

Tax Legislative Update

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

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Amendments to Senate healthcare tax title change outlook for reform

The Senate Finance Committee has completed work on its healthcare reform bill and is scheduled to vote on the measure on Tuesday, Oct. 8. The Congressional Budget Office gave it a favorable cost estimate, but minor changes could be made before the vote.

Several major changes were made to the bill's tax provisions before and during its markup:

- Increase in the excise tax rate for high-cost health plans to 40 percent; a higher cost threshold added for high-risk workers and non-Medicare retirees over 55
- Reduction of penalties for taxpayers who do not obtain qualifying coverage from a maximum of \$3,800 per family to \$750 per adult
- Delay of the effective date of many provisions from Jan. 1, 2013, to July 1, 2013

Finance Committee Chair Max Baucus, D-Mont., may have enough votes to pass the bill at the committee level, but final enactment of a bill is less clear. Baucus's bill is only one of 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:** Baucus chose to write a completely separate bill designed to attract bipartisan support. A committee vote is scheduled for Oct. 13, and the bill may attract the support of at least one Republican.
- **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 negotiates changes in the bill with Democratic members.

Contact information

Mel Schwarz
Partner
National Tax Office
T 202.521.1564
E Mel.Schwarz@gt.com

Dustin Stamper
Manager
National Tax Office
T 202.861.4144
E Dustin.Stamper@gt.com

www.GrantThornton.com/tax

Senate Majority Leader Harry Reid, D-Nev., has indicated he wants to merge the HELP Committee and Finance Committee bills before bringing the combined version to the floor. The HELP Committee bill attracted no bipartisan support, while the Senate Finance Committee may attract the support of moderate Republican Olympia Snowe, R-Maine. Unless every moderate Senate Democrat and both independents vote for healthcare reform, it is likely that one or more Republican votes will be needed to pass a bill in the Senate. Senate Democrats could also use the reconciliation process to pass a bill with a simple majority vote. Reconciliation is a budget mechanism fraught with complications, but precludes 60-vote hurdles like filibusters.

The Senate bill, if passed, would still need to be merged with a House version without losing support of moderate senators. The House is having its own trouble moving a bill, and House Democratic leaders are still negotiating a final compromise with members.

The following charts compare the healthcare-related tax provisions and the revenue titles of the bills from the Finance Committee, HELP Committee and House Democrats (the HELP Committee bill does not contain a revenue title). The charts are based on:

- the HELP committee bill as passed on July 15;
- the Senate Finance Committee bill as completed on Oct. 2; and
- the tax title of the House bill as passed by the Ways and Means Committee on July 17, with modifications made for any subsequently announced compromises.

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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 completed Baucus on Oct. 2	Senate HELP committee bill as passed by committee on July 15
Individual mandate	<ul style="list-style-type: none"> Individuals would be required to obtain a minimum level of health coverage or pay a penalty. 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). Penalty would be capped at the average national cost for basic health insurance coverage. Generally effective beginning in 2013. 	<ul style="list-style-type: none"> Individuals would be required to obtain a minimum level of health coverage unless no insurance is available with a premium equal to 8% or less of an individual's income. Provides exemptions from the penalty for "hardship," Native Americans and individuals at or below 133% of poverty level. Penalty for failure to obtain coverage is \$750 per adult in the household. No criminal penalties imposed for failure to pay, no interest or penalties imposed for late payments, and collection can only come through federal payment withholding. Penalty would phase in at \$200 in 2014, \$400 for 2015, \$600 for 2016, and \$750 in 2017, and indexed to CPI-U after 2017. 	<ul style="list-style-type: none"> 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. Penalty for failure to obtain coverage is left largely to the discretion of Treasury, but the minimum penalty cannot exceed \$750.
Individual assistance	<ul style="list-style-type: none"> Credits would be available on a sliding scale for individuals between 133% and 400% of poverty level. Credits would apply against the cost of premiums for the basic plan available in a new healthcare exchange created by the bill. 	<ul style="list-style-type: none"> Tax credits would be available on a sliding scale for those between 134% and 300% of poverty level in 2013 and to those at between 100% and 133% of poverty level in 2014. Tax credits would be refundable and advanceable and based on the ratio of premium cost to income. Cost-sharing assistance would be available on a sliding scale for those between 100% and 300% of poverty level. Premium credits would be available at a percentage of income for those between 300% and 400% of poverty level. 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 July 1, 2013. 	<ul style="list-style-type: none"> Credits would be available on a sliding scale for individuals up to 400% of poverty level. Credits would be calculated with a formula using the premiums of the three lowest-cost qualified plans offered in the geographic area.

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 completed Baucus on Oct. 2	Senate HELP committee bill as passed by committee on July 15
Employer mandate	<ul style="list-style-type: none"> Beginning in 2013, employers would choose to either offer insurance or pay an 8% tax on wages. Separate elections could be made for separate lines of business and for full-time and part-time employees. 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. 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. 	<ul style="list-style-type: none"> Employers would not be required to offer health insurance coverage. 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. Fee would be based on the amount of credits received by employees, capped at \$400 per employee (indexed for premium growth) regardless of how many receive a credit. Fees would not be deductible. Because of the individual tax credit's eligibility restrictions, only employers who do not offer qualifying health insurance would have employees who could receive the credit. New rules generally effective starting July 1, 2013. 	<ul style="list-style-type: none"> Employers would have to offer qualifying coverage and pay at least 60% of premiums or face a fee. Fee would be \$750 fee for every uncovered employee (\$375 for part-time employees), adjusted for inflation beginning in 2013. No fee would be levied on the first 25 employees, and employers with fewer than 25 employees would be totally exempt.
Employer assistance	<ul style="list-style-type: none"> 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. 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. Effective for tax years beginning in 2013 and later. 	<ul style="list-style-type: none"> Tax credit of up to 35% of coverage costs would be available for small firms in 2011 and 2012. Full credit would be available for firms with 10 employees or less and average wages below \$20,000, with the credit phasing out between 10 and 25 employees and average pay between \$20,000 and \$40,000. Phaseout thresholds would be indexed to CPI-U for years beginning in 2014 and seasonal workers would be excluded from the calculation. 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. Reduced credit would be available for nonprofits (25% in 2011 and 2012 and 35% for 2013+). 	<ul style="list-style-type: none"> 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. Subsidy would be based on firm size and premium contribution up to a maximum of \$1,800 per employee. Employers could take credit only three out of every four years.

