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Prescription for change 'filled'

Tax provisions in the Patient Protection and Affordable Care Act

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Contents

Headings in italics indicate provisions that would be added to the Patient Protection and Affordable Care Act (the comprehensive health care legislation now approved by the House and Senate) under the reconciliation agreement passed by the House on March 21 and currently awaiting consideration in the Senate.

Introduction

Congress has approved and President Obama will soon sign into law a comprehensive health care reform bill that raises nearly $400 billion over 10 years through tax increases on high-income individuals, excise taxes on high-cost group health plans, and new fees on selected health care-related industries.

The Patient Protection and Affordable Care Act (the Act) cleared the House of Representatives on March 21 and the Senate last December 24. But its path to the White House has been difficult and the debate over its provisions is not finished. Under an agreement between congressional Democratic leaders and the White House, the House approved the Act as well as a separate package of modifications (the Reconciliation Agreement). Plans are under way to move the Reconciliation Agreement through the Senate in the coming days under an expedited procedure that will prevent it from being filibustered and allow for its consideration and passage in that chamber by a simple majority. Although House leaders expect the Senate to pass this agreement promptly and without modification, changes and delay still are possible in the Senate.

This publication examines the tax provisions in the Patient Protection and Affordable Care Act, and, separately, the modifications that the Reconciliation Agreement as approved by the House would make to those provisions. A brief — and primarily tax-focused — discussion of the mandate requiring individual coverage and the penalty on employers for failure to offer coverage is also included. This publication does not describe nontax provisions such as individual and group market reforms; expanded access to coverage; changes in government programs such as Medicare, Medicaid, and the State Children's Health Insurance Program; and provisions intended to improve health care delivery.

The Act represents a significant legislative milestone. While disagreeing dramatically on their approaches, politicians across the political spectrum have long sought solutions to twin challenges of the rising number of Americans without health insurance and the rising cost of health care. Six of our last 11 presidents have offered proposals to address the problem of the uninsured. These ranged from Eisenhower's proposal for a federal reinsurance service that would encourage private insurers to cover high-risk individuals; to Nixon's recommendation for a combination of actions that included employer mandates, subsidies for the poor to purchase insurance, elimination of pre-existing conditions, and malpractice reform; to much more comprehensive insurance programs offered by Presidents Truman, Carter, and Clinton.

Three modern presidents have overseen dramatic expansions of health coverage and government involvement in health care. President Johnson pushed President Kennedy's Medicare proposals through Congress. President Clinton worked with a Republican Congress to create the State Children's Health Insurance Program, and President George W. Bush pushed the addition of prescription drug coverage to Medicare through Congress over fierce and nearly successful opposition in the House.

In this Congress as in the past, the major debates have been over (1) how large a role the federal government should play, (2) how best to expand coverage for the uninsured and underinsured, (3) how to reduce the cost and increase the effectiveness of health care delivery, and (4) how to finance the federal government's commitments to health care.

We do not expect that the Act and the Reconciliation Agreement will end the national health care reform debate. Many observers believe that this legislation does not address the lingering challenge posed by the expansion of health care costs as the retirement of the baby-boom generation shifts more and more of these costs onto Medicare. Future Congresses will return to health care reform to address the cost of medical care, the benefits provided under various federal health care programs, and the taxes needed to support those government commitments.

Provisions targeting high-income individuals

Democratic leaders have sought to roll back President Bush's tax cuts as they applied to individuals earning more than $200,000 ($250,000 for joint returns) ever since those provision were enacted in 2001 and 2003. To that end, President Obama has proposed allowing the top ordinary tax rates of 33 and 35 percent to return to 36 and 39.6 percent and setting the top tax rate on capital gain and qualified dividend income at 20 percent.

The Act takes this impulse to find revenue from high-income taxpayers in a new direction. A significant portion of the revenue raised by the Act — $86.8 billion over 10 years — comes in the form of an additional Medicare tax hike that will affect higher-income taxpayers.

Medicare tax hike

Beginning in 2013, the Act imposes an additional 0.9 percentage Medicare Hospital Insurance tax (HI tax) on self-employed individuals and employees with respect to earnings and wages received during the year above specified thresholds. This additional tax applies to earnings of self-employed individuals or wages of an employee received in excess of $200,000. If an individual or employee files a joint return, then the tax applies to all earnings and wages in excess of $250,000 on that return. The Act does not change the employer HI tax. Self-employed individuals are not permitted to deduct any portion of the additional tax.

If a self-employed individual also has wage income, then the threshold above which the additional tax is imposed is reduced by the amount of wages taken into account in determining the taxpayer's liability for the additional tax on wages. For example, assume a taxpayer had self-employment income of $500,000 and also received wage income of $75,000. In determining the additional self-employment tax, the threshold would be reduced from $200,000 to $125,000.

In contrast to income tax brackets and the wage cap on Social Security taxes, thresholds for the additional HI tax are not indexed for inflation. (See Table 1.)

Observation

Social Security taxes are only imposed on wages up to a certain amount ($106,800 for 2010). This cap is subject to indexation for inflation. Today, a taxpayer is subject to a wage tax of 7.65 percent until he or she reaches the wage cap and then the payroll tax drops to 1.45 percent. Under the Act, the payroll tax will go up once the individual receives $200,000 in wages, in effect, to 2.35 percent. If this wage cap were to increase by 3 percent a year, then, because the threshold is not indexed, by the twentieth year of the new 0.9 percent HI tax (2032), the HI tax would apply to some income to which Social Security taxes also apply. In that case, an individual would be subject to a tax of 7.65 percent until he or she reached $200,000 of wages, then the wage tax would go up to 8.55 percent. Once the wage cap is reached, the tax would drop to 2.35 percent.

Table 1. Impact of additional Hospital Insurance tax

This table shows how the new Medicare tax increase would affect a variety of high-income wage earners.

Single taxpayer		Joint return	
Earnings	Additional HI tax	Earnings	Additional HI tax
$250,000	$450	$250,000	-
$500,000	$2,700	$500,000	$2,250
$1,000,000	$7,200	$1,00,000	$6,750
$5,000,000	$43,200	$5,000,000	$42,750

For wage earners, the Act requires the employer to withhold the employee's tax from wages paid to the employee in excess of $200,000. In determining its withholding obligation, the employer is not required to consider wages that may be received by the employee's spouse that would be subject to this tax. As a result, some married couples may have liability for the additional HI tax that is not satisfied by withholding.

To illustrate, consider a husband and wife who earn $100,000 and $200,000 in wages, respectively. Neither spouse would be subject to additional withholding through their employers. However, when they file a joint return, their wages together would exceed the $250,000 threshold, subjecting $50,000 of wages to the new tax, amounting to $450.

If the employer fails to collect the tax, and the employee subsequently pays the tax, then the tax will not be collected from the employer, but the employer will remain liable for penalties.

Effective date – The additional HI tax applies to wages received and taxable years beginning after December 31, 2012.

Observation

Social Security and HI (FICA) taxes are imposed on both wages received by the employee in cash (in the year received), plus on the value of amounts deferred under a nonqualified deferred compensation plan (generally at the time deferred). For "nonaccount balance" deferred compensation plans, the regulations give employers some degree of choice as to when the value of an employee's deferred compensation will be subjected FICA taxes. The new HI tax, with the delayed effective date, may cause some employees with substantial deferred compensation to seek acceleration of the time those benefits are subjected to FICA taxation, so that this increase can be avoided. Even though this tax is imposed only on the employee, it is solely the employer's decision whether to accelerate the timing of FICA taxes for these amounts.

A Deloitte Tax analysis illustrates the effect of the increase in payroll or self-employment taxes, along with other proposed FY2011 budget proposals, on representative taxpayers. A single taxpayer with household income of $350,000 could expect an increase of $2,000 attributable to these changes. A married couple with equal income would see a savings of $5,700 due to a decrease in their alternative minimum tax (AMT) liability.

Taxpayers with substantially higher income should expect to owe considerably more. A single taxpayer with household income of $5 million could expect a tax increase of $276,200 attributable to the changes. A married couple with equal income would see an increase of $277,600. (See Table 2.)

Table 2: Effects of Hospital Insurance tax increase and proposed high-income tax increases in president's FY 2011 budget

This table shows how the new Medicare tax increase will affect a variety of high-income earners. Effects of the new tax are calculated assuming that other high-income taxpayer proposals recommended in the president's FY2011 budget will also be effective for 2010.*

Household income	Tax under current law	Tax with Medicare tax and other Obama proposals	Additional cost imposed
Single filers			
$75,000	$9,300	$9,300	-
$150,000	$24,900	$24,200	($700)
$350,000	$81,100	$83,100	$2,000
$5,000,000	$1,361,400	$1,637,600	$276,200
Joint filers			
$75,000	$2,800	$2,800	-
$150,000	$19,800	$16,400	($3,400)
$350,000	$79,700	$74,000	($5,700)
$5,000,000	$1,350,200	$1,627,800	$277,600

* The proposals assumed are (1) the increase in ordinary tax rates, (2) the increase in capital gains and dividend rates, (3) restoration of the phase-out of personal exemptions, (4) restoration of the 3 percent reduction in itemized deductions, and (5) extension of the higher exemption for AMT purposes.

Reconciliation changes ahead

Unearned income Medicare contribution

The Reconciliation Agreement includes a proposal offered by President Obama for an unearned income Medicare contribution levied on income from interest, dividends, capital gains, annuities, royalties, and rents, other than such income that is derived in the ordinary course of a trade or business and not treated as a passive activity. The Reconciliation Agreement would tax this income at a rate of 3.8 percent (up from 2.9 percent in the president's plan). Because the tax applies to "gross income" from these sources, income that is excluded from gross income, such as tax-exempt interest, would not be taxed. The tax would be applied against the lesser of the taxpayer's net investment income or modified adjusted gross income (AGI) in excess of the threshold amounts. These thresholds are set at $200,000 for singles and $250,000 for joint filers.

The contribution and the 0.9 percent additional HI tax on earned income apply independently. For example, if an individual had wages of $190,000, investment income of $30,000, and modified AGI of $210,000, that individual would pay no wage tax and would pay the contribution on the $10,000 by which his or her modified AGI exceeded $200,000. Alternatively, if the taxpayer had wages of $300,000, investment income of $60,000, and modified AGI of $350,000, then the taxpayer would pay the wage-based HI tax on $100,000 and the 3.8 percent unearned income Medicare contribution on $60,000.

Net investment income from a passive activity as well as income from a trade or business of trading financial instruments or commodities as defined by existing mark-to-market tax rules for dealers of commodities would be subject to tax. Income on an investment of working capital would also be taxed. Generally, a taxpayer could reduce net investment income by any deductions properly allocable to taxed income.

Some types of income would be exempt from the tax, including income from the disposition of certain active partnerships and S corporations, distributions from qualified plans, and any item taken into account in determining self-employment income. The tax would not apply to nonresident aliens or trusts for which all of the unexpired interests are devoted to charitable purposes.

The proposal defines modified adjusted gross income as AGI increased by any income excluded by the foreign earned income exclusion over the deductions and exclusions disallowed with respect to that income.

The new tax would be subject to general estimated tax rules for individuals.

For estates and trusts, the tax would apply on the lesser of the undistributed net investment income or the excess of adjusted gross income over the dollar amounts at which the 39.6 percent tax bracket for estates and trusts begins.

The proposal clarifies the thresholds that would apply under the Medicare tax increase on wages for married taxpayers filing separately. In this case, it would be one-half of the amount for joint filers. The proposal also clarifies that the Medicare tax on wages would also be subject to estimated tax payment rules.

If the unearned income Medicare contribution — and other proposed tax hikes on high-income individuals included in the president's FY 2011 budget — were to become law, a high-income taxpayer could expect an effective tax rate on capital gains and qualified dividends of 23.8 percent. Significantly, however, the effective tax rate on nonqualified dividends would be 43.4 percent.

(See Table 3 for examples of how the Medicare tax increase in the Act and the proposed unearned income Medicare contribution in the Reconciliation Agreement would affect a variety of high-income earners.)

The new unearned income Medicare contribution would apply to taxable years beginning after December 31, 2012.

Table 3: Effects of Hospital Insurance tax increase, unearned income Medicare contribution, and proposed high-income tax increases in president's FY 2011 budget

This table shows how the new Medicare tax increase, along with the unearned income Medicare contribution, would affect a variety of high-income earners. Tax effects are calculated assuming that other high-income taxpayer proposals recommended in the president's FY2011 budget will also be effective for 2010.*

Household income	Tax under current law	Tax with Medicare tax and other Obama proposals	Additional cost imposed
Single filers			
$75,000	$9,300	$9,300	–
$150,000	$24,900	$24,200	($700)
$350,000	$81,100	$83,800	$2,700
$5,000,000	$1,361,400	$1,647,100	$285,700
Joint filers			
$75,000	$2,800	$2,800	–
$150,000	$19,800	$16,400	($3,400)
$350,000	$79,700	$74,600	($5,100)
$5,000,000	$1,350,200	$1,637,300	$287,100

* The proposals assumed are (1) the increase in ordinary tax rates, (2) the increase in capital gains and dividend rates, (3) restoration of the phase-out of personal exemptions, (4) restoration of the 3 percent reduction in itemized deductions, and (5) extension of the higher exemption for AMT purposes.

To further illustrate the effects of the new Medicare tax on wages and the unearned income Medicare contribution, a single taxpayer earning $1 million of wages and $100,000 of capital gain income would owe an additional $11,000. A married couple earning the same amount would owe an additional $10,550.

Excise tax on high-cost employer health plans

Beginning in 2013, the Act imposes a nondeductible 40 percent excise tax on the "excess benefit" provided in any month under any employer-sponsored health plan. This provision is projected to raise $149 billion through 2019. An excess benefit is a benefit the cost of which, on an annual basis, exceeds $8,500 a year for individuals or $23,000 for families. Beginning in 2014, these threshold amounts will be indexed annually to the Consumer Price Index for All Urban Consumers (CPI-U) plus 1 percentage point.

The excise tax is imposed proportionately on each coverage provider. To the extent that coverage is provided under an employer plan provided through insurance coverage, the issuer of the coverage is liable for the tax. The plan administrator must 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 must pay with respect to employer contributions to a health savings account (HSA) or medical savings account (MSA).

In determining the aggregate cost, all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a Health FSA or an HRA, contributions to an HSA, and coverage for dental, vision, and other supplementary health insurance. Employer-sponsored health coverage is health coverage offered by an employer to an employee without regard to whether the employer provides the coverage or the employee pays the coverage with after-tax dollars. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for which a deduction is allowable with respect to all or any portion of the coverage.

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.

Increased thresholds

The Act adjusts the threshold for the excise tax in the case of certain individuals as follows:

- **"High-cost" states** – The excise tax phases in for the 17 "highest cost" states for employer-sponsored coverage. In these states, the excess benefit threshold for a high-cost plan is 120 percent for 2013 ($27,600 for family/$10,200 single), phasing down to 110 percent for 2014, and 105 percent for 2015. This transition ends for taxable years beginning after 2015 when the increased threshold for plans in high-cost states is eliminated.

- **Retirees and "high-risk" professions** – 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. Beginning in 2014, these threshold amounts will be indexed annually to the CPI-U plus 1 percentage point. 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.

In addition, the Act also exempts plans that provide some already legally excepted benefits under the Health Insurance Portability and Accountability Act of 1996, including coverage only for accident and disability income, coverage for a specific disease or illness, and hospital indemnity insurance.

Under the Act, 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 high-cost plan excise tax applies to taxable years beginning after 2012.

Observation

Congress anticipated that the excise tax will make the provision of excess benefits prohibitively expensive. As a result, employers likely will reduce tax-free compensation provided in the form of excess benefits and shift toward taxable compensation. Employees will face reduced benefits in the form of specific exclusions from coverage or in the form of higher deductibles and co-pays. To the extent they continue to consume health care that was previously covered under the high-cost plan, they will have to do so with after tax dollars.

Reconciliation changes ahead

The Reconciliation Agreement would delay implementation of the excise tax on high-cost health plans until 2018 and modify the tax in five other important ways. First the threshold for the tax would be increased from $23,000 to $27,500 of annual premium for families and from $8,500 to $10,200 for individuals. The premium thresholds would be further increased in 2018 if Congressional Budget Office projections regarding premium inflation between 2010 and 2018 underestimate cost growth. Second, dental and vision plans would not be included when calculating the total benefit value. Third, phase-ins for the 17 "highest cost" states would be eliminated. Fourth, the premium thresholds for retirees and employees in high-risk professions would increase from $3,000 to $3,450 for families and from $1,350 to $1,650 for individuals. Finally, the Reconciliation Agreement would modify the cost of living adjustment for years after 2019. For those years, the adjustment will be based on CPI-U.

Industry fees

The Act provides for several new fees to be levied on companies in certain segments of the health care industry to help defray the costs of expanding coverage. The fees generally are computed by reference to the prior year's economic activity within each industry segment and assessed by the Secretary of the Treasury on each affected company based on its pro-rata share of that particular marketplace. The fees are not deductible for income tax purposes and are expected to raise $101 billion over 10 years.

Annual fee on health insurance providers

An annual fee will be imposed on covered entities providing health insurance with respect to U.S. health risks. The fee does not apply to accident and disability, indemnity, long-term, or Medicare supplemental insurance. The fee is apportioned among the providers based on their relative market share and is calculated by taking the provider's net premiums written with respect to health insurance as a percentage of the total net premiums written with respect to health insurance for all U.S. health insurance providers.

The fee is assessed by the Secretary of Treasury by reference to the provider's market share for each calendar year and is to be paid on a date determined by the Secretary in the following year, but not later than September 30. To determine market share and the fee imposed on each covered entity, health insurance providers are required to report, by a date to be determined by the Secretary, net premiums written. A failure to report this information will result in the imposition of penalties, unless reasonable cause is shown. The Secretary is permitted to rely on any other sources of available information (e.g., annual financial statements) to verify or supplement the reports submitted by covered entities.

Market-share calculation – The Act provides that the first $25 million of net premiums written will not be taken into account and only half of net premiums between $25 and $50 million will be considered. For net premiums written in excess of $50 million, 100 percent are included in the calculation. For this purpose, "net premiums written" is intended to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded and certain commissions paid.

(See Table 4 for an example of how the fee would apply to a covered entity with $100 million of net premium.)

Table 4: Pro-rata imposition of annual fee on health insurance providers (based on market share for a covered entity with $100 million of net premium)

Net premium	Applicable net premium	Percentage	Net premium taken into account
Up to $25 million	$25 million	0 percent	$0
$25 - $50 million	$25 million	50 percent	$12.5 million
$50 - $100 million	$50 million	100 percent	$50.0 million
Total net premium	$100 million		$62.5 million

Exceptions – Under the Act, covered entities subject to the fee do not include employers to the extent they self-insure employee health risks, governmental entities (other than those providing insurance through the Act's community health insurance option), certain nonprofit insurers of last resort, and certain nonprofit insurers with a medical loss ratio of 90 percent or more.

For health insurance providers, the aggregate annual fees imposed 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 provision raises $59.6 billion over 10 years.

Effective date – The fee will first be payable in 2011 with respect to net premium written in 2010.

Fee on pharmaceutical manufacturers and importers

The Act imposes an annual fee on pharmaceutical manufacturers and importers of branded prescription drugs (including certain biological products). The aggregate annual fees imposed on covered entities will be $2.3 billion, beginning in 2010. The fees will be allocated by reference to each entity's proportionate share of total branded prescription drug sales during the prior calendar year to (or pursuant to coverage under) a "specified government program," meaning Medicare Part D, Medicare Part B, Medicaid, Departments of Veterans Affairs and Defense programs, or the TRICARE retail pharmacy program. The Secretary of the Treasury will assess the fees on the basis of information provided by the Departments of Health and Human Services, Veterans Affairs and Defense; and the Secretary may also consider any other sources of available information. The fees imposed with respect to drug sales during the prior calendar year must be paid by a date during the current year to be determined by the Secretary of the Treasury, but not later than September 30.

Market-share calculation – If during a calendar year a covered entity (including its affiliates under common control) has less than $5 million of branded prescription drug sales to a specified government program or pursuant to coverage under such a program, it will be treated as having no market share and no fee will be imposed. For sales of branded prescription drugs between $5 million and $125 million, only 10 percent of such sales are taken into account when determining the applicable fee. For sales between $125 million and $225 million, 40 percent of such sales are taken into account; and for sales between $225 and $400 million, 75 percent of such sales are considered. To the extent that a covered entity's sales of branded prescription drugs to a specified government program exceed $400 million, 100 percent of such excess sales are taken into account to compute the entity's market share.

(See Table 5 for an example of how the fee would apply to a covered entity with $1 billion in qualifying sales during the prior calendar year.)

Table 5: Pro-rata imposition of annual fee on pharmaceutical manufacturers and importers (based on market share for a covered entity with $1 billion in sales during prior calendar year)

Gross receipts	Applicable drug sales	Percentage	Covered entity's sales taken into account
Up to $5 million	$5 million	0 percent	$0
$5 - $125 million	$120 million	10 percent	$12 million
$125 - $225 million	$100 million	40 percent	$40 million
$225 - $400 million	$175 million	75 percent	$131 million
Above $400 million	$600 million	100 percent	$600 million
Total sales	$1 billion		$783 million

Exceptions – Sales of so called "orphan drugs" for rare diseases and conditions are disregarded for purposes of determining fee amount, until such drugs are approved for broad use by the Food and Drug Administration (FDA).

