calendar year.

The method for determining the liability could create uncertainty with respect to financial operations planning for companies. A business would not know liabilities until after the conclusion of a year and would likely not know how its market share compares with competitors for purposes of anticipating the fee. The fees would not be deductible for U.S. income tax purposes.

Executive comp restrictions for health insurance providers

The approved bill would prohibit any health insurance provider from deducting under section 162(m) executive pay over \$500,000 per year if at least 25 percent of the provider's gross premium income is derived from health insurance plans that meet the minimum creditable coverage requirements in the legislation. This limitation also would apply to performance-based compensation and commissions. Currently, businesses not subject to restrictions under the Troubled Asset Relief Program may deduct up to \$1 million per year per executive. Individuals subject to the restriction include all officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of a covered health insurance provider. Employers with self-insured plans are not considered covered health insurance providers for purposes of this provision. The provision would be effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009, and would raise an estimated \$600 million over 10 years according to the JCT.

Other revenue provisions

Corporate information reporting – Businesses would be required to file a Form 1099 to report payments made to a corporation totaling \$600 or more in a calendar year, effective for payments made after December 31, 2011. The change could significantly increase the number of 1099s issued by a business. (JCT 10-year revenue estimate: \$17.1 billion.)

Itemized deduction for medical expenses – The bill would increase the threshold for claiming the itemized deduction for medical expenses from 7.5 percent of adjusted gross income (AGI) to 10 percent for regular income tax purposes. The provision would not change the alternative minimum tax treatment of the deduction. For seniors age 65 and older and their spouses, the threshold would remain at 7.5 percent until 2017. The proposal would be effective for taxable years beginning after December 31, 2012. (JCT 10-year revenue estimate: \$15.2 billion.)

Limit on FSA contributions – The bill would impose a limit of \$2,500 per taxable year on employee salary reductions for coverage under a cafeteria plan FSA. The limit would be indexed

for inflation based on CPI-U after 2011. The provision would be effective for years beginning after December 31, 2010. It would not apply to HRAs. (JCT 10-year revenue estimate: \$13.3 billion.)

Excise tax on indoor tanning services – The bill would impose a 10 percent tax on amounts paid for indoor tanning services, replacing the tax on cosmetic surgery that was included in the “merged” Senate bill that Majority Leader Reid introduced last month. The tax would be effective for services on or after July 1, 2010. (JCT 10-year revenue estimate: \$2.7 billion.)

Definition of qualified medical expenses – This provision would revise the definition of qualified medical expenses for HRAs, health FSAs, HSAs, and Archer Medical Savings Accounts (MSAs) to conform to the existing definition under the itemized deduction for medical expenses. The modification would not apply to doctor-prescribed over-the-counter medication. Nonprescription over-the-counter drugs would not be eligible for reimbursement through an HSA or Archer MSA. The modification would be effective for taxable years beginning after December 31, 2010. (JCT 10-year revenue estimate: \$5 billion.)

Deduction for subsidies for retiree drug benefits – The bill would repeal the subsidy provided to companies that offer retiree prescription drug plans eligible for Medicare Part D. This would be effective for taxable years beginning after December 31, 2010. (JCT 10-year revenue estimate: \$5.4 billion.)

Higher penalties for ineligible HSA withdrawals – The current-law penalty of 10 percent on withdrawals from HSAs not used for qualified medical expenses would be increased to 20 percent for ineligible withdrawals made before age 65, effective for disbursements made during tax years starting after December 31, 2010. (JCT 10-year revenue estimate: \$1.3 billion.)

Special deduction for Blue Cross Blue Shield organizations – The bill would limit the special deduction for Blue Cross Blue Shield organizations under section 833 in the case of organizations with a low medical loss ratio, effective for taxable years beginning after December 31, 2009. (JCT 10-year revenue estimate: \$400 million.)

Tax-exempt hospitals – The bill would impose new requirements on section 501(c)(3) tax-exempt hospitals, including a requirement to conduct community needs assessments at least once every three years and to report the findings to the IRS. Failure to complete a needs assessment would result in a penalty on the organization of up to \$50,000. A hospital that fails to disclose how it is meeting needs identified in the assessment would be subject to existing incomplete-return penalties. The bill also includes provisions related to financial assistance and collection policies, as well as new reporting requirements. The modifications would be effective for taxable years beginning after the date of enactment. (JCT 10-year revenue estimate: negligible revenue effect.)

Employer health insurance reporting – The bill would require an employer to disclose the value of health benefits it provides for each employee’s health insurance coverage on the employee’s annual Form W-2. To the extent that the employee receives health insurance coverage under multiple plans, the employer would disclose the aggregate value of all such health coverage, but exclude the value of a health FSA. The provision would be effective beginning in the first taxable year after December 31, 2010. (JCT 10-year revenue estimate: negligible revenue effect.)

Targeted tax credits

The bill includes several tax credits targeted to small businesses, low-income individuals, and Indian tribes:

- **Small Business Health Care Affordability Tax Credit** – From 2010 through 2013, small businesses that provide health insurance for their employees would be eligible for a small business credit of up to 35 percent of their contribution. Once health insurance exchanges begin to operate in 2014, qualified small employers purchasing insurance through the exchanges could receive a tax credit for two years that covers up to 50 percent of the employer's contribution. Nonprofit companies also could take advantage of the credit, although at a lower rate.
- **Refundable tax credit for low-income individuals** – The bill would provide a refundable tax credit for individuals and families who purchase insurance through a state health exchange. The credit would be available for single or joint filers with modified gross income between 134 percent and 300 percent of the federal poverty level between enactment and December 31, 2012. Beginning in 2013, the credit would be available for those making between 100 percent and 133 percent of poverty. A cost estimate is not currently available.
- **Indian tribe health benefits** – Native Americans would be permitted to exclude the value of specified Indian tribe health benefits from gross income for tax purposes. According to the JCT, the new provision would cost less than \$50 million over 10 years and would be effective for health benefits and coverage provided after the date of enactment.
- **Temporary credit for chronic disease therapy** – The bill provides a credit for businesses with 250 or fewer employees to invest in acute and chronic disease research. The credit would equal 50 percent of the qualified investment. The credit has a \$1 billion cap, and qualifying investments made during 2009 and 2010 would be eligible. Treasury would award certification for eligibility. The JCT estimates that the provision would cost \$900 million over 10 years.
- **Expanded adoption tax credit** – The bill would increase the child adoption tax credit and adoption assistance exclusion by \$1,000 and would extend the credit through 2011. The credit would be made refundable. The new provision would cost \$1.2 billion over 10 years.

Individual and employer mandates

The bill would require individuals to obtain and maintain a minimum level of health insurance coverage beginning after 2013. Existing health plans would be grandfathered. An excise tax of the greater of \$750 or 2 percent of income (up to a cap of the national average bronze plan premium) per adult in the household would be imposed on individuals who fail to obtain adequate coverage. The penalty for failure to pay the excise tax would be limited to withholding of federal payments due. The tax would phase in beginning in 2014 and would reach \$750 or 2 percent of income in 2017. The Congressional Budget Office (CBO) has estimated that the excise tax would raise \$15 billion between 2010 and 2019.

Employers would not be required to provide coverage to employees. An employer with at least 50 employees that does not offer coverage would be charged a fee for each full-time employee (defined as those working 30 or more hours a week) who receives a tax credit for health insurance through a state exchange. The fee would be based on the average exchange subsidy received by the employees and would be capped at \$750 multiplied by the total number of employees (whether they are receiving a tax credit or not). Fees would not be deductible for federal income tax purposes.

An employer that has at least 50 employees and offers health insurance coverage would be subject to a nondeductible fee if it imposes an extended waiting period for employees to enroll in a company-sponsored plan. The fee would equal \$400 for any employee in a waiting period of more than 30 but fewer than 60 days, and \$600 for any employee in a waiting period exceeding 60 days.

An employer that provides health insurance coverage and has 200 or more employees must automatically enroll employees into the health insurance plan it offers. Individuals with other acceptable coverage may opt out of an employer-provided plan.

The CBO estimates that employer fees would raise \$28 billion between 2010 and 2019.

Outlook

Passage of the Senate health care reform bill sets the stage for House and Senate negotiators to resolve differences between their two plans in conference. Although nontax issues will likely dominate the public discussion, the disparities in how the two chambers have funded their plans through taxes will also be addressed.

The House bill, which was approved November 7, raises \$560 billion in taxes over 10 years. The largest piece of this – \$450 billion – comes from a proposed 5.4 percent surtax on modified AGI over \$500,000 a year for individuals and modified AGI over \$1 million for couples.

In contrast, the Senate bill raises approximately \$400 billion, chiefly through the excise tax on “Cadillac” insurance plans (\$149 billion), specified industry fees (\$101 billion), and the increase in the hospital insurance tax on high-income individuals (\$87 billion).

Conferees likely will begin negotiating the tax package once they have agreed on provisions for expanding insurance coverage, determined the net cost of those provisions, and agreed on how much revenue they will need to raise to cover the expected shortfall (after spending cuts and other cost-saving measures are taken into account).

Once the conferees reach a consensus on their revenue target, negotiating a funding solution will involve acting on five broad categories of revenue-raising provisions.

Areas of general agreement – First, for revenue purposes, both bills are substantially the same with respect to provisions that would:

- Eliminate deduction of expenses allocable to the Medicare Part D subsidy;
- Impose fees or taxes on medical device manufacturers;
- Conform the definition of medical expenses for various purposes;
- Limit flexible spending account contributions;
- Increase the penalty on disqualified medical account distributions;
- Fund comparative effectiveness or outcomes research; and
- Impose information reporting on business payments made to corporations.

These provisions, which raise roughly \$64 billion, are likely to be in the final legislation. Taxpayers affected by these changes should consider preliminary planning for their implementation.

Industry fees – Second, the Senate would impose \$82 billion of fees on pharmaceutical manufacturers and health insurance providers that are similar to its fees on medical device manufacturers. For its part, the House bill would impose a tax on the sale of certain medical devices but does not call for annual fees on pharmaceutical manufacturers or health insurance providers. House conferees will have to determine whether, or to what extent, they will accede to these other industry fees.

Taxes on high-income individuals – Third, each chamber would tax high-income individuals to fund part of the reform effort, albeit in very different ways. While the conferees are likely to include some form of an additional tax on high-income taxpayers, they will need to agree on:

- The total amount of tax to be raised from high-income individuals;
- The definition of “high income”; and
- Whether to tax all income including investment income or only wage and self-employment income.

High-income individuals are already thinking about strategies to accelerate income into 2010 and defer deductions into 2011 in response to likely increases in tax rates as the 2001 and 2003 tax cuts expire. In analyzing the costs and benefits of such strategies, they will want to factor into their planning the likelihood of an additional tax increase.

Health care revenue provisions – The fourth category of conference issues encompasses five health care-related provisions in the Senate bill. The two largest are the tax on high-cost plans and an increase in the threshold for deducting itemized medical expenses. Although proponents of these measures see them as supporting efforts to control medical costs, opponents regard them as having a direct impact on a significant number of taxpayers who do not fall within any definition of high income. These conflicting views may be the most difficult for negotiators to resolve.

Non-health care provisions – Finally, the House bill contains a collection of miscellaneous revenue raisers that are not germane to health care reform. These provisions, to the extent they are relatively noncontroversial in the eyes of the Senate, could find their way into a conference agreement if resolution of the larger issues leaves a modest shortfall in needed revenues.

Timing

The House is scheduled to reconvene on January 12 while the Senate does not plan to return to Washington until a week later. Democratic leaders in the two chambers are likely to begin preliminary negotiations on a conference agreement before the new congressional session officially begins, however.

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