

# Tax Legislative Update

Breaking news from Capitol Hill  
from Grant Thornton's National Tax Office

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## Side-by-side comparison of healthcare bill tax provisions

The president has begun offering more specific guidance in his push for healthcare reform, spurring action in both chambers of Congress. House and Senate Democrats each now have sweeping healthcare reform bills moving through the legislative process.

A slew of tax increases have been proposed to offset much of the cost of reform. The tax code is also playing an important role in so-called “pay or play” provisions: healthcare mandates that require individuals and employers to obtain and offer health insurance or face penalties.

There are currently three separate major healthcare reform bills in play:

- **Senate HELP committee:** The Senate Committee on Health, Education, Labor and Pensions (HELP) approved a broad reform bill on July 15. It was passed without Republican support, and the committee left many of the tax provisions for the Senate Finance Committee to complete.
- **Senate Finance Committee:** Senate Finance Committee Chair Max Baucus, D-Mont., chose to write a completely separate bill designed to attract bipartisan support. His bipartisan negotiations largely failed, and the bill scheduled for markup on Sept. 22 may not attract any Republican votes. A number of amendments will be considered during markup, although it is not clear whether any will succeed.
- **House compromise:** A unified Democratic healthcare reform bill was approved by the three House committees of jurisdiction without Republican support. A floor vote has been postponed until October as House Democratic leadership negotiate changes in the bill with conservative Democrats nicknamed “Blue Dogs.”

At this point, the focus is on the Senate. Had Baucus been successful in reaching a compromise with at least some Finance Committee Republicans, his bill may have been brought straight to the Senate floor. Without a bipartisan compromise, the Democratic leadership in the Senate may try and merge the HELP committee and Baucus bills.

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The lack of a compromise may force Senate Democrats to try and use the reconciliation process. Reconciliation is a budget mechanism fraught with complications, but precludes 60-vote hurdles like filibusters and allows bills to progress on majority votes.

At this time, the most controversial debates standing in the way of enactment of a final bill are outside the tax arena. Major changes are more likely to focus on the restructure of the health care system, rather than the tax provisions necessary to pay for it. The president signaled his willingness recently to compromise on two important issues by agreeing to include a healthcare tort reform pilot program and consider legislation without a so-called “public option.” On the tax side, the president offered his support for Baucus’s proposal to tax high-cost health plans rather than the House “surtax” on high-income taxpayers.

The following charts contain side-by-side comparisons of the important tax provisions in bills crafted by Baucus, the House Democrats and the Senate HELP Committee. First, healthcare-related tax changes are compared in all three bills. Next, the revenue titles of the Baucus bill and House bill are compared (the HELP committee included no revenue title). The charts are based on the HELP committee bill as passed on July 15 and the Baucus bill as described in the Senate Finance Committee’s Sept. 16 release. The descriptions of the House bill are based on the tax title as passed by the Ways and Means Committee on July 17, with modifications made for any publicly announced compromises with the Blue Dogs. Additional changes could be made before negotiations wrap up.

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Side-by-side comparison of tax-related health care provisions  
in Congressional reform bills  
Individual and employer mandates and assistance

Provision	House bill as passed by Ways and Means Committee on July 17 with modifications for public Blue Dog agreements	Senate Finance Committee proposal as outlined by Baucus on Sept. 16	Senate HELP committee bill as passed by committee on July 15
<b>Individual mandate</b>	<ul style="list-style-type: none"> <li>Individuals would be required to obtain a minimum level of health coverage or pay a penalty.</li> <li>Penalty would be a tax of 2.5% of adjusted gross income above a taxpayer's standard deduction and exemption amount (\$8,950 for a single taxpayer in 2008).</li> <li>Tax penalty would be capped at the average national cost for basic health insurance coverage.</li> <li>Generally effective beginning in 2013.</li> </ul>	<ul style="list-style-type: none"> <li>Beginning in 2013, individuals would be required to obtain a minimum level of health coverage unless no insurance is available with a premium equal to 10% or less of an individual's income.</li> <li>Provides exemptions from the penalty for "hardship," Native Americans, individuals below 100% of poverty level (2010) and individuals at or below 133% of poverty level (2013+).</li> <li>Penalty for failure to obtain coverage is \$750 per year for those between 100-300% of poverty level (maximum family penalty of \$1500) and \$950 per year (maximum family penalty \$3800) for those above 300% of poverty level.</li> </ul>	<ul style="list-style-type: none"> <li>Beginning in 2011, individuals 150% or more above poverty level would be required to obtain a minimum level of health coverage unless no insurance is available with a premium equal to 12.5% or less of the individual's AGI.</li> <li>Penalty for failure to obtain coverage is left largely to the discretion of Treasury, but the minimum penalty cannot exceed \$750.</li> </ul>
<b>Individual assistance</b>	<ul style="list-style-type: none"> <li>Credits would be available on a sliding scale for individuals between 133% and 400% of poverty level.</li> <li>Credits would apply against the cost of premiums for the basic plan available in a new healthcare exchange created by the bill.</li> </ul>	<ul style="list-style-type: none"> <li>Tax credits would be available on a sliding scale for those between 134% and 300% of poverty level beginning in 2013 and to those at 100-133% of poverty level in 2014.</li> <li>Tax credits would be refundable and advanceable and based on the ratio of premium cost to income.</li> <li>Cost-sharing assistance would be available on a sliding scale for those between 100% and 300% of poverty level.</li> <li>Premium credits would be available at a %age of income for those between 300% and 400% of poverty level.</li> <li>Tax credits, cost-sharing and premium credits would be tied to specific categories of coverage created by the bill and would generally be available beginning in 2013.</li> </ul>	<ul style="list-style-type: none"> <li>Credits would be available on a sliding scale for individuals up to 400% of poverty level.</li> <li>Credits would be calculated with a formula using the premiums of the three lowest-cost qualified plans offered in the geographic area.</li> </ul>