The Act does not contain any provisions requiring the manufacturers and importers themselves to provide information regarding their sales of branded prescription drugs. Instead, information reporting requirements with respect to sales of branded prescription drugs (taking into account certain rebates, discounts, or other price concessions) apply to the government agencies that administer the specified government programs that directly purchase such drugs or that provide coverage for the purchase of such drugs by others.

The fees collected will be credited to the Medicare SMI trust fund.

Effective date – The fee will first be payable in 2010 with respect to sales in 2009.

Medical device fee

The Act imposes an annual fee on medical device manufacturers and importers beginning in 2011. The aggregate annual fees imposed on medical device manufacturers and importers will be $2 billion for the years 2011 through 2017 and $3 billion for years after 2017. The fees will be allocated based on each manufacturer's or importer's proportionate share of prior-year aggregate domestic gross receipts from medical device sales, and will be determined by the Secretary of Treasury on the basis of information required to be reported by the covered manufacturers and importers, as well as any other source of information available to the Secretary. The fees imposed with respect to medical device sales during the prior calendar year must be paid by a date during the current year to be determined by the Secretary of the Treasury, but not later than September 30. Penalties will apply should a company fail to report information regarding its medical device sales, unless reasonable cause is shown.

Covered devices – The Act generally applies to sales for use in the United States of any medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans. The Act excludes all Class I medical devices (as designated by FDA) such as elastic bandages, exam gloves, and hand-held surgical devices, as well as Class II medical devices (such as pregnancy tests, contact lenses, and blood pressure monitors) sold at retail for not more than $100 per unit.

For the purposes of calculating market share, a company (including its affiliates under common control) with less than $5 million in medical device sales in the calendar year will be treated as having no market share and will not be subject to a fee. For sales of medical devices between $5 million and $25 million, 50 percent of such sales are taken into account; and for sales above $25 million, 100 percent of such excess sales are taken into account when determining market share.

(See Table 6 for an example of how the fee would apply to a covered entity with $100 million of medical device sales.)

Effective date – The fee will first be payable in 2011 with respect to sales in 2010.

Table 6: Pro-rata imposition of annual fee on medical device manufacturers and importers (based on market share for a covered entity with $100 million in medical device sales)

Gross receipts	Applicable sales	Percentage	Covered entity's sales taken into account
Up to $5 million	$5 million	0 percent	$0
$5 - $25 million	$20 million	50 percent	$10 million
$25 - $100 million	$75 million	100 percent	$75 million
Total sales	$100 million		$85 million

Observation

As businesses plan their future cash flow and financial operations, the inability to precisely estimate any liabilities associated with the new industry fees could create challenges. In each case the fees must ultimately be determined by the Treasury based on collective data reflecting market share for the prior calendar year. Companies competing in highly volatile markets or introducing new products might find this especially unpredictable.

Reconciliation changes ahead

The Reconciliation Agreement would modify the fee provisions by:

- Increasing the fee on manufacturers of brand-name pharmaceuticals by $4.8 billion over 10 years, and delaying the effective date of the provision by one year (until 2011). The fee would equal $2.5 billion for 2011, $2.8 billion for 2012 and 2013, $3 billion for 2014 through 2016, $4 billion for 2017, $4.1 billion for 2018, and $2.8 billion a year thereafter. The provision would also add joint and several liability for the fee if, with respect to a single covered entity, more than one person is liable for payment under the controlled group rules.
- Converting the fee on medical device manufacturers to an excise tax of 2.3 percent of the price for which the medical device is sold and delaying the effective date until 2013 (from 2011). The tax would not apply to eyeglasses, contact lenses, hearing aids, and any other device deemed by the Secretary to be of the type available for regular retail purposes.
- Delaying the effective date of the fee imposed on health insurance providers by three years (until 2014). The proposal would also create limited exceptions for plans that serve a critical purpose, including plans serving a high percentage of seniors and disabled individuals. For tax-exempt service providers, only 50 percent of net premiums written would be taken into account. The fee would equal $8 billion for 2014, $11.3 billion for 2015 and 2016, $13.9 billion for 2017, and $14.3 billion for 2018. For years after 2018, the fee would be the amount applicable for the preceding year, increased by the rate of premium growth as calculated for the premium tax credits included in the Act.)

Excise tax on indoor tanning services

The Act imposes a 10 percent tax on amounts paid for indoor tanning services, whether or not an individual's insurance policy covers the service. The tax imposed is to be paid by the individual on whom the service is performed. The service provider is obligated to collect the tax from the customer and becomes liable for the tax if it does not do so. Indoor tanning services are defined as services that use an electronic product with one or more ultraviolet lamps to induce skin tanning.

Effective date – The provision is effective for services performed on or after July 1, 2010.

Comparative effectiveness fee

The Act establishes a new Patient-Centered Outcomes Research Trust Fund (PCORTF) to fund comparative effectiveness research that is mandated by the Act. The trust fund is to be funded by a fee imposed on private insurance plans equal to $2 for each individual covered under a specified individual or group health insurance policies. For fiscal years beginning after September 30, 2014, the fee is increased to reflect increases in the per capita amount of national health expenditures. This fee is provided for under the Internal Revenue Code and is subject to the code's procedures and administration rules. The fee is reduced to $1 for policy plan yeas ending before October 1, 2013.

Effective date – The fee is effective for each policy plan year ending after September 30, 2012, and before September 30, 2019.

Study on impact of fees on veterans' health care

The Act directs the Secretary of Veterans Affairs to conduct a study on the effect (if any) of the newly imposed fees on the health-related industries on the cost of medical care provided to veterans, as well as their access to medical devices and branded prescription drugs. The Secretary is directed to report the results of the study to the House Committee on Ways and Means and to the Senate Committee on Finance not later than December 31, 2012.

Business-related provisions

Measures to encourage employer health coverage

The Act does not require employers to provide health coverage to employees; but beginning in 2014, it penalizes them for failing to do so through penalties (administered by the IRS) that are imposed on certain employers with at least 50 full-time employees (those working 30 or more hours per week). These penalties and other aspects of the rules encouraging employer-provided coverage are discussed in a later chapter that also describes design issues and individual mandates.

Elimination of Medicare Part D subsidy

An employer offering retiree prescription drug coverage that is at least as valuable as Medicare Part D is entitled to a subsidy. Employers can deduct the entire cost of providing the coverage, even though a portion is offset by the subsidy. For taxable years beginning after December 31, 2010, the Act repeals the current rule permitting deduction of the portion of the expense that offset by the Part D subsidy.

Effective date – The provision is effective for taxable years beginning after December 31, 2010.

Observation

Increasing costs have already placed pressure on many employers to reduce or eliminate retiree medical benefits. Those who continue to do so may be contractually obligated to the benefits or may regard them as essential tools for recruitment and retention of their workforce. The increased cost resulting from denial of the deduction will be one more factor that employers will take into account as they design or modify their benefit plans.

ASC 740 implications – The employer's promise to provide post-retirement prescription drug coverage (coverage) is recorded as a component of the other post-employment benefit (OPEB) obligation. When that coverage benefit meets certain criteria, the employer becomes eligible to receive the Retiree Drug Subsidy, which is then recorded as an offset against the obligation (the obligation is recorded net of the subsidy and the net amount is actuarially determined). In determining the deferred tax asset related to the OPEB obligation, companies have been required to "unbundle" the net amount into the "pre-subsidy" liability and the offsetting subsidy receivable. Since the obligation has historically been deductible when paid, a deferred tax asset has historically been recorded for the future tax deduction related to the grossed-up "pre-subsidy" amount. The unbundled subsidy receivable has not required a deferred tax liability since it has not been taxable when received. With the change in law, the subsidy "receivable" will remain not taxable, but a corresponding amount of liability will become not deductible. Therefore, the expected future tax deduction will be reduced by an amount equal to the subsidy and the corresponding deferred tax asset must be adjusted (reversed in this instance).

Under ASC 740, the expense or benefit related to adjusting deferred tax liabilities and assets as a result of a change in tax laws must be recognized in income from continuing operations for the period that includes the enactment date. Therefore, if President Obama signs the Act into law on or before March 31 as expected, the expense resulting from this change will be recognized in the first quarter of 2010 even though the change in law will not be effective until 2011 or later (however, the deferred tax asset is not adjusted for the part of the OPEB obligation that is expected to be settled prior to the effective date of the new law).

In the event that there is a valuation allowance recorded against the deferred tax asset, the reversal of the deferred tax asset will not result in an immediate deferred tax expense, as the decrease to the deferred tax asset will be offset by a corresponding decrease in the valuation allowance. However, the expense related to the change in the law has only been deferred, since the amount of valuation allowance that can be reversed to tax benefit at a later date (if and when the company returns to profitability) has been permanently reduced.

Reconciliation changes ahead

The Reconciliation Agreement delays the repeal of the deduction for expenses allocable to the Medicare Part D subsidy by two years. The repeal would then take effect beginning after December 31, 2012.

Deduction limits for compensation paid by health insurance providers

The Act limits the deduction for compensation for services provided by certain individuals to a "covered health insurance provider" to $500,000 per year. For this purpose, an employer is a "covered health insurance provider" for a year (after 2012) 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. Prior to 2012, a "covered health insurance provider" is any employer qualifying as a health insurance provider that receives premiums for providing health insurance coverage.

The deduction limits apply to compensation attributable to services performed by an "applicable individual." Applicable individuals include all officers, employees, directors, and other workers or service providers (such as non-employee independent contractors) performing services for or on behalf of a covered health insurance provider. Thus, the deduction restrictions will apply to any individual providing compensated services to a covered health insurance provider, not just the top executives.

Under the Act, for purposes of determining whether remuneration of a particular applicable individual exceeds $500,000, compensation paid to the individual from any member of the controlled group of the covered health insurance provider as determined by applying rules applicable to qualified retirement plans is considered.

The deduction limits apply to both current and deferred compensation. The limit that applies to deferred compensation earned in a year is equal to the $500,000 limit for that year, reduced by the amount of current compensation paid. Thus, if an employee receives salary of $400,000 in 2013, the deduction for deferred compensation attributable to the same year is limited to $100,000 in the year in which the compensation is otherwise deductible. In this example, deferred compensation for that year that exceeds $100,000 will not be deductible in the year paid.

Although this limit is an amendment to the existing $1 million limitations on executive compensation under section 162(m), this deduction limit applies differently in many respects:

- The limit is based on the year in which compensation is earned, rather than the year in which the deduction is claimed. A limit based on when compensation is earned requires determination of the period to which compensation is attributable, and has the effect of limiting deductions for both current and former service providers. It will also have the effect of limiting deductions for compensation earned when the company is considered a health insurance provider, even if the company ceases to be a health insurance provider by the time the compensation is paid.
- The limit applies to compensation to any individual service provider, including independent contractors as well as all employees, rather than just the chief executive officer and highest three officers, as disclosed in Securities and Exchange Commission (SEC) filings.
- The deduction limitations apply to covered insurance providers, regardless of whether the provider is a "publicly held corporation" that is subject to SEC registration requirements.
- The deduction limits apply to compensation paid by all entities within the insurer's controlled group. For this purpose, controlled group status is determined using rules similar for determining controlled group status for qualified plans.
- The exceptions for certain performance-based compensation and commission compensation are inapplicable.