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

Revenue title*

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 completed on Oct. 2
New tax benefits		<p>Qualified therapeutic discovery credit (no estimate)</p> <ul style="list-style-type: none"> • Businesses with 250 or fewer employees could apply for a 50% credit for investments in qualified therapeutic discovery projects in 2009 and 2010. • \$1 billion would be allocated to the program. • Treasury loan would be available in lieu of credit.
Primary tax revenue raiser	<p>High-income surtax (\$544 billion)</p> <ul style="list-style-type: none"> • 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. • Surtax includes three brackets (1%, 1.5% and 5.4%) indexed for inflation. • 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. 	<p>Excise tax on high-cost insurance (\$201 billion)</p> <ul style="list-style-type: none"> • Excise tax of 40% would be levied on insurance companies for employer health insurance plans above \$8,000 for singles and \$21,000 for family plans. • Thresholds increased to \$9,850 and \$26,000 for high-risk workers and non-Medicare retirees over 55. • Generally all employer plans — including medical, dental, vision plans and health FSAs — count towards the cap, with an exception for indemnity plans. • Effective for tax years beginning in 2013 with threshold indexed for inflation in 2014 using CPI-U + 1%, and a transition rule would raise the threshold by 20%, 10% and 5% for the 17 highest-cost states for first 3 years.
Health-related tax revenue raisers	<p>Healthcare account spending (\$8.2 billion)</p> <ul style="list-style-type: none"> • 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. 	<p>Deduction for medical expenses (no estimate)</p> <ul style="list-style-type: none"> • The 7.5% AGI floor for the itemized deduction for medical expenses would temporarily increase to 10% of AGI for taxpayers aged 64 and younger. • Would apply to tax years beginning after 2012 and ending before 2017 <p>Exclusion for employer Part D subsidy (\$4 billion)</p> <ul style="list-style-type: none"> • Exclusion from gross income for the subsidy for drug plans for Medicare Part D-eligible retirees would be eliminated, effective for tax years beginning after 2010. <p>Flexible Spending Account limits (\$14.6 billion)</p> <ul style="list-style-type: none"> • Contributions to health FSAs would be limited to \$2,500, effective for tax years beginning after 2010. <p>Standard qualified medical expenses (\$5.4 billion)</p> <ul style="list-style-type: none"> • HSA, FSA and HRA expenditures would be limited to items qualifying for the medical expenses itemized deduction (except for prescribed over-the-counter drugs), effective for tax years beginning after 2009. <p>Increased HSA penalties (\$1.3 billion)</p> <ul style="list-style-type: none"> • Additional tax for improper HSA expenditures would increase from 10% to 20%, effective for disbursements in tax years beginning after 2010. <p>Executive compensation deductions (no estimate)</p> <ul style="list-style-type: none"> • Insurance companies could not deduct any employee pay over \$500,000 if at least 25% of their premium income comes from plans that meet the minimum creditable coverage requirements of the bill. • Effective for compensation paid in tax years beginning after 2012 with respect to services after 2009.

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 completed on Oct. 2
Non-health-related tax revenue raisers	<p>Worldwide interest allocation (\$29 billion)</p> <ul style="list-style-type: none"> Implementation of worldwide interest allocation rules would be delayed 10 years until 2020. <p>Treaty rates for deductible payments (\$7.5 billion)</p> <ul style="list-style-type: none"> Reduced withholding rates available under tax treaties would be limited for certain deductible related-party payments. 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. Generally effective for payments made after the date of enactment. <p>Economic substance and penalties (\$3.6 billion)</p> <ul style="list-style-type: none"> 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. Understatement penalty for a transaction lacking economic substance would be 40% (or 20% with disclosure). "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. 	<p>Corporate information reporting (\$17.1 billion)</p> <ul style="list-style-type: none"> 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.
Notable non-tax revenue raisers	<p>Medicare and Medicaid savings</p> <ul style="list-style-type: none"> \$219 billion in savings would be achieved from changes to Medicare, Medicaid, Children's Health Insurance and other federal health spending programs. 	<p>Medicare and Medicaid savings</p> <ul style="list-style-type: none"> \$404 billion in savings would be achieved from changes to Medicare, Medicaid, Children's Health Insurance and other federal health spending programs (estimate of savings made before amendments). <p>Fees on healthcare industries (\$121.2 billion)</p> <ul style="list-style-type: none"> \$2.3 billion annual fee would be imposed on drug manufacturers. \$4 billion annual fee would be imposed on medical device manufacturers, with exemption for sales of all Class I devices and any Class II devices under \$100. \$6.7 billion annual fee would be imposed on health insurers. Fees would begin in 2010 and be allocated by market share. Fees would not be deductible.

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