Provision	House bill as passed by Ways and Means Committee on July 17 with modifications for public Blue Dog agreements	Senate Finance Committee proposal as outlined by Baucus on Sept. 16	Senate HELP committee bill as passed by committee on July 15
<b>Employer mandate</b>	<ul style="list-style-type: none"> <li>• Beginning in 2013, employers would choose to either offer insurance or pay an 8% tax on wages.</li> <li>• Separate elections could be made for separate lines of business and for full-time and part-time employees.</li> <li>• 8% tax on wages would not apply to employers with annual payrolls below \$500,000 and would phase in at payroll levels between \$500,000 and \$750,000.</li> <li>• Employers electing to offer insurance but who fail to meet required minimum standards would be subject to a \$100 daily penalty for each employee not covered.</li> </ul>	<ul style="list-style-type: none"> <li>• Employers would not be required to offer health insurance coverage.</li> <li>• Employers with more than 50 full-time employees (30 hours and above) would be required to pay a fee for each employee who receives a tax credit for health coverage.</li> <li>• Fee would be based on the amount of credits received by employees, capped at \$400 per employee regardless of how many receive a credit.</li> <li>• Because of the individual tax credit's eligibility restrictions, only employers who do not offer health insurance or offer insurance with premiums above 13% of income would have employees who could receive the credit.</li> <li>• New rules generally effective in 2013.</li> </ul>	<ul style="list-style-type: none"> <li>• Employers would have to offer qualifying coverage and pay at least 60% of premiums or face a fee.</li> <li>• Fee would be \$750 fee for every uncovered employee (\$375 for part-time employees), adjusted for inflation beginning in 2013.</li> <li>• No fee would be levied on the first 25 employees, and employers with fewer than 25 employees would be totally exempt.</li> </ul>
<b>Employer assistance</b>	<ul style="list-style-type: none"> <li>• Tax credit of up to 50% of coverage costs would be available for businesses with 25 or fewer employees and average wages under \$40,000.</li> <li>• Tax credit would phase out based on number of employees and AGI per employee; coverage for employees with over \$80,000 of income would not be eligible for the credit.</li> <li>• Effective for tax years beginning in 2013 and later.</li> </ul>	<ul style="list-style-type: none"> <li>• Tax credit of up to 35% of coverage costs would be available in 2011 and 2012 for firms with fewer than 25 employees and average wages below \$40,000.</li> <li>• After 2012, the tax credit would be increased to a maximum of 50% but would only be available for insurance purchased through newly created state exchanges and only for the first two years an employer offers coverage.</li> </ul>	<ul style="list-style-type: none"> <li>• Premium subsidies would be available starting in 2010 for employers with 50 or fewer full-time employees and who pay at least 60% of premiums.</li> <li>• Subsidy would be based on firm size and premium contribution up to a maximum of \$1,800 per employee.</li> <li>• Employers could take credit only three out of every four years.</li> </ul>

Side-by-side comparison of tax-related health care provisions  
in Congressional reform bills