Employers with self-insured plans are not considered covered health insurance providers for purposes of this provision.

Effective date – The provision will be effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009. Thus, the limits will apply to current compensation paid in years after 2012, but will apply to deferred compensation earned after 2009.

Nonprofit hospital requirements

The Act imposes four new requirements that a hospital must satisfy to be tax-exempt: (1) the periodic preparation of a community health needs assessment; (2) maintenance of a qualified financial assistance policy; (3) limitations on charges to individuals eligible for assistance; and (4) avoidance of certain billing and collections activities.

The new requirements apply to organizations that operate a facility required by a state to be licensed, registered, or otherwise recognized as a hospital, and are determined to have hospital care as its primary function or purpose for exemption. If an organization operates more than one hospital, every hospital facility in the organization must adhere to the provisions of the Act separately to qualify for its tax-exempt status.

Community health needs assessment – To preserve its tax-exempt status under section 501(c)(3) the organization must conduct a community health needs assessment at least once during any three-year period (specifically, the current taxable year or the two immediately preceding years), as well as have an implementation strategy, which is available to the public, to meet the needs identified through the assessment. The needs assessment must take advice from people who represent the community interest including people who have public health expertise. Failure to comply with performing the assessment results in a penalty of $50,000.

In addition the assessment requirements, organizations:

- Will be subject to Treasury review of their community benefit activities at least once every three years to ensure compliance;
- Must have a description of how they address community health needs, what needs are not addressed, and why those needs are not addressed; and
- Must also have audited financial statements (either stand-alone or part of a consolidation).

Financial assistance policy requirements – Each hospital must adopt, implement, and publicize a written financial assistance policy that includes a description of the criteria for assistance (free or discounted), the basis for calculating amounts charged to patients, the method for applying assistance, the actions an organization may take to collect outstanding debts, methods to widely publicize the financial assistance policy, and a requirement that the organization provide nondiscriminatory emergency care regardless of the ability to qualify under the written financial policy.

Charges – Hospitals are limited as to how much they can bill patients who qualify for financial assistance. The prescribed rules on fees require that the amounts charged for emergency or other necessary procedures performed on those patients be no more than the lowest amounts generally billed to insured individuals. The Act also prohibits the use of gross charges when billing those who qualify for financial assistance.

Collections – With respect to billing and collection, a hospital cannot engage in extraordinary means of collection until reasonably exploring the eligibility for assistance under the financial assistance program (guidance may be released relating to what constitutes reasonable efforts).

Effective date – Generally, the requirements apply to taxable years beginning after the enactment date, however, the community health needs assessment requirement applies to taxable years beginning two years after the date of enactment.

Treasury report on charity care – The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, will submit an annual report to Congress that addresses issues related to charitable care. These include issues related to the level of charity care, bad debt expense, unreimbursed costs for services provided through means-tested government programs, unreimbursed costs for services provided through non-means-tested government programs, and information about costs incurred by private hospitals for community benefit activities. The Secretary shall also within five years of the date of enactment issue a report that analyzes trends in the information collected under the new reporting requirements.

Credit for small-business employee health coverage

Small businesses and eligible tax-exempt employers who are required to make certain non-elective contributions toward the costs of employee health benefits will be eligible for a small business credit to offset the cost of employee health insurance.

When fully effective, the new credit will be up to 50 percent of the lesser of: (1) the employer's aggregate contributions towards premiums paid to a qualified health plan offered by the employer through an exchange; or (2) the aggregate contributions an employer would have made if the employee had enrolled in a qualified health plan having a premium equal in value to the average premium for the small group market in which the employee enrolls. For years 2010 through 2013, the credit is 35 percent of the lesser of: (1) employer's nonelective contributions for premiums paid for health insurance coverage; or (2) the average premium for the small group market in the employer state.

In order to qualify, the business must have no more than 25 full-time equivalent employees, pay average annual wages of less than $50,000, and provide qualifying coverage. The full amount of the credit will be available to employers with 10 or fewer employees and average annual wages of less than $25,000, and will phase out when those thresholds are exceeded. The average wage threshold for determining the phase-out of credits will be adjusted for inflation after 2013.

For tax-exempt employers, the maximum credit is 25 percent for years 2010 through 2013, increasing to 35 percent in 2014.

Employers will not be eligible to use the credit for certain employees, including defined "seasonal workers," self-employed individuals, 2 percent shareholders of an S corporation (as defined by section 1372(b), 5 percent owners of a small business (as defined by section 416(i)(1)(B)(i)), and dependents or other household members. However, leased employees are eligible employees for the credit.

Employers receiving credits will be denied any deduction for health insurance costs equal to the credit amount.

Effective date – The provision is effective for amounts paid or incurred after December 31, 2009, and to the determination of AMT credits after that date and their carryback.

Cafeteria plan nondiscrimination safe harbor for small employers

Small employers (generally those with 100 or fewer employees) will be allowed to adopt new "simple cafeteria plans," which are conceptually similar to simple 401(k) plans and simple IRAs under current law. In exchange for satisfying minimum participation and contribution requirements, these plans will be treated as meeting the nondiscrimination requirements that would otherwise apply to the cafeteria plan.

Effective date – The provision is effective for taxable years beginning after December 31, 2010.

Therapeutic Project Tax Credit

The Act provides a credit for businesses with 250 or fewer employees that make a qualified investment in acute and chronic disease research during 2009 or 2010. Control group rules apply in determining the number of employees. The credit will equal 50 percent of the qualified investment. The Secretary of the Treasury is authorized to provide a grant in lieu of the credit.

The credit has a $1 billion cap. The Department of the Treasury in consultation with the Department of Health and Human Services will award certification for eligibility.

The Act provides for elimination of double benefits by denying tax credits, deductions, and favorable basis adjustments for expenditures funded through these credits or grants.

Effective date – The provision is effective for amounts paid or incurred after December 31, 2008, in taxable years beginning after December 31, 2008.

Observation

There appears to be nothing in the Act that would make a qualifying taxpayer hesitate to take advantage of this provision because it would curtail future research credits or orphan drug credits. The credit/grant is larger than the research credit, is computed on a broader base of qualifying expenses, and base amount adjustments would not be a critical factor. One minor consideration is that qualifying taxpayers may have to amend 2009 returns to reduce reported carryforward credits to the extent that they are awarded grants/credits for expenses incurred in 2009 that were also considered in determining research credits.

Modification of section 833 treatment of certain health organizations

The Act limits the special deduction for Blue Cross Blue Shield organizations of 25 percent of the amount by which certain claims, liabilities, and expenses incurred on cost-plus contracts exceed the organizations adjusted surplus. The special deduction will be available only to those otherwise qualifying organizations that expend at least 85 percent of their total premium on reimbursement for clinical services provided to enrollees.

Effective date – The provision is effective for taxable years beginning after December 31, 2009, and will raise $400 million over 10 years.

Reconciliation changes ahead

Tax treatment of black liquor

The Reconciliation Agreement includes a new provision that would modify the cellulosic biofuel producer credit under section 40(b) to preclude "black liquor" — the wood pulp byproduct that paper companies use to power their mills — from eligibility.

This provision is intended to resolve a debate over the tax treatment of black liquor that has continued since 2007. When section 6426(d)(2)(G) was clarified in 2007 to apply to "liquid fuel derived from biomass," paper mills became eligible to claim the refundable alternative fuel mixture credit under section 6426(e) by adding a small amount of diesel fuel to their black liquor. The alternative fuel mixture credit expired on December 31, 2009. If Congress decides to extend the credit, it is generally expected to add a provision that will make black liquor ineligible.

But a new issue in the debate emerged recently when the IRS held in an internal legal memorandum (ILM 200941011) that black liquor also is eligible for the nonrefundable cellulosic biofuel producer credit under section 40(b)(6), which is not scheduled to expire until December 31, 2012.

To address this, the Reconciliation Agreement would modify section 40(b)(6) (which allows taxpayers to claim a $1.01-per-gallon nonrefundable credit for certain liquid fuels produced) to provide that a fuel is ineligible for the cellulosic biofuel producer credit if:

- Its combined water-and-sediment content is greater than 4 percent (determined by weight) or
- Its ash content exceeds 1 percent (determined by weight).
- The effect of this statutory change is that black liquor will not qualify for a nonrefundable credit under section 40(b)(6).

Effective date – The provision would be effective for fuels sold or used after December 31, 2009.

Reconciliation changes ahead

Corporate estimated taxes

The Reconciliation Agreement would increase the estimated tax payment for corporations with assets of at least $1 billion by 15.75 percentage points for payments otherwise due in July, August, or September of 2014 and reduce the first payment due after September 2014 correspondingly. This provision is simply a means of satisfying technical budget rules that set requirements for the first five years of a ten-year budget window. Previous such accelerations have been repealed once they were no longer necessary to satisfy budget rules. (See Public Law 111-42, section 201.)

Reporting and compliance provisions

Reconciliation changes ahead

Economic substance codification

The Reconciliation Agreement would codify the economic substance doctrine. Proposals to codify the economic substance doctrine date at least back to President Clinton's FY2000 budget submitted to Congress in February 1999. House and Senate taxwriters subsequently have included similar measures in a number of bills and President Obama included a codification proposal in his fiscal 2011 budget.

This provision would mandate a conjunctive analysis of economic substance under which taxpayers would have to show both that (1) a transaction changed their economic position in a meaningful way apart from the federal income tax effects and (2) they had a substantial business purpose apart from federal income tax effects for entering into the transaction.

A 40 percent strict-liability penalty would apply to tax understatements attributable to undisclosed noneconomic substance transactions. The penalty would be 20 percent if a transaction is adequately disclosed. There is no reasonable-cause exception to the penalty; thus, outside opinions would not protect a taxpayer from imposition of a penalty if it is determined that the transaction lacks economic substance. Additionally, this provision provides that noneconomic substance transactions are deemed to lack reasonable basis for purposes of the 20 percent penalty under section 6676 for erroneous claims for refunds or credits. This provision would apply to transactions entered into after the date of enactment.

According to the explanation issued with the legislation, the provision is not intended to alter the tax treatment of basic business transactions in which the choice between meaningful economic alternatives is largely or entirely based on comparative tax advantages. These basic transactions include:

- The choice between capitalizing a business enterprise with debt or equity;
- A U.S. person's choice between utilizing a foreign corporation or a domestic corporation to make a foreign investment;
- The choice to enter a transaction or series of transactions that constitute a corporate organization or reorganization; and,
- The choice to utilize a related-party entity in a transaction provided that the arm's length standard of section 482 and other applicable concepts are satisfied.

A number of commentators and former government officials have expressed concern that codification of the economic substance doctrine would introduce additional complexity into the tax system while limiting the ability of the government and courts to evaluate all of the relevant facts and circumstances of particular transactions. Concerns have also been raised about the fairness of imposing a large, strict-liability penalty on taxpayers when the statutory requirements that trigger the penalty are untested and ambiguous.

Wage (W-2) reporting

The Act imposes additional reporting requirements on all employers. Beginning in 2011, W-2 statements issued to taxpayers must include the aggregate cost of employer-sponsored health benefits. The amount to be reported is the aggregate cost determined under rules similar to the applicable premium rules for COBRA continuation coverage.

If the employee receives health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage, but exclude all contributions to HSAs and Archer MSAs and salary reduction contributions to FSAs.

Effective date – The new W-2 reporting is effective after 2010.

Business payment (1099) reporting

The Act significantly expands the current-law obligation of persons engaged in a trade or business to report on payments of other fixed and determinable income or compensation. First, to the Act extends reporting to include payments made to corporations other than corporations exempt from income tax under section 501(a). Second the Act expands the kinds of payments subject to reporting to include reporting of the amount of gross proceeds paid in consideration for property or services.

Effective date – The new 1099 reporting is effective for payments made after December 31, 2011.

Reporting related to individual mandate, employer penalties

The Act also contains two additional reporting requirements that support the individual health insurance mandate and the penalty on large employers for failure to provide insurance. The required reports must be filed as information returns with the IRS.

Reporting by persons providing minimal essential health coverage – Insurers (including employers who self-insure and governmental units) who provide the minimum essential health coverage to an individual during each calendar year must report certain information to the covered individual and the Treasury Secretary.

Generally the information to be reported with respect to insured individuals includes identifying information, dates of coverage, and any premium tax credit or cost sharing subsidy received by the individual with respect to such coverage, and any other information required by the Treasury Secretary. For insurance provided through an employer's group health plan, the insurer must report the name, address and EIN of the employer maintaining the plan, the portion of the premium required to be paid by the employer, and any information the Secretary may require to administer the new tax credit for qualified small employers. Failure to comply with the requirement would trigger existing penalties associated with the filing of information returns.

Reporting by large employers – Any large employer subject to rules for maintaining minimum essential coverage, must file a return that identifies the employer; certifies whether it offers to its full-time employees the option to enroll in a minimum essential coverage plan; and provides the number of full-time employees during each month of the calendar year and information identifying each full-time employee covered under the employer-provided health plan.

If the employer does certify that it offered its employees the opportunity to enroll in minimum essential coverage, it must report additional information relating to the cost and availability of that coverage. Governmental units providing coverage are subject to the same reporting requirements. Failure to comply with the requirement would trigger existing penalties associated with the filing of information returns.

Effective date – These new reporting requirements apply for calendar years beginning after 2013.

Observation
These new reporting requirements will significantly increase the amount of information that must be reported to the IRS as well as the number of information returns that businesses must file. Employers will need to implement the appropriate record keeping and data collection processes to meet the reporting requirements, including, where necessary, processes to effectively communicate the required information to third parties providing payroll administration or managing other reporting obligations.

Information reporting requirements bring with them the necessity of obtaining appropriate taxpayer identification numbers from payees to avoid backup withholding obligations. Businesses will need to implement additional procedures to collect the data necessary to meet these new obligations.

Disclosure of tax return information

The Act also authorizes the Treasury to disclose to the Secretary of Health and Human Services relevant individual income tax return information used for determining eligibility for premium tax credits; cost-sharing reduction; and participation in a State Medicaid program, a State children's health insurance program, or a basic health program under the Act. The Health and Human Services agency could in turn provide the information to an exchange created by the Act.

Effective date – The change in disclosure rules is effective upon enactment.

Provisions affecting individuals

Individual mandate

The Act generally requires that all individuals either obtain health insurance or pay a penalty on their federal tax return beginning in 2014. The details of this mandate are discussed in a later chapter.

Refundable health care premium tax credit

The Act provides a new refundable health care premium tax credit to assist individuals and families who purchase health care on the individual market, including those who obtain coverage through the health insurance exchange established by this Act. The credit, which Treasury can distribute as an advance payment, is provided for single or joint filers on a sliding scale for taxpayers whose household income falls between 100 percent and not more than 400 percent of the poverty line as determined by family size. The actual amount of the credit is calculated on the basis of identifiable standard monthly premiums, the taxpayer's household modified adjusted gross income, and the number of months during which the taxpayer is insured. Taxpayers eligible for the credit are U.S. citizens and aliens lawfully present in the U.S. who meet income requirements.

Advanced payments of the credit will be made by Treasury to insurers of the qualified health plans in order to reduce premiums paid by individuals eligible for the credit. For employed individuals who purchase health insurance through state exchanges, the premium payments are expected to be made through payroll deductions. A taxpayer's credit will be reduced (but not below zero) by the amount of advance payment received. Taxpayers will be liable for any amounts paid in advance that exceed their credits.

Effective date – The credit will be available for taxable years ending after December 31, 2013.

Reconciliation changes ahead

For individuals with incomes up to 400 percent of the poverty level, the Reconciliation Agreement alters slightly the formula used to determine the amount of the tax credits to make premiums more affordable as a percent of income. Further, beginning in 2019, the Agreement would limit the growth of the tax credits if premiums are growing faster than the Consumer Price Index, unless spending is more than 10 percent below current Congressional Budget Office projections.

Restrictions on health-related accounts and reimbursements

The Act tightens a number of the rules related to flexible spending arrangements, health reimbursement arrangements, health savings accounts, and medical savings accounts.

Over-the-counter drugs – The Act conforms the definition of medical expense for purposes of employer-provided health coverage (including reimbursements under employer-sponsored health plans, HRAs, and Health FSAs), HSAs, and MSAs to the definition for purposes of the itemized deduction for medical expenses. Thus, the Act eliminates nontaxable reimbursements of over-the-counter medications unless the over-the-counter medications are prescribed by a doctor. Prescribed medicines, drugs, and insulin will still qualify for nontaxable reimbursements from those accounts.

Limit on health flexible spending arrangements – Beginning with years after 2010, the Act imposes a limit of $2,500 per taxable year on employee salary reductions for coverage under a cafeteria plan FSA. The limit, which does not apply to health reimbursement arrangements, is indexed for inflation based on CPI-U, after 2011. If a cafeteria plan does not contain the required limitation, then benefits from the FSA will not be qualified benefits.

Penalty on nonqualified health savings account distributions – The Act increases the penalty on withdrawals from HSAs and Archer MSAs not used for qualified medical expenses from 10 to 20 percent for HSAs and from 15 to 20 percent for Archer MSAs.

Effective date – These changes to medical savings vehicles are effective for tax years beginning after December 31, 2010.

Observation

Many employer plans currently allow reimbursements for over-the-counter medicines in reliance on an IRS ruling. As a result, this change will require them to amend plans and administrative policies.

Currently, there is no limit on health FSAs, although many employers routinely limit annual contributions to a health FSA to $5,000. Thus, FSA plans that either have no limit or provide limits in excess of $2,500 will need to be amended to provide for a $2,500 limitation.

Reconciliation changes ahead

The Reconciliation Agreement would delay the annual $2,500 limitation on contributions to a health flexible spending arrangements by two years. The limitation would then take effect beginning with years after 2012. The limit would be indexed for inflation based on CPI-U after 2013.

Itemized deduction for medical expenses

The Act increases the threshold for claiming an itemized deduction for unreimbursed medical expenses for regular tax purposes from 7.5 percent of the taxpayer's AGI to 10 percent. The Act does not change the current-law 10 percent of AGI threshold that applies under the alternative minimum tax.

Effective date – The change generally applies for taxable years beginning after December 31, 2012. For any taxpayer who is age 65 and older or whose spouse is 65 or older, the threshold for regular tax purposes remains at 7.5 percent until 2017.

Reconciliation changes ahead

Medicare 'donut hole'

The Reconciliation Agreement would provide a $250 rebate to Medicare beneficiaries who hit the Medicare prescription "donut hole" in 2010. The Agreement also builds on pharmaceutical manufacturers' 50 percent discount on brand-name drugs beginning in 2011 to completely close the donut hole with 75 percent discounts on brand-name and generic drugs by 2020.

Indian tribe health benefits

Under the Act, Native Americans may exclude from gross income the value of qualified health benefits received directly or indirectly from the Indian Health Service or from an Indian tribe or tribal organization.

Effective date – The provision is effective for health benefits and coverage provided after the date of enactment.

State loan repayment

The Act excludes from gross income any amount received under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved areas or areas where there is a shortage of health professionals.

Effective date – The provision is effective for taxable years beginning after December 31, 2008.

Modification to adoption credit

The Act increases the amount of child adoption tax credit and adoption assistance exclusion from $12,170 for 2010 to $13,170 and provides for indexing. The Act also extends the adoption credit through 2011 and makes the credit refundable.

Effective date – The increases are effective for 2010.

Individual mandate

The Act generally requires that all individuals either obtain health insurance or pay a penalty on their federal tax return beginning in 2014. The penalty is not an insurance premium, and paying it does not entitle the individual to any health insurance coverage.

To encourage individuals to obtain health insurance rather than pay the penalty, the Act includes a number of provisions intended to increase the availability and affordability of coverage. Most of these provisions are designed to help small employers and individuals who, unlike large employers, generally have little bargaining power in the market for health insurance and sometimes find insurance prohibitively expensive or completely unavailable due to prior or existing health problems. Examples of these provisions include credits and subsidies for low-income individuals, a prohibition against discrimination based on health status, and insurance exchanges in which insurers would compete for individual and small-employer business.

Coverage and penalties

To avoid the penalty, individuals will need to obtain and maintain "minimum essential coverage" for themselves and their dependents. "Minimum essential coverage" includes coverage under any employer-provided plan, governmental programs (for example, Medicare and Medicaid), and any plan offered in the individual market. Coverage under grandfathered plans — those in effect on the date of enactment that are not required to be amended to comply with the Act — also qualifies. There are virtually no specific benefit requirements for a plan's coverage to be considered minimum essential coverage, so long as the plan primarily covers medical benefits. Examples of plans that do not qualify include workers' compensation and long-term care insurance.

The annual penalty will be phased in starting in 2014, reaching the greater of $750 or 2 percent of income in 2016, and indexed for inflation thereafter. The penalty is capped at the national average bronze plan premium. An individual must pay the applicable penalty amount for himself and each of his dependents lacking minimum essential coverage, but the penalty amount for minors is one-half of that for adults. The penalty for an entire family is capped at $2,250. For example, an individual with two minor dependents all of whom lacked minimum essential coverage for all of 2014 would be $190 ($95 + (½ x $95) + (½ x $95)). The maximum amount an individual would be required to pay for himself and his dependents in a year is three times the adult penalty amount for the year (for example, $285 in 2014). The tax applies pro rata on a monthly basis based on whether minimum essential coverage was maintained for that month.

The penalty will be reported on the individual's tax return. Spouses filing joint returns are jointly and severally liable for one another's penalties, as are dependents and the individuals claiming them as dependents.

Exceptions

There are several exceptions. A three-month coverage gap is permitted to facilitate the transition from one plan to another, and individuals who lack coverage due to a hardship (as determined by the Health and Human Services Secretary) will not be subject to the penalty. There are also two exceptions for low-income individuals. The first applies if the individual's contribution toward self-only coverage offered through his employer or an exchange exceeds 8 percent of the individual's household income. After 2014, that percentage will increase to reflect increases in premium costs as a percentage of income. The second applies to individuals with income under 100 percent of the poverty line. Other exceptions exist for members of an Indian tribe, individuals residing outside the United States, unlawful aliens, incarcerated individuals, and individuals with religious objections or who participate in a health care sharing ministry.

Reconciliation changes ahead

The Reconciliation Agreement would modify the mandate penalty assessed against individuals who choose to remain uninsured. The Act calls for a phased-in excise tax based on the greater of a flat-dollar amount or a percentage of household income. The Reconciliation Agreement would exempt income below the filing threshold, lower the flat payments required from $495 to $325 in 2015 and from $750 to $695 in 2016, and would increase the percent-of-income thresholds.

The Agreement would extend the exclusion from gross income for employer-provided health coverage for adult children up to age 26.

It also would allow self-employed individuals to deduct the cost of coverage for adult children up to age 26.

Employer penalties and other requirements

The Act contains many provisions affecting employers. They generally fall into two broad categories. The first category is a set of penalties that must be paid by certain large employers that either do not offer health insurance or offer health insurance that employees opt out of in favor of acquiring coverage through an exchange. The second category is comprised of changes that employers may be required to make to their health plans. In general, however, the Act provides a broad grandfathering provision for plans in existence on the date of enactment.

Penalty provisions

The Act does not require employers to provide health coverage to employees, but beginning in 2014 it imposes penalties on certain employers with at least 50 full-time employees (those working 30 or more hours per week) to encourage them to do so. The penalty will be collected by the IRS, and the Act grants the Treasury Secretary the authority to establish rules for the timing of payment.

Whether an employer exceeds the 50-employee threshold is generally determined by reference to the average number of employees during the preceding calendar year, with special rules for an employer's first year of business and employers with seasonal workforces. All of the employees of entities that are treated as a single employer under the qualified retirement plan controlled group rules are included. For example, a parent corporation and its two subsidiaries, each with 40 full-time employees, are treated as a single employer with more than 50 employees.

Observation

Under current law, the IRS frequently challenges taxpayers' classifications of workers as independent contractors rather than employees, and the Act may draw additional IRS attention to worker classification issues.

The penalty for failing to offer health coverage applies if any of an employer's full-time employees become entitled to a tax credit. The penalty is equal to equal $750 multiplied by the total number of full-time employees. Beginning in 2015, this amount will be indexed for medical inflation based on the per capita increase in health insurance premiums in the United States. Employers are prohibited from discriminating against employees who receive a tax credit.

Even if an employer does offer health coverage, it will be required to pay a penalty if any of its employees obtains a tax credit, but in that case the penalty is $3,000 multiplied only by the number of employees who actually obtain the credit, and in no case more than the amount the employer would have paid if it had not offered coverage.

These penalties apply pro rata on monthly basis.

Other requirements

In addition to the penalty provisions described above, the Act imposes a number of requirements on employer health plans. A comprehensive discussion of these requirements is beyond the scope of this publication, but some of the more significant requirements are discussed below.

Nondiscrimination rules for insured plans – Under current law, if a self-insured employer health plan discriminates in favor of highly compensated employees, then the excess benefits are taxable to those employees. Insured employer health plans, on the other hand, are not subject to any nondiscrimination requirements. As a result, many employers currently provide top executives with generous nontaxable health insurance coverage that is unavailable to other employees. Under the Act, the nondiscrimination rules for self-insured plans do not change, but insured plans are prohibited from discriminating in favor of highly compensated employees. Thus, excess benefits provided to highly compensated employees are permissible but taxable to highly compensated employees if offered through a self-insured plan and prohibited under an insured plan.

Improving participation – The Act contains several provisions designed to improve participation levels in employer-provided health plans. One provision generally requires an employer that provides health insurance coverage and has more than 200 full-time employees to automatically enroll employees in the plan. An exception applies for employees who opt out after demonstrating other acceptable coverage. Beginning in 2014, another provision imposes a penalty on employers with more than 50 employees whose plans impose an extended enrollment waiting period. The penalty would equal $400 for any employee in a waiting period of more than 30 but no more than 60 days, and $600 for any employee in a waiting period exceeding 60 days. (Waiting periods of more than 90 days are prohibited.) These amounts will be indexed for

medical inflation based on increases in health insurance premiums beginning in 2015.

Exchanges – The Act includes requirements intended to encourage employees to consider whether coverage through an exchange rather than from their employers would be better for them. One provision requires employers to inform employees upon hire (by March 1, 2013, for current employees) about the exchanges and the possibility that the employee may be eligible for a tax credit, as well as any loss in employer contributions toward the employee's health benefits (and the associated tax exclusion) if the employee purchases health insurance through an exchange. Another provision requires employers that contribute toward the costs of their employees' health coverage to make the employer contribution available as a voucher that certain employees could use to purchase insurance through an exchange. Vouchers are only required for employees whose contributions toward the plan would be between 8 and 9.8 percent of their income and whose household income is less than 400 percent of the federal poverty level. The entire amount of the voucher is deductible by the employer and, to the extent used to purchase insurance through an exchange, nontaxable to the recipients.

Other requirements – The Act imposes several other requirements affecting employer plans. Some are effective for plan years beginning six months after enactment (January 1, 2011, for calendar year plans), while others are not effective until 2014. The provisions with the earlier effective date include a prohibition against lifetime or unreasonable annual limits, a requirement to cover preventive services and immunizations without any cost sharing, and a requirement that all plans offering dependent coverage allow unmarried children to remain covered under a parent's plan through age 26. Beginning in 2014, plans will generally be prohibited from imposing annual out-of-pocket limits that exceed the maximum HSA contribution (adjusted for inflation based on increases in health insurance premiums beginning in 2015); all annual limits will be prohibited; and employers with more than 50 employees will be required to report whether they offer their full-time employees and dependents health coverage, the length of the waiting period, the lowest-cost option in each enrollment category, the employer's share of the total allowed costs of benefits, and the number and names of covered employees.

Encouraging wellness programs – The Act eases some current-law restrictions on employer-provided incentives for employee participation in wellness programs. Under current regulations, employers are permitted to provide incentives for employees to participate in wellness programs, but if they are based on a health-status factor, then they are limited to 20 percent of the cost of employee-only coverage under the employer's health plan, and there must be a reasonable alternative standard for obtaining the reward. For example, the 20-percent limit applies to incentives an employer offers employees who participate in a smoking cessation program (regardless of whether they quit smoking as a result). The Act increases the limit to 30 percent and authorizes the Secretaries of Labor, Health and Human Services, and Treasury to increase it to as high as 50 percent. It also relaxes the requirements for the reasonable alternative standard and makes other favorable changes.

Reconciliation changes ahead

Like the Act, the Reconciliation Agreement does not provide for an employer mandate but would impose a fee on larger businesses that do not provide insurance for their employees. Under the Act, the fee will apply to employers with at least 50 full-time employees and would be calculated based on the number of full-time employees. The Reconciliation Agreement would modify the Act provision by dropping the first 30 employees from the payment calculation. It also would change the applicable payment amount for firms with at least 50 full-time employees that do not offer coverage to $2,000 per full-time employee. The Reconciliation Agreement would eliminate the assessment for workers in a waiting period, while maintaining the 90-day limit on the length of any waiting period beginning in 2014.

Plan design issues

Even though the Act will not become fully effective for a number of years, employer-sponsored group health plans will feel a much more immediate impact. In fact, a number of plan design changes will need to be implemented in time for the 2011 plan year. These include:

- Eliminating lifetime and annual limits on benefits;
- Providing first-dollar coverage for preventive care;
- Extending eligibility for dependent coverage (if offered) to employees' unmarried children who are not yet 26 years old; and
- Establishing a new internal and external review procedure for claims determinations.

Two significant design changes to employers' health flexible spending accounts also will be required for 2011. The first is a new $2,500 cap on the amount of salary reduction contributions employees can make to their FSAs each year. Although this will not affect most employees in most years, it will prevent some employees from fully utilizing their health FSAs in years when they anticipate significant out-of-pocket medical expenses. The second change is more subtle, but likely will affect a larger percentage of the employee population on a consistent basis. That is, health FSAs can no longer reimburse employees for the cost of over-the-counter medicines — a loss of flexibility that may make participants more vulnerable to the use-or-lose rule. (The Reconciliation Agreement would delay the effective date for changes to FSAs until 2013.)

This second change will have implications for health reimbursement arrangements and health savings accounts (HSA) as well. Like health FSAs, HRAs will no longer be eligible to reimburse participants' expenses for over-the-counter medicines. HSAs will continue to have the flexibility to reimburse these expenses, except those reimbursements will be treated as taxable income and may be subject to an additional 20 percent excise tax.

Another provision of the Act that may force design changes to some employers' group health plans is the 40 percent excise tax on high-cost plans. This excise tax, which will begin to apply in 2013 (2018 under the Reconciliation Agreement), is based on the total cost of benefits provided under the plan regardless of how those costs are allocated among the employer and employee. So avoiding the excise tax will require plan design changes as opposed to just shifting some or all of the premium cost to employees.

Finally, the individual and employer mandates may force plan design changes to conform to minimum standards. These mandates will become effective in 2014.

Conclusion

Once the Senate has completed its consideration of the House-passed Reconciliation Agreement, Congress must begin to confront a host of priority 2009 and 2010 tax policy issues that were delayed by the drawn out health care reform debate. These include 2009 expired tax provisions, 2010 expiring tax provisions, estate and gift tax extension and reform, the year-end expiration of the 2001 and 2003 tax cuts, any necessary additional jobs or stimulus legislation, and efforts to address other administration priorities including financial regulatory reform and climate change.

Near-term tax increase risks

Congress will find the taxwriting process more complicated with each bill it passes. The recently enacted statutory pay-as-you go (PAYGO) budget rules allow for permanent extension of middle-class tax relief. These PAYGO rules are consistent with the president's proposals to allow ordinary tax rates on joint filers with incomes over $250,000 and individuals with incomes over $200,000 to return to their pre-2001 levels and for capital gains rates for these same taxpayers to return to 20 percent. The PAYGO rules are not as generous on other fronts. They allow restoration of the estate tax at its 2009 levels (rather than higher pre-2001 levels) only through 2011, and a further patch to the AMT only for 2010 and 2011 without requiring PAYGO offsets. The president also has proposed moving the tax rate on qualified dividends received by high-income individuals to 20 percent rather than to 39.6 percent as would happen with expiration of the Bush tax cuts. PAYGO legislation would require that this dividend proposal be offset, making that policy objective of setting the rate at 20 percent more difficult to reach.

Like the relief for dividends, any additional tax cuts that Congress may wish to address that are not covered by PAYGO exceptions will require revenue offsets. Now that enacted jobs and health care legislation have soaked up many of the relatively "easy" revenue-raising options, lawmakers will increasingly be forced to confront difficult choices as they seek to pay for items such as extenders, any additional jobs legislation, and the portions of expiring 2001 and 2003 tax cuts that are not provided for under PAYGO rules. This opens up the risk that some revenue-raising provisions from the president's FY 2011 budget that were previously considered too controversial could begin to gain traction as offsets for priority legislation.

Greater long-term challenges

Current federal tax and spending policy is unsustainable over the long term and, perhaps, even in the relatively near term. The past 15 months of debate over health care may come to be viewed as a mere prologue to a more protracted and difficult debate over entitlement and tax reform.

Although some propose solving these challenges primarily through entitlement and other spending reforms, others see revenue as the primary near-term path to fiscal responsibility. History suggests that a combination of approaches will be pursued. The extent of our fiscal challenges suggests that the required actions on both taxes and spending will be substantial and politically difficult.

Medicare spending and interest costs are the driving components of long-term spending increases. As a result, Congress likely will return to health care reform as it seeks additional ways to constrain the growth in health care costs. It will also have to consider reducing Medicare entitlements. In such a debate, painful tax increases may be the alternative to additional painful entitlement cuts.

On the tax side, many in Washington now believe that the income tax cannot, or should not, generate the additional revenue that they believe will be necessary for future deficit reduction efforts. Increasingly, conversation is turning to consideration of a value-added tax or other consumption tax option.

With the passage of health care reform, Congress has cleared away one major legislative challenge. Nonetheless, Congress now confronts a set of priorities that seems undiminished by the completion of the reform effort.

Charts and tables

Major tax revenue sources in Patient Protection and Affordable Care Act and Reconciliation Agreement

Figure 7. Patient Protection and Affordable Care Act

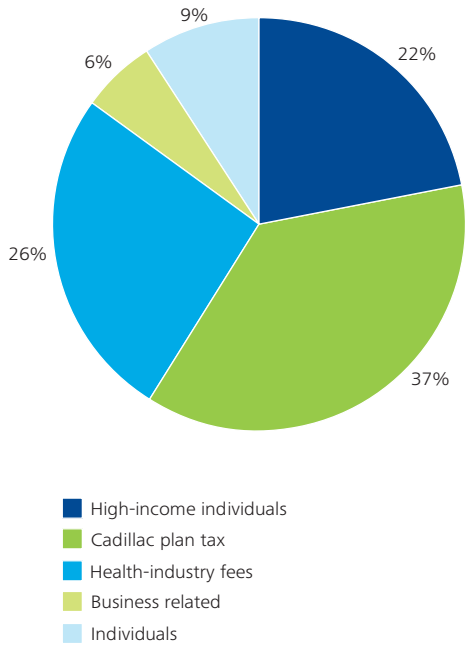
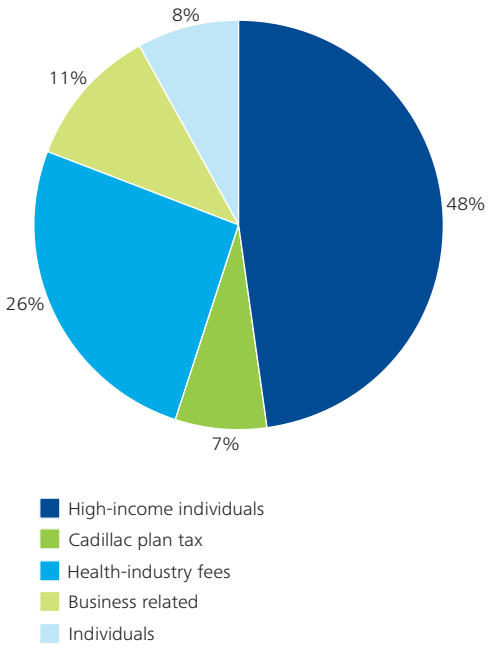
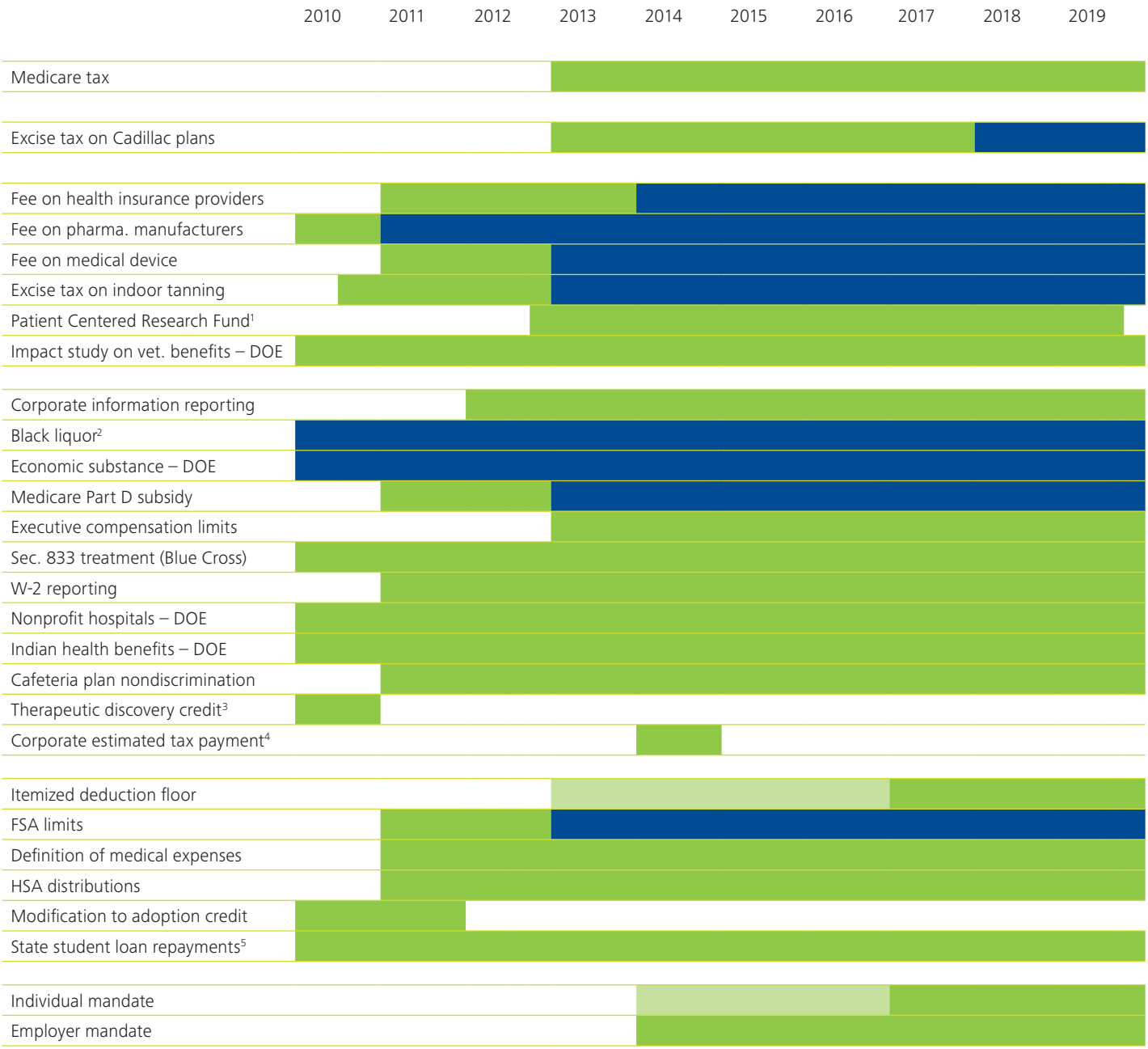


Figure 8. Reconciliation



Revenue provision effective dates



Green boxes represent the effective periods for each provision under the Patient Protection and Affordable Care Act. The lightly shaded boxes represent phase-in periods. The blue boxes represent changes that Congress intends to make through the Reconciliation Agreement.
DOE = date of enactment

[1] Effective for each policy plan year ending after September 30, 2012, but does not apply to policy years ending after September 31, 2019.
[2] Fuel sold or used after December 31, 2009
[3] Amounts paid or incurred after December 31, 2008
[4] Applies to payments due in July, August and September 2014
[5] Taxable years beginning after December 31, 2008

Changes ahead: Modifications to the Patient Protection and Affordable Care Act included in the reconciliation agreement

The tables below outline the changes to be made to the Patient Protection and Affordable Care Act as a result of the reconciliation agreement hammered out between congressional Democratic leaders and the White House. Unless otherwise indicated, revenue estimates are provided by the Joint Committee on Taxation (JCT) staff.

Provisions targeting high-income individuals		
Provision	**Patient Protection & Affordable Care Act**	**Reconciliation Agreement**
Medicare tax increases	Additional 0.9 percent hospital insurance (HI) tax on wages over $200,000 ($250,000 for joint filers) **Effective date:** Tax years beginning after Dec. 31, 2012 10-year revenue estimate: $86.8 billion	**Earned income** – Follows HI tax provision in Senate bill **Unearned income** – New 3.8 percent Medicare contribution levied on certain unearned income of individuals with AGI over $200,000 ($250,000 for joint filers) Revenue credited to Supplemental Medical Insurance trust fund **Effective date (both provisions):** Tax years beginning after Dec. 31, 2012 **10-year revenue estimate (both provisions):** $210.2 billion

Health care-related provisions		
Provision	**Patient Protection & Affordable Care Act**	**Reconciliation Agreement**
Excise tax on 'Cadillac' group health plans	40 percent nondeductible excise tax levied at insurer level on employer-provided health coverage in excess of $8,500 for individuals ($23,000 for families), indexed for inflation, with higher thresholds for retirees over age 55 and employees in certain high-risk professions Employer aggregates and issues information returns indicating amount subject to excise tax Transition relief for 17 identified high-cost states **Effective date:** Tax years beginning after Dec. 31, 2012 **10-year revenue estimate:** $148.9 billion	**Follows Senate bill, but:** • Increases premium threshold to $10,200 for individuals ($27,500 for families) • Premium thresholds for retirees and high-risk professions would be increased $1,650 for individuals ($3,450 for families) • Adjust premiums for unexpected growth in health insurance costs • Inflation adjustment for CPI-U after 2019 (CPI-U + 1 percent only for 2019) • Delays effective date until 2018 **10-year revenue estimate:** $32 billion

Health care-related provisions		
Provision	**Patient Protection & Affordable Care Act**	**Reconciliation Agreement**
Fee on health insurance providers	Impose annual fee on U.S. health insurance providers: $2 billion for 2011; $4 billion for 2012; $7 billion for 2013; $9 billion for years 2014 through 2016; and $10 billion for years after 2016; allocated to taxpayers based on net premiums for U.S. health risks **Effective date:** Calendar years beginning after Dec. 31, 2010; fee allocated based on market share of net premiums for U.S. health risks written for calendar years beginning after Dec. 31, 2009 **10-year revenue estimate:** $59.64 billion	**Follows Senate bill, but:** • Delays effective date until calendar years beginning after Dec. 31, 2013; fee allocated based on market share of net premiums for U.S. health risks written for calendar years beginning after Dec. 31, 2012 • Fee would equal $8 billion for 2014, $11.3 billion for 2015 and 2016, $13.9 billion for 2017, and $14.3 billion for 2018. Fee is adjusted for premium growth thereafter. • Limited exceptions for voluntary employee benefit associations and some nonprofit providers that serve low-income, elderly, or disabled populations • Adds joint and several liability **10-year revenue estimate:** $60.1 billion
Fee on branded drug manufacturers and importers	Impose annual fee of $2.3 billion on manufacturers and importers of branded drugs; allocated to taxpayers based on market share **Effective date**: Calendar years beginning after Dec. 31, 2009; fee allocated based on market share of branded prescription drug sales for calendar years beginning after Dec. 31, 2008 **10-year revenue estimate:** $22.2 billion	**Follows Senate bill, but:** • Increases fee by $4.8 billion • Delays effective date until 2011; (fee is $2.5 billion for 2011, $2.8 billion for 2012 and 2013, $3 billion for 2014 through 2016, $4 billion for 2017, $4.1 billion for 2018, and $2.8 billion for 2019 and thereafter) • Adds joint and several liability **10-year revenue estimate:** $27 billion
Fee on medical devices	Impose annual fee of $2 billion on manufacturers and importers of certain medical devices for 2011 through 2017 and $3 billion for years after 2017 **Effective date:** Calendar years beginning after Dec. 31, 2010; fee allocated based on market share of medical device sales for calendar years beginning after Dec. 31, 2009 **10-year revenue estimate:** $19.2 billion	**Follows Senate bill, but:** • Replaces annual fee with 2.3 percent excise tax • Does not apply to eyeglasses, contact lenses, hearing aids, and any other device deemed by the Secretary • Delays effective date until 2013 **10-year revenue estimate:** $20 billion
Itemized deduction for medical expenses	Raise floor for itemized deduction for medical expenses to 10 percent of AGI (from 7.5 percent); retain 7.5 percent floor for individuals over age 65 (and their spouses) **Effective date:** Tax years beginning after Dec. 31, 2012; provision retaining 7.5 percent floor for individuals over age 65 expires Dec. 31, 2016 **10-year revenue estimate:** $15.2 billion	**Follows Senate bill**
Health FSAs	Limit annual salary-reduction contributions to health flexible spending arrangements in cafeteria plans to $2,500, indexed for inflation **Effective date:** Tax years beginning after Dec. 31, 2010 **10-year revenue estimate:** $14.3 billion	**Follows Senate bill, but:** • Effective for tax years beginning after Dec. 31, 2012 • Indexed for inflation after 2013 **10-year revenue estimate:** $13 billion
Excise tax on indoor tanning services	Impose 10 percent excise tax on indoor tanning services **Effective date:** Services provided on or after July 1, 2010 **10-year revenue estimate:** $2.7 billion	**Follows Senate bill**

Health care-related provisions		
Provision	**Patient Protection & Affordable Care Act**	**Reconciliation Agreement**
Definition of 'medical expenses' for employer-provided health coverage	Conform definition of medical expenses for purposes of health flexible spending arrangements, health reimbursement arrangements, health savings accounts, and Archer Medical Savings Accounts to the definition for the itemized deduction **Effective date:** Expenses incurred after Dec. 31, 2010 **10-year revenue estimate:** $5.0 billion	**Follows Senate bill**
Comparative Effectiveness Research Trust Fund	Impose fee on insured and self-insured health plans to finance patient-centered outcomes research trust fund **Effective date:** Effective for policies and plans for portion of policies or plan years beginning on or after Oct. 1, 2012 **10-year revenue estimate:** $2.6 billion	**Follows Senate bill**
Medicare Part D subsidy	Eliminate deduction for expenses allocable to Medicare Part D subsidy **Effective date:** Tax years beginning after Dec. 31, 2010 **10-year revenue estimate:** $5.4 billion	**Follows Senate bill, but:** • Effective for tax years beginning after Dec. 31, 2012 **10-year revenue estimate:** $4.5 billion
Health savings account distributions	Increase penalty for nonqualified distributions from health savings accounts to 20 percent **Effective date:** Distributions made during tax years beginning after Dec. 31, 2010 **10-year revenue estimate:** $1.3 billion	**Follows Senate bill** **10-year revenue estimate:** $1.4 billion
Executive comp caps for health insurance providers	Limit deduction on taxable year remuneration to officers, employees, directors, and service providers of covered health insurance providers to $500,000 **Effective date:** Effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009 **10-year revenue estimate:** $600 million	**Follows Senate bill**
Special deduction for Blue Cross Blue Shield organizations	Limit special deduction for Blue Cross Blue Shield organizations under section 833 in the case of organizations with a low medical loss ratio **Effective date:** Tax years beginning after Dec. 31, 2009 **10-year revenue estimate:** $400 million	**Follows Senate bill**
Employer reporting of value of health insurance benefits	Require employer W-2 reporting of value of health benefits provided to employees **Effective date:** Taxable years beginning after Dec. 31, 2010 **10-year revenue estimate:** Negligible	**Follows Senate bill**
Nonprofit hospitals	Impose additional compliance and reporting requirements on section 501(c)(3) hospitals **Effective date:** Taxable years beginning after date of enactment **10-year revenue estimate:** Negligible	**Follows Senate bill**
Veterans health care	Study and report on effect of the bill on veterans' health care **Effective date:** Date of enactment **10-year revenue estimate:** Negligible	**Follows Senate bill**

Business provisions (Non-health care)		
Provision	**Patient Protection & Affordable Care Act**	**Reconciliation Agreement**
Tax treatment of 'black liquor'	No provision	Make 'black liquor' ineligible for the cellulosic biofuel producer credit under section 40(b)(6) **Effective date:** Fuel sold or used after January 1, 2010 **10-year revenue estimate:** $23.6 billion
Information reporting	Mandatory Form 1099 reporting for payments made to a corporation totaling $600 or more in a calendar year **Effective date:** Payments made after Dec. 31, 2011 **10-year revenue estimate:** $17.1 billion	**Follows Senate bill**
Economic substance	No provision	• Codify economic substance doctrine. Require conjunctive analysis of economic substance under which taxpayers would have to show both that (1) a transaction changed their economic position in a meaningful way apart from the federal income tax effects, and (2) they had a substantial purpose apart from federal income tax effects for entering into the transaction. • Impose 40 percent strict liability penalty on tax understatements attributable to undisclosed noneconomic substance transactions (20 percent if a transaction is adequately disclosed) **Effective date:** Transactions entered into after date of enactment **10-year revenue estimate:** $4.5 billion

Individual & employer mandates		
Provision	**Patient Protection & Affordable Care Act**	**Reconciliation Agreement**
Individual mandate	Excise tax of the greater of $750 or 2 percent of income per adult in the household would be imposed on individuals who fail to obtain adequate coverage; capped at national average bronze premium Tax would phase in beginning at $95 or 0.5 percent of income in 2014, reaching $750 or 2 percent of income in 2016 (indexed for inflation thereafter) **Effective date:** Tax years beginning after Dec. 31, 2013 **CBO 10-year revenue estimate:** $15 billion	**Follows Senate bill, but:** • Phases in tax beginning at the greater of $95 or 1 percent of income in 2014, reaching $695 or 2.5 percent of income in 2016 (indexed for inflation thereafter) • Extends exclusion for employer-provided health care for adult children up to age 26 **CBO 10-year revenue estimate:** $17 billion
Employer mandate	No mandate, but employers with at least 50 full-time employees generally would be subject to nondeductible fees if they: • Do not offer coverage to employees ($750 per full-time employee) • Impose a waiting period of more than 30 days for employees to enroll in a company-sponsored health plan ($400 for any employee in a waiting period greater than 30 but less than 60 days, $600 for any employee in a waiting period greater than 60 days) • Offer coverage but have at least one full-time employee receiving premium assistance tax credit (lesser of $3,000 for each employee receiving a tax credit or $750 for each full-time employee) **Effective date:** Tax years beginning after Dec. 31, 2013 **CBO 10-year revenue estimate:** $28 billion	**Follows Senate bill, but:** • Employers not offering coverage to employees subject to fee of $2,000 per employee (first 30 employees are not counted in the payment calculation) • No assessment for workers in a waiting period, but retains 90-day limit on length of any waiting period beginning in 2014 **CBO 10-year revenue estimate:** $52 billion

Miscellaneous provisions		
Provision	**Patient Protection & Affordable Care Act**	**Reconciliation Agreement**
Indian health benefits	Provide income exclusion for specified Indian health benefits **Effective date:** For health benefits and coverage provided after date of enactment **10-year revenue estimate:** Loss of less than $50 million	**Follows Senate bill**
Cafeteria plan nondiscrim-ination safe harbor	Simplify cafeteria plan nondiscrimination safe harbor for certain small employers **Effective date:** Tax years beginning after Dec. 31, 2010 **10-year revenue estimate:** Negligible	**Follows Senate bill**
Qualifying therapeutic discovery credit	Provide exclusion from gross income for assistance provided to participants in state student loan repayment programs for certain health professionals **Effective date:** For taxable years beginning after Dec. 31, 2008 **10-year revenue estimate:** Loss of $100 million	**Follows Senate bill**
State loan repayment tax relief for health professionals	Provide exclusion from gross income for assistance provided to participants in state student loan repayment programs for certain health professionals **Effective date:** For taxable years beginning after Dec. 31, 2008 **10-year revenue estimate:** Loss of $100 million	**Follows Senate bill**
Modifications to adoption credit	Make adoption credit refundable, increase credit amount, and extend through 2011 **Effective date:** For taxable years beginning after Dec. 31, 2009 **10-year revenue estimate:** Loss of $1.2 billion	**Follows Senate bill**

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