Grant Thornton

Tax Legislative Update

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

2009-16
Oct. 30, 2009

New House health bill makes changes to tax proposals

House Democratic leaders have unveiled a new healthcare reform bill (H.R. 3296) in anticipation of a floor vote the first week of November. America's Affordable Health Choices Act combines earlier versions of healthcare legislation passed by various House committees and makes several changes to attract Democratic votes for passage.

The changes include many departures from the tax title originally passed by the House Ways and Means Committee. Most importantly, the bottom two tax brackets in the proposed high-income surtax are eliminated. Originally, the surtax included a 1-percent bracket for income over $280,000 ($350,000 for joint filers) and a 1.5-percent bracket for income over $400,000 ($500,000 for joint filers). The new proposal retains only the 5.4-percent tax on income over $500,000 ($1 million for joint filers), effective beginning in 2011, but does not index this level for inflation.

The bill makes up the $83 billion lost in the surtax changes with several new revenue raisers, many taken from the Senate Finance Committee healthcare bill. These revenue raisers include:

- a $2,500 limit on Flexible Spending Account (FSA) contributions;
- increased penalties on improper Health Savings Account (HSA) distributions;
- a 2.5-percent excise tax on the sale of a medical device (excluding retail sales); and
- an expansion of Form 1099 information reporting to include payments made to corporations and for sales of property.

The bill retains the 8-percent payroll tax on employers who do not offer insurance, but increases the small business exemption to $500,000 in annual payroll with the tax phasing in between payroll levels of $500,000 to $750,000.

The floor vote for the House bill is expected to be close. Leaders currently plan to use a manager's amendment to further tweak the bill in preparation for the vote. While changes to the tax provisions will be considered, the most controversial aspect of the bill remains a proposal to create a "public option" to compete with private insurance companies.

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

© 2009 Grant Thornton LLP
All rights reserved
U.S. member firm of Grant Thornton International Ltd

Senate activity

Senate Democrats are still working toward a unified bill. Senate Majority Leader Harry Reid, D-Nev., is currently negotiating the merger of a Senate Finance Committee healthcare bill with a separate bill completed by the Senate Committee on Health, Education, Labor and Pensions (HELP).

Reid could make significant changes to the tax provisions passed by the Senate Finance Committee. Recent negotiations have focused on increasing the threshold for a 40-percent excise tax on high-cost health insurance. Reid's recent decision to include a "public option" with a state opt-out also assures that a Senate vote on the measure will be close.

If the Senate and House each pass a bill, leaders will have to merge the bills without losing the support of moderate senators or upsetting the compromise between moderate and liberal House Democrats.

The following charts compare the healthcare-related tax provisions and revenue titles of the Senate bills that Reid is combining and the unified House bill created by Democratic leadership (the HELP bill contains no revenue title). The charts are based on:

- the HELP committee bill as passed on July 15;
- the Senate Finance Committee bill as approved on Oct. 13; and
- the House bill as introduced by Democratic leadership on Oct. 29.

Tax professional standards statement

This document supports the marketing of professional services by Grant Thornton LLP. It is not written tax advice directed at the particular facts and circumstances of any person. Persons interested in the subject of this document should contact Grant Thornton or their tax advisor to discuss the potential application of this subject matter to their particular facts and circumstances. Nothing herein shall be construed as imposing a limitation on any person from disclosing the tax treatment or tax structure of any matter addressed. To the extent this document may be considered written tax advice, in accordance with applicable professional regulations, unless expressly stated otherwise, any written advice contained in, forwarded with, or attached to this document is not intended or written by Grant Thornton LLP to be used, and cannot be used, by any person for the purpose of avoiding any penalties that may be imposed under the Internal Revenue Code.

The information contained herein is general in nature and based on authorities that are subject to change. It is not intended and should not be construed as legal, accounting or tax advice or opinion provided by Grant Thornton LLP to the reader. This material may not be applicable to or suitable for specific circumstances or needs and may require consideration of nontax and other tax factors. Contact Grant Thornton LLP or other tax professionals prior to taking any action based upon this information. Grant Thornton LLP assumes no obligation to inform the reader of any changes in tax laws or other factors that could affect information contained herein. No part of this document may be reproduced, retransmitted or otherwise redistributed in any form or by any means, electronic or mechanical, including by photocopying, facsimile transmission, recording, re-keying or using any information storage and retrieval system without written permission from Grant Thornton LLP.

© 2009 Grant Thornton LLP
All rights reserved
U.S. member firm of Grant Thornton International Ltd

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

Individual and employer mandates and assistance

Provision	America's Affordable Health Choices Act (H.R. 3200) on Oct. 29	Senate Finance Committee proposal as approved on Oct. 13	Senate HELP committee bill as passed by committee on July 15
Individual mandate	• 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 ($9,350 for a single taxpayer and $18,700 for a couple in 2009). • Hardship waivers would be available if coverage is unaffordable. • Penalty would be capped at the average national cost for basic health insurance coverage. • Generally effective 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 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.	• 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	• Credits would be available on a sliding scale for individuals up to 400% of poverty level. • Credits would be available to those with employers who offer no coverage or offer coverage with costs over 12% percent of their income. • Credits would apply against the cost of premiums for the basic plan available in a new healthcare exchange created by the bill.	• 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.	• 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.