Revenue raisers\*

Provision	House bill as passed by Ways and Means Committee on July 17 with modifications for public Blue Dog agreements	Senate Finance Committee proposal as outlined by Baucus on Sept. 16
<p><b>Primary tax revenue raiser</b></p>	<p><b>High-income surtax (\$544 billion)</b></p> <ul style="list-style-type: none"> <li>Beginning in 2011, a surtax would be imposed outside of normal tax brackets on AGI above \$280,000 for single filers and \$350,000 for joint filers.</li> <li>Surtax includes three brackets (1%, 1.5% and 5.4%) indexed for inflation.</li> <li>The 1% and 1.5% brackets would either double, stay the same or disappear in 2013, depending on the amount of savings then estimated to be achieved by other provisions in the bill.</li> </ul>	<p><b>Excise tax on high-cost insurance (\$215 billion)</b></p> <ul style="list-style-type: none"> <li>Excise tax of 35% would be levied on insurance companies for any health insurance plan above \$8,000 for singles and \$21,000 for family plans (\$215 billion).</li> <li>The tax would not apply to plans sold in the individual market.</li> <li>The threshold would be indexed for inflation and a transition rule would raise the threshold by 20%, 10% and 5% for the 17 highest-cost states for the first three years.</li> <li>Effective for tax years beginning in 2013 or later.</li> </ul>
<p><b>Health-related tax revenue raisers</b></p>	<p><b>Healthcare account spending (\$8.2 billion)</b></p> <ul style="list-style-type: none"> <li>HSAs, FSAs, HRAs and the Archer MSA could no longer be used to purchase over-the-counter drugs (except insulin), effective for expenses incurred after 2009.</li> </ul>	<p><b>Health benefits reporting (no revenue effect)</b></p> <ul style="list-style-type: none"> <li>Employers would be required to disclose the value of the benefit of any health coverage on an employee's annual Form W-2.</li> </ul> <p><b>Eliminate exclusion for employer Part D subsidy (\$4 billion)</b></p> <ul style="list-style-type: none"> <li>Exclusion from gross income for the subsidy for employers who maintain prescription drug plans for their Medicare Part D-eligible retirees would be eliminated, effective for tax years beginning after 2010.</li> </ul> <p><b>Flexible Spending Account limits (\$16.5 billion)</b></p> <ul style="list-style-type: none"> <li>Contributions to health FSAs would be limited to \$2,000, effective for tax years beginning after 2012.</li> </ul> <p><b>Standardize qualified medical expenses (\$5.4 billion)</b></p> <ul style="list-style-type: none"> <li>HSA, FSA and HRA expenditures would be limited to items qualifying for the medical expenses itemized deduction, with an exception for over-the-counter drugs with a prescription, effective for tax years beginning after 2009.</li> </ul> <p><b>Increase the HSA penalties (\$1.3 billion)</b></p> <ul style="list-style-type: none"> <li>Additional tax for improper HSA expenditures would increase from 10% to 20%, effective for disbursements in tax years beginning after 2009.</li> </ul> <p><b>Nonprofit hospital reporting (no revenue effect)</b></p> <ul style="list-style-type: none"> <li>New reporting requirements would be instituted for nonprofit hospitals effective in tax years beginning after the date of enactment.</li> </ul>

Provision	House bill as passed by Ways and Means Committee on July 17 with modifications for public Blue Dog agreements	Senate Finance Committee proposal as outlined by Baucus on Sept. 16
<b>Non-health-related tax revenue raisers</b>	<p><b>Worldwide interest allocation (\$29 billion)</b></p> <ul style="list-style-type: none"> <li>• Implementation of worldwide interest expense allocation rules would be delayed 10 years until 2020.</li> </ul> <p><b>Treaty benefits for deductible payments (\$7.5 billion)</b></p> <ul style="list-style-type: none"> <li>• Reduced withholding rates available under tax treaties would be limited for certain deductible related-party payments.</li> <li>• Reduced rates would be denied for deductible related-party payments to a foreign person if the person and the U.S. payor were members of a foreign controlled group and the top-tier foreign member corporation is not located in a country subject to a tax treaty that allows for reduced rates.</li> <li>• Generally effective for payments made after the date of enactment</li> </ul> <p><b>Economic substance and new penalties (\$3.6 billion)</b></p> <ul style="list-style-type: none"> <li>• Transaction entered into on or after the date of enactment would have economic substance only if it changed the taxpayer's economic position in a meaningful way and the taxpayer had a substantial economic purpose for the transaction.</li> <li>• Understatement penalty for a transaction lacking economic substance would be 40% (or 20% with disclosure).</li> <li>• "Reasonable cause" exception for the underpayment and fraud penalties would exclude tax shelter transactions, transactions lacking economic substance, and transactions by corporations with gross receipts over \$100 million.</li> </ul>	<p><b>Corporate information reporting (\$17.1 billion)</b></p> <ul style="list-style-type: none"> <li>• Required Form 1099 and other information reporting would be extended to cover payments for goods and services, and to require reporting of payments to corporations, effective 2012.</li> </ul>
<b>Notable non-tax revenue raisers</b>	<p><b>Medicare and Medicaid savings</b></p> <ul style="list-style-type: none"> <li>• \$219 billion in savings would be achieved from changes to Medicare, Medicaid, Children's Health Insurance, and other federal health spending programs.</li> </ul>	<p><b>Medicare and Medicaid savings</b></p> <ul style="list-style-type: none"> <li>• \$409 billion in savings would be achieved from changes to Medicare, Medicaid, Children's Health Insurance, and other federal health spending programs.</li> </ul> <p><b>Fees on healthcare industries (\$93.2 billion)</b></p> <ul style="list-style-type: none"> <li>• \$2.3 billion annual fee would be imposed on drug manufacturers.</li> <li>• \$4 billion annual fee would be imposed on medical device manufacturers.</li> <li>• \$6 billion annual fee would be imposed on health insurers.</li> <li>• \$750 million annual fee would be imposed on clinical labs.</li> <li>• Fees would begin in 2010 and be allocated by market share.</li> </ul>

\*The Senate HELP committee bill did not contain revenue raisers.