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ALERT:
HEALTH CARE REFORM BILL

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BEYOND THE EXCISE TAX: NEW HEALTH CARE REFORM TAXES AND FEES

Health care reform does not come cheap. Costs associated with the reform measure were already controversial to start with and less than two months after enactment, the Congressional Budget Office has issued revised numbers showing that its original projections may have been grossly understated.

Health care reform funding is slated to derive from a variety of different sources, including employers and employees. Although the high profile excise tax, also known as the "Cadillac" plan tax, that will be imposed on high cost coverage provided by employers starting in 2018 has gotten quite a bit of press (the excise tax will be the subject of a separate article), health care reform legislation* authorizes numerous other more subtle taxes and fees that will affect employers. This article specifically deals with the important revenue generating provisions including the loss of the Medicare Part D subsidy deduction, the comparative effectiveness research fee, the health insurance providers' annual fee and the changes to the Medicare tax under the Federal Insurance Contributions Act (FICA).

Other tax-related changes introduced by health care reform, such as the change in the law regarding the taxability of health coverage provided to adult dependents, the requirement to include the value of the employer-provided medical coverage on an employee's W-2, and tax credits for small employers providing health insurance to employees are addressed in different Willis publications. For details concerning these mandates see **Willis' Human Capital Practice *Alert*, Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011," Willis' Human Capital Practice *Alert*, Vol. 3, No. 5, "Health Care Reform: Impact on Small Employers,"** and **Willis' Human Capital Practice *Alert*, Vol. 3, No. 6, "IRS Guidance Regarding Tax-Free Coverage for Adult Children**."

* Please note: The final enacted version of the health care reform legislation incorporates three component pieces: 1) The Patient Protection and Affordable Care Act (PPACA), 2) a PPACA "manager's amendment" and 3) the "fixer" measure passed through the budget reconciliation process (HR 4872), the Health Care and Education Affordability Reconciliation Act of 2010 (HCEARA). For purposes of simplicity though, we will refer to the entire package of law as health care reform.

GOOD-BYE MEDICARE PART D SUBSIDY DEDUCTION

Congress launched the Medicare Part D program as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. That law authorized a tax-free subsidy payment through the Retiree Drug Subsidy (RDS) program for plan sponsors that provide prescription drug coverage to retirees who are eligible for Medicare Part D. The subsidy's tax-favored elements helped entice employers to maintain prescription drug coverage for retirees (and enabled the government to rely on the private sector to absorb at least some of

the burden associated with delivering prescription drug benefits).

Although a detailed summary of the Medicare Part D subsidy rules exceeds the scope of this article, in general an employer providing retiree prescription drug benefits is entitled to a subsidy payment if the sponsor's prescription drug coverage is at least as generous, actuarially, as Medicare's standard prescription drug benefit. The subsidy payment is based on the retirees who are eligible for, but not enrolled in, Medicare Part D. For each qualifying covered retiree enrolled in a qualified retiree prescription drug plan, the sponsor receives a subsidy payment of 28% of allowable retiree costs in the plan year between the cost threshold ($310 in 2010 and 2011) and the cost limit ($6,300 in 2010 and 2011). Of course, while specific amounts will vary by plan design and other individual factors, some resources note that in recent years subsidy payments have averaged between $600 and $800 per participant.

In addition to the 28% subsidy payment not being taxable, the employer was also able to deduct the full cost of the prescription drug benefits. (IRS rules governing that deduction specifically approve costs that were used for purposes of claiming the subsidy. This is a special exception to the tax code's general prohibition against "double-dipping.") For additional information on how to qualify and apply for the subsidy, please see Chapter 12 of Willis' on-line *Compliance Manual*.

Unfortunately those beneficial tax rules are going away. Effective for tax years beginning after December 31, 2012, employers will no longer be able to take a deduction for the portion of prescription drug costs that are offset by the subsidy it receives.

This change has already affected some organizations. For employers paying corporate income tax, the loss of the RDS tax exclusion will generate immediately new reportable liabilities. Specifically, generally accepted U.S. accounting rules require immediate recognition of the law's effect on future income – regardless of the fact that the law is not poised to actually go into effect for several years. Tax law changes must be accounted for in the company's income statement within the period that includes the date of the enactment.

In the days following the enactment of health care reform it was widely reported that AT&T would take a charge of $1 billion, Deere & Company a charge of $150 million, Caterpillar a charge of $100 million and 3M a charge of $90 million. Employers should direct any questions regarding the reporting of any tax liabilities to their tax advisers.

Some respected experts note that this deduction take-away is entirely counter-productive and will prompt many organizations to terminate RDS program participation and instead force affected participants to enroll in Medicare Part D. An exodus of RDS employers will likely impact federal Medicare Part D costs and cause them to rise. Employers will need to analyze what the loss of the deduction will mean for them and their bottom line and what strategic move represents the most cost effective means of providing prescription drug benefits to their retirees (to the extent that employers continue to provide retiree benefits).

COMPARATIVE EFFECTIVENESS RESEARCH FEE

Comparative effectiveness research (CER) is designed to assist with health care decisions by providing evidence on the effectiveness, benefits and harms of different treatment options. Health care reform requires the Secretary of Health and Human Services (HHS) to establish a Patient-Centered Outcomes Research Institute. The institute will conduct and support research regarding the effectiveness and appropriateness of health care services in order to identify the ways in which diseases and health conditions can be most effectively prevented, diagnosed and treated. To fund the new institute, the Treasury Department will create the Patient-Centered Outcomes Research Trust "Fund." Funding for this trust will come, in part, from CER fees imposed on health plans.

For employers with fully insured health plans, the health insurer will be assessed the CER fee. By contrast, for self-insured plans the plan sponsor (e.g., the employer) is assessed the fee. The fee applies to accident and health insurance plans other than plans covering benefits exempt under HIPAA (e.g., qualifying health flexible spending accounts, stand-alone dental and vision plans and coverage for only accident or disability). For a detailed explanation of these rules, please see the May Willis EB *Alert,* "**Devil in the Details.**" Additional information is also contained in Chapter 9 of Willis' on-line *Compliance Manual*. Governmental entities are not exempt from the fee but certain governmental programs, such as Medicare and Medicaid, are exempt.

The CER fee, which is treated as a tax, is effective for plan years ending after September 30, 2012. For each plan year ending after September 30, 2012, a fee is imposed equal to $2 ($1 for plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan. For future plan years (that end in any fiscal year beginning after September 30, 2014), the $2 amount is adjusted for increases in projected per capita health care spending. The fee is intended to be of limited duration and will not apply to plan years ending after September 30, 2019.

EXAMPLE ABC Company employs 1000 full time employees. 900 of those employees take benefits in the ABC Company health plan. Including dependents, the ABC Company health plans offers benefits to 2700 people (covered lives).

This means that for plan years ending after September 30, 2014 the ABC Company will be assessed a CER fee of $5,400 ($2 X 2700 "covered lives").

Unfortunately, although the fee will be treated as a tax, specific information about how the fee will be collected is not yet available. While employers will be able to estimate the cost of the fee to them (based on current enrollment), they do not have the information necessary to determine what administrative steps need to be taken to get the fee paid. It is likely that insurers will pass this fee, as with many of the costs that will be generated due to health care reform, onto employers.

HEALTH INSURANCE PROVIDERS' ANNUAL FEE

Beginning after December 31, 2013, certain health insurance providers (e.g., those providing medical, dental and vision insurance) will be subject to an annual excise tax based on their market share of health insurance premiums. Health insurers will also be required to report annually (after the end of the calendar year) its net premiums written for any U.S. health risks in the calendar year.

The fee is a percentage of an annual amount which is set by the law. The annual amount is the aggregate annual fee for all health insurers subject to the law. The aggregate annual amount for 2014 is $8 billion. The fee increases to $11.3 billion in 2015-2016, $13.9 billion in 2017 and $14.3 billion in 2018. For years after 2018 the fee will be based on the previous year and adjusted for the premium growth rate.

The aggregate annual fee is allocated among health insurers and the amount that the insurer pays reflects its market share of U.S. health insurance business. More specifically, the fee equals the amount that bears the same ratio to the aggregate annual fee (as provided above) as (1) the insurer's net health insurance premiums (that are subject to the fee) for the preceding calendar year bears to (2) the aggregate net health insurance premiums of all covered entities that are taken into account during such preceding calendar year.

EXAMPLE The following calculation is to determine the insurer's 2015 fee.

Insurance Company A's net health insurance premiums for 2014 were $2 billion dollars (as discussed below, 100% of the premiums are taken into account for purposes of calculating the fee). The total health insurance premiums for all health insurers for 2014 were $100 billion. Based on this information, Insurance Company A's percentage of the fee is 2%. For 2015, the aggregate annual fee is $11.3 billion. Insurance Company A's fee for 2015 would be $226 million (2% of the aggregate annual fee).

The fee must be paid no later than September 30 of each calendar year (the specific due date is yet to be determined).

Entities subject to the fee are any that provide health insurance for any U.S. health risk (a health risk of any individual who is a U.S. citizen, etc.) during the calendar year in which the fee is due. Important exceptions apply. Consequently, for purposes of this fee health insurance does not include coverage only for accident insurance or disability income insurance (or any combination), coverage for a specified disease or illness, hospital or other fixed indemnity insurance, long-term care insurance or Medicare supplemental insurance.

Perhaps most importantly, self-funded group health plans are exempt from this fee. In addition to self-funded plans, government entities, voluntary employee benefit associations (that are established by an entity other than an employer) and non-profits that receive more than 80% of gross revenues from government programs that target low-income, elderly and disabled populations are also exempt.

Those health insurers with net premiums in a calendar year of $25 million or less are exempt from the fee because their net premiums are below the premium threshold that is used to calculate the fee owed. For an insurer whose net premiums are more than $25 million but not more than $50 million, 50% of the net premiums are taken into account for purposes of calculating the fee. If net premiums are excess of $50 million, 100% of the premiums will be taken into account.

Why should fees generally targeted at insurers be an employer concern? Although such fees are not directly imposed on employers (and self-insured benefits are not subject to the fee), health insurers are fully expected to pass the added expense onto employers in the form of increased premiums and fees.

INCREASE IN MEDICARE TAXES

FICA imposes two taxes on both employers and employees. One tax finances Social Security while the other tax finances Medicare. Both employees and employers pay a total Social Security tax of 12.4% (6.2% each) of the employee's wages (up to the Social Security wage base of $106,800 (for 2010)). For purposes of the Medicare tax, employers and employees both currently pay a total tax of 2.90% (1.45% each) of the employee's wages. Although not addressed in this article, self-employed individuals are also subject to a self-employment tax consisting of the same components and are similarly affected by the increase in Medicare taxes (on self employment income in excess of the threshold amounts).

Health care reform will impose an additional Medicare tax increment on high income earners. As a result, in addition to the 1.45% Medicare tax, a 0.9% Medicare tax will be imposed on taxpayers who receive wages in excess of $200,000 ($250,000 for taxpayers filing a joint return and $125,000 for married taxpayers filing a separate return). This will increase the employee's portion of the Medicare tax to 2.35% (a total Medicare rate of 3.8% on wages in excess of the threshold amount). While both employers and employees currently pay the 1.45% Medicare tax, the 0.9% increase **only affects employees**. This tax applies to wages received for tax years beginning after December 31, 2012.

The additional 0.9% Medicare tax is based on the combined wages of both the employee and the spouse (unlike the 1.45% tax) but employers will only be obligated to withhold the additional Medicare tax if the employee receives wages from the employer in excess of $200,000. The employer has no responsibility relative to wages received by the spouse. The employee is responsible for paying the additional tax if the employer is not. Any underpayments of the tax will be subject to penalties. Employers will need to review their current payroll processes to ensure that it applies the increased tax to its high income employees.

NEW MEDICARE TAX ON UNEARNED INCOME

Effective for tax years beginning after December 31, 2012, a new Medicare tax will be imposed on "high income taxpayers" and estates and trusts. A 3.8% tax will be imposed on the lesser of an individual's net investment income for the tax year or modified adjusted gross income (AGI) in excess of $200,000 ($250,000 for taxpayers filing a joint return and $125,000 for married taxpayers filing a separate return).

Net investment income means the excess of the sum of the following items less any otherwise allowable deductions which are properly allocable to such gross income or net gain:

- Gross income from interest, dividends, annuities, royalties and rents unless such income derived is in the ordinary course of any trade or business (this excludes any trade or business that is either a passive activity of the taxpayer or involves trading in financial instruments)

- Other gross income from any passive activity of the taxpayer or involves trading in financial instruments and commodities

- Net gain (to the extent it is included in computing taxable income) that is attributable to the disposition of property other than property held in any trade or business that is not passive activity of the taxpayer or involves trading in financial instruments and commodities

Net investment income includes any income, gain or loss that is attributable to an investment of working capital. The Joint Committee Technical Explanation (available by **clicking here**) further provides that investment income "does not include items, such as interest on tax exempt bonds, veterans' benefits and excluded gain from the sale of a principal residence that are excluded from gross income under the income tax."

Investment income does not include any distribution from qualified employee benefits plans or arrangements as described in Internal Revenue Code (IRC) Sections 401(a), 403(a) or (b), 408, 408A, or 457(b). It also does not include any item taken into account in determining self-employment income for the tax year on which an individual pays the FICA Medicare tax.

Special rules govern certain types of partnership. For example, with regard to the disposition of a partnership interest or stock in an S corporation, the gain or loss from the disposition is only taken into account to the extent of the net gain or loss that would be taken into account by the partner or shareholder if all property of the partnership or S corporation were sold at fair market value immediately before the disposition of the interest.

Estates and trusts also must pay the 3.8% Medicare tax each tax year. The tax is based on the lesser of the undistributed net investment income for the tax year, or the excess (if any) of their adjusted gross income over the dollar amount at which the highest tax bracket for estates and trusts begins for the tax year.

The tax does not apply to nonresident aliens or a trust whose unexpired interests are devoted to one or more particular charitable purposes (e.g., religious, charitable, scientific, literary, educational purposes), or to a trust that is exempt from tax under IRC section 501 or a charitable remainder trust exempt from tax under IRC section 164.

This tax applies to tax years beginning after December 31, 2012. Payment of this tax is the responsibility of the taxpayer and not the employer (as it is based on unearned income rather than employer-paid wages). Affected taxpayers should be directed to seek the advice of their tax advisors regarding this tax.

CONCLUSION

Although most attention is understandably fixed on looming health care reform changes slated to go into effect for 2010 and 2011, it will not be long before other elements of the new legislation go into effect and employers will need to be ready to respond. The cost of insurance is certain to rise and employers will be required to set up the processes necessary to collect and pay the applicable taxes. It is ultimately the employer's bottom line, regardless of whether the applicable taxes and fees are paid by employers, employees or insurers, that will be affected.

Moreover, while many of the changes discussed in this article do not generally occur until 2013 (or later) and specific guidance is not yet available (apart from very vague plain statutory language), these changes nevertheless represent important concerns that employers will need to address sooner rather than later. For example, what effect will the loss of the Medicare Part D subsidy have on an organization's decision to continue RDS program participation? What is more cost effective: to have retirees participate directly in the Medicare Part D program or to continue to provide prescription benefits under its retiree plan (and apply for the subsidy)? What changes will employers have to make to current payroll processes to capture the additional 0.9% Medicare tax?

For more information on health care reform, including a timetable and an in-depth analysis of those changes occurring in 2010 and 2011, **click here**.

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