

# House-passed health reform bill would fundamentally alter health-care related tax rules, and include many tax crackdowns

Note: The text of H.R. 3962 may be found at <http://www.house.gov/rules> .

As passed by the House of Representatives on November 7, H.R. 3962, the “Affordable Health Care for America Act,” would make massive changes in the health insurance delivery system, and, along the way, would fundamentally alter the way in which employers provide health coverage to employees. It also would require most people to get health coverage or pay a penalty tax, hit high earners with a surtax, and change a number of information reporting, compliance and foreign-tax rules to raise revenue to pay for health reform.

The following is a summary of the tax-related provisions in H.R. 3962 as it was passed by the House.

## **“Shared Responsibility” Tax Changes**

Following are highlights of “employer and individual responsibilities” in H.R. 3962, as well as the tax provisions in Title V (Amendments to Internal Revenue Code of 1986) of Division A (Affordable Health Choices) of the House-passed bill.

- For periods beginning after 2012, employers would have to either provide health insurance to their employees or make a contribution to help fund affordable health insurance. Those choosing to offer coverage would contribute at least 72.5% of premiums for workers, 65% for families. Low-wage workers who find employer coverage unaffordable could choose subsidized coverage in the health insurance exchange and the employer would have to make a contribution to the exchange. Employers not offering qualified coverage would pay a payroll tax equal to 8% of their payroll to help cover expenses of employees who seek coverage through the exchange. Small businesses (annual payrolls below \$500,000) would be exempt from coverage requirements, including the 8% payroll contribution for failure to provide health benefits to their workers. The 8% contribution requirement would be phased in for small businesses with an annual payroll between \$500,000 and \$750,000.
- For tax years beginning after 2012, tax credits would be available for businesses with 10 or fewer employees and \$20,000 or less in average wages. They would phase-out if the employer has 25 or more employees or if average wages are \$40,000 or more. The credits would be available for the first two years that an employer offers qualified coverage.
- For tax years beginning after 2012, individuals would be required to obtain health insurance coverage or pay an additional tax equal to the lower of 2.5% of their

adjusted income above the filing threshold (e.g., if the new rule were in effect for 2009, for taxpayers under age 65, the threshold would be \$9,350 for singles and \$18,700 for couples), or the average premium on the insurance exchange. Individuals and families below the income tax filing threshold would be exempt. Individuals could apply for a hardship waiver if coverage were unaffordable; selected exemptions from the coverage mandate would apply. The bill would provide financial assistance for premiums and cost sharing for individuals and families with incomes up to 400% of the federal poverty level (FPL). Affordability credits would be offered on a sliding scale.

- Providers of health insurance coverage would be subject to new information reporting requirements (i.e., they'd have to report name, address, and taxpayer identification number of all individuals covered), for calendar years beginning after 2012.
- For expenses incurred after 2010, nontaxable reimbursements from health flexible spending accounts, health reimbursement arrangements, and health savings accounts or Archer medical savings accounts would not include a medicine or drug unless it is prescribed or is insulin.
- For tax years beginning after 2012, salary reduction contributions to health flexible spending arrangements would be limited to \$2,500 (indexed to the consumer price index). The new rule would not limit the amount permitted to be available for reimbursement under employer-provided health coverage offered through a health reimbursement account, including a flexible spending arrangement that is not part of a cafeteria plan.
- For tax years beginning after 2010, the penalty on distributions from health savings accounts that are not used to pay for health related expenditures would be increased from 10% to 20%.
- For tax years beginning after 2012, the deduction for expenses allocable to Medicare Part D subsidy would be eliminated.
- Coverage purchased through the insurance exchange could not be purchased on a pre-tax salary reduction basis (i.e., in a cafeteria plan) unless the purchaser's employer is eligible to offer employer coverage through the exchange.
- Sec. 111 of the bill would establish a temporary reinsurance program, to be established not later than 90 days after the enactment date, to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. The program would reimburse participating employment-based plans for 80% of the cost of benefits provided per enrollee in excess of \$15,000 and below \$90,000. The plans would have to use the funds to lower costs borne directly by participants and

beneficiaries. Subsidies received by an employer or health plan under Sec. 111 of the bill would not be includable in gross income.

- For tax years beginning after 2009, Code Sec. 105 and Code Sec. 106 would be amended to extend the general exclusion for employer-provided health coverage to “eligible beneficiaries” (the parallel provisions for excluding employer-provided health care from payroll taxes also would be so amended). An eligible beneficiary would be defined as any individual who is eligible to receive benefits or coverage under an accident or health plan. There would be no limit on the number of eligible beneficiaries an individual could claim for purposes of the exclusion.
- For tax years beginning after 2009, the bill would amend Code Sec. 162(1) to permit self-employed individuals to take a deduction for an individual who meets the following criteria: (1) younger than age 19 (24 for full-time students); (2) has the same principal abode as the taxpayer and is a member of the taxpayer's household for the taxable year; and (3) receives more than one-half of his or her support from the taxpayer for the calendar year in which the taxable year begins. There would be no limit on the number of such individuals a taxpayer is able to claim for purposes of the deduction. Additionally, a self-employed individual could take a deduction for an individual who is (1) older than age 19 (or 24 for students); (2) has the same principal abode as the taxpayer and is a member of the taxpayer's household for the taxable year; and (3) is not the individual's spouse, qualifying child or qualifying relative. Individuals could take a deduction for one such individual in any tax year.

### **Broadened Group Health Coverage Provisions**

Title I of Division A of the bill, captioned “Immediate Reforms,” would broaden the Code's group-health coverage requirements as follows:

- Effective on the enactment date, COBRA coverage periods for covered individuals would be extended until individuals become eligible for (a) acceptable coverage (as defined in Sec. 302(d)(2) of the bill), or (b) health insurance coverage through the bill's Health Insurance Exchange (or a State-based Health Insurance Exchange operating in a State or group of States). The extension of the COBRA continuation coverage period would apply only to individuals whose coverage period is due to end because of the expiration of a specified number of months; there would be no extension of the COBRA continuation coverage period in the case of other terminating events (e.g. failure to make timely payment of premiums). The extension of COBRA coverage continuation periods would not be available for health flexible spending arrangements.
- For plan years beginning on or after Jan. 1, 2010, a group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for dependent children would be required to make such coverage available, at the

election of participants, to their qualified children. A qualified child would be defined as an individual under the age of 27 who would, but for his or her age, be treated as a dependent child of the participant under the plan and who is not enrolled as a participant, beneficiary or enrollee under any health insurance coverage or group health plan. A group health plan or health insurance issuer could increase premiums for coverage provided to a qualified child, consistent with standards established by the Secretary of Health and Human Services based on family size.

- Effective generally for plan years beginning on or after Jan. 1, 2010, the permissible look-back period for preexisting conditions would be reduced to a thirty-day period ending on the enrollment date and the permissible preexisting condition exclusion period would be reduced to three months after the enrollment date.
- For plan years beginning after 2010, group health plan would not be able to impose any preexisting condition exclusion on the basis of domestic violence. In addition, a health insurance issuer in the individual market could not impose any preexisting condition exclusion on the basis of domestic violence.
- For plan years beginning after 2010, a group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits would have to provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's (a child age 21 or younger) congenital or developmental deformity, disease, or injury.
- For plan years beginning after 2010, a group health plan could not impose an aggregate lifetime limit with respect to benefits payable under the plan. With respect to benefits under a group health plan, this would be a dollar limitation on the total amount that may be paid with respect to an individual (or other coverage unit) on a lifetime basis.

### **Revenue Offset Provisions**

The following provisions in the House bill would help pay for health care reform:

- For tax years beginning after 2010, a 5.4% tax surcharge would be levied on modified adjusted gross income in excess of \$1 million in the case of a joint return (\$500,000 in the case of other returns). No credits would be allowed against this tax and the surcharge would not be taken into account in computing alternative minimum tax liability.
- For sales (as well as leases and uses treated as sales) of medical devices after 2010, a 2.5% excise tax would apply to the first taxable sale of a medical device (any device, as defined by Sec. 201(h) of the Federal Food, Drug, and Cosmetic

Act) intended for humans). It would not apply to exported devices or to retail sales of devices.

- Effective for payments made after 2011, a business would be required to file an information return for all payments aggregating \$600 or more in a calendar year to a single payee whether or not the payee is a corporation, (other than payees that are tax-exempt corporation), notwithstanding any reg promulgated prior to the enactment date.
- The bill would repeal the liberalized rule for allocating interest expenses between U.S. and foreign sourced income for purpose of a taxpayer's foreign tax credit limitation
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- For payments made after the enactment date, the bill would limit tax treaty benefits with respect to U.S. withholding tax imposed on deductible related-party payments. The amount of U.S. withholding tax imposed on deductible related-party payments could not be reduced under any U.S. income tax treaty unless the withholding tax would have been reduced under a U.S. income tax treaty if the payment were made directly to the foreign parent corporation of the payee. A payment would be a deductible related-party payment if it is made directly or indirectly by any entity to any other entity, it is allowable as a deduction for U.S. tax purposes, and both entities are members of the same foreign controlled group of entities.
- For transactions entered into after the enactment date, the economic substance doctrine would be codified. For any transaction to which the economic substance doctrine is relevant, the transaction would be treated as having economic substance only if (1) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and (2) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction. The codification would not change current law standards in determining when to utilize an economic substance analysis, and is not intended to alter the tax treatment of certain basic business transactions that, under longstanding judicial and administrative practice are respected, merely because the choice between meaningful economic alternatives is largely or entirely based on comparative tax advantages.
- For transactions entered into after the enactment date, corporations with more than \$100 million of gross receipts for the tax year involved, or publicly traded persons (those required to file periodic or other reports under Sec. 13 of the Securities and Exchange Act), would be made subject to a more-likely-than-not standard for avoiding tax penalties on underpayments.
- For fuel sold or used after the enactment date, the cellulosic biofuel producer credit (Code Sec. 40) would be modified to exclude fuels with significant water, sediment, or ash content, such as “black liquor.”