© 2009 Grant Thornton LLP
All rights reserved
U.S. member firm of Grant Thornton International Ltd

Provision	America's Affordable Health Choices Act (H.R. 3200) on Oct. 29	Senate Finance Committee proposal as approved on Oct. 13	Senate HELP committee bill as passed by committee on July 15
Employer mandate	• Beginning in 2013, employers would choose to either: 1) offer insurance and contribute to premiums or 2) pay an 8% tax on wages. • Employers electing to offer insurance would have to cover at least 72.5% of individual premiums and 65% of family premiums. • Separate elections could be made for separate lines of business and for full-time and part-time employees. • Employees offered unaffordable coverage could use the exchange created by the bill, and the employer would have to make a contribution to healthcare of 8% of wages. • 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.	• 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.	• 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	• 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, and coverage for employees with over $80,000 of income would not be eligible for the credit. • Tax credit available for only two taxable years total. • Effective for tax years beginning in 2013 and later.	• 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+).	• 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.

© 2009 Grant Thornton LLP
All rights reserved
U.S. member firm of Grant Thornton International Ltd

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

Revenue title*

Provision	America's Affordable Health Choices Act (H.R. 3200) on Oct. 29	Senate Finance Committee proposal as approved on Oct. 13
New tax benefits	**Exclusion for family health benefits (costs $4 billion)** • Individuals could exclude from income any employer-provided coverage allowed under the employer plan — including coverage for domestic partners and their dependents, beginning in 2010. **Exclusion for Indian healthcare (under $50 million)** • Health benefits provided to Indian tribes would not be included in income, effective on the date of enactment.	**Qualified therapeutic discovery credit (no estimate)** • 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	**High-income surtax ($461 billion)** • Beginning in 2011, a 5.4% surtax would be imposed outside of normal tax brackets on AGI above $500,000 for single filers, trusts and estates, and $1 million for joint filers. • Threshold not indexed for inflation. • The surtax would apply to modified adjusted gross income, including both ordinary and capital gains, and could not be reduced by credits.	**Excise tax on high-cost insurance ($201.4 billion)** • 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	**Exclusion for employer Part D subsidy ($3.0 billion)** • 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. **Flexible Spending Account limits ($13.3 billion)** • Contributions to health FSAs would be limited to $2,500 (adjusted for cost of living), effective for tax years beginning after 2012. **Standard qualified medical expenses ($5.0 billion)** • HSA, FSA and HRA expenditures would be limited to items qualifying for the medical expenses itemized deduction (plus insulin and prescribed over-the-counter drugs), effective for tax years beginning after 2010. **Increased HSA penalties ($1.3 billion)** • Additional tax for improper HSA expenditures would increase from 10% to 20%, effective for disbursements in tax years beginning after 2010. **Excise tax on medical devices ($20 billion)** • A 2.5% excise tax would be levied on the first sale or use of medical devices effective after 2012. • Exceptions would be provided for sales for use in further manufacture, for resale and for export, and for normal sales to the general public in a retail establishment. **Insurance fee ($2 billion)** • A fee would be imposed on insurance and self-insurance plans at the rate needed to raise $375 million per year, effective for policy or plan years beginning on or after Oct. 1, 2012.	**Deduction for medical expenses ($15.2 billion)** • The 7.5% AGI floor for the medical expenses itemized deduction would temporarily increase to 10% of AGI for taxpayers aged 64 and younger, effective for tax years beginning after 2012 and ending before 2017. **Exclusion for employer Part D subsidy ($4.0 billion)** • 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. **Flexible Spending Account limits ($14.6 billion)** • Contributions to health FSAs would be limited to $2,500, effective for tax years beginning after 2010. **Standard qualified medical expenses ($5.4 billion)** • 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. **Increased HSA penalties ($1.3 billion)** • Additional tax for improper HSA expenditures would increase from 10% to 20%, effective for disbursements in tax years beginning after 2010. **Executive compensation deductions ($600 million)** • Insurance companies could not deduct employee pay over $500,000 if at least 25% of premium income comes from plans meeting minimum creditable coverage requirements of the bill. • Effective for compensation paid in tax years beginning after 2012 with respect to services after 2009.

© 2009 Grant Thornton LLP
All rights reserved
U.S. member firm of Grant Thornton International Ltd

Provision	America's Affordable Health Choices Act (H.R. 3200) on Oct. 29	Senate Finance Committee proposal as approved on Oct. 13
Non-health-related tax revenue raisers	**Worldwide interest allocation ($26.1 billion)** • Implementation of worldwide interest allocation rules would be delayed 10 years until 2020. **Corporate information reporting ($17.1 billion)** • 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. **Treaty rates for deductible payments ($7.5 billion)** • Reduced withholding rates available under tax treaties would be limited for certain deductible related-party payments, generally effective for payments made after the date of enactment. • 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. **Economic substance and penalties ($5.7 billion)** • Transactions would have economic substance only if they change 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 equals 40% (20% with disclosure). • "Reasonable cause" exception for the underpayment and fraud penalties would exclude tax shelter transactions and transactions lacking economic substance, and non-economic substance could not have "reasonable basis" to avoid refund penalties. • Corporations with gross receipts over $100 million or required to file reports by Section 13 of the Securities and Exchange Act of 1934 would have to reach a "more likely than not" standard to qualify for the "reasonable cause" exception for underpayment and fraud penalties. • Generally effective with respect to transactions entered into after the date of enactment.	**Corporate information reporting ($17.1 billion)** • 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	**Medicare and Medicaid savings** • Billion in savings would be achieved from changes to Medicare, Medicaid, Children's Health Insurance and other federal health spending programs.	**Medicare and Medicaid savings** • $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). **Fees on healthcare industries ($121.2 billion)** • $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 would be non-deductible and allocated by market share.

*The Senate HELP committee bill did not contain revenue raisers.
** Revenue estimates represent the reduction in government receipts over 10 years as estimated by the Joint Committee on Taxation.

© 2009 Grant Thornton LLP
All rights reserved
U.S. member firm of Grant Thornton International Ltd