



Health Care Reform Law and You

May 21, 2010
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■ HEALTH CARE REFORM LAW AND YOU

Without question, the health care reform bills signed into law in March ignited a firestorm of emotion, ranging from glee to outrage among many American citizens. Political affiliations and differing worldviews drove much of the overheated conversation.

Flash forward to the present, and, though health care has slipped to the back burner in the news of late, it continues to be a hotbed of activity for both the government and insurance companies. Insurance companies have had to address provisions of the law that take effect later this year and some have already acted to make changes in coverage effective immediately. The Treasury has already issued several notices clarifying provisions of the law. We can expect those clarifications to continue as the rules for implementing the new laws are written.

At Laird Norton Tyee, we examined the law over the past few months, though we admit we didn't read all 2,000-plus pages of the bills. Instead, we focused on the parts that will affect you, our clients, and we thought it would be helpful to distribute a paper that focuses on those pieces that could touch you, your family, your pocketbook and your business, if you own one.

What is the legislation?

There are actually two separate bills that comprise the new health care reform law, both enacted in March. The Reconciliation Act (H.R. 4872: Health Care and Education Reconciliation Act) is a supplement to the Health Care Act (H.R. 3590: Patient Protection and Affordable Care Act). For purposes of this article, we'll refer to both as the health care acts.

A common one-word description of the health care acts is "complicated." Read on, and you'll see why.

When are the health care acts effective?

Most of the provisions that improve access to health care coverage and raise revenue to help do so do not take effect until 2013. There are, however, several provisions that do take effect this year and next year which you should know about.

■ INDIVIDUALS AND UNIVERSAL HEALTH COVERAGE

This legislation requires all individuals to obtain and maintain health insurance coverage for themselves and their families, unless an exemption or exception applies. This is referred to as "shared responsibility" throughout the health care acts. Individuals' access to coverage is broadened by provisions that encourage employers to provide that access and encourage insurance companies to offer policies to everyone. An individual's ability to purchase health

INDIVIDUALS AND UNIVERSAL HEALTH COVERAGE (continued)

insurance is facilitated through tax credits and reductions in costs, referred to as “cost sharing.” The responsibility of carrying coverage remains an individual obligation, and the failure to comply can result in an individual penalty. The effective date for individuals’ “shared responsibility” is January 1, 2014.

Some individuals are not subject to the “shared responsibility” provisions, including members of certain religious organizations, those who can’t live in the U.S. legally and incarcerated individuals. Others are not required to pay the “shared responsibility penalty,” including those with income below income-tax-filing thresholds, those who cannot afford coverage and members of Indian tribes. Finally, there are exemptions from the penalty for short-coverage gaps (up to three months) and hardships.

The health insurance coverage that individuals are required to maintain for themselves and their dependents is “minimum essential coverage” (see graphic). Coverage is delivered through one of the following plans or programs: Medicare or Medicaid; eligible employer-sponsored plans; plans in the individual market; grandfathered health plans; or coverage approved by Health and Human Services (HHS).

What’s “*minimum essential*” coverage?

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services/chronic disease management
- Pediatric services, including oral and vision care
- “Minimum” means insurance must pay 60% of costs

PAYING FOR UNIVERSAL HEALTH COVERAGE

While all individuals are required to obtain and maintain health insurance coverage under the health care acts, they are not necessarily required to pay the full cost as noted above. For individuals who are U.S. citizens or nationals residing outside of the U.S. on a permanent or long-term basis, coverage is assumed. For those whose coverage is obtained through a government-sponsored plan for low-income individuals, there may be no payment requirement.

In addition, to encourage small employers to offer and share in paying for employee health care coverage, payment assistance in the form of tax credits is extended to them. Who pays for this? A host of new taxes and penalties for individuals and businesses is expected to partially offset the total cost of the program, with the balance of the costs “paid for” by cost

■ PAYING FOR UNIVERSAL HEALTH COVERAGE (continued)

savings in Social Security and Medicare. The current estimate from the Congressional Budget Office (CBO) is that over the next 10 years, the health care acts will decrease deficits by \$143 billion. Since much of the legislation does not take effect for several years, amendments that clarify and enhance it are likely to result in changes to its estimated costs (presumably the CBO will modify its cost estimates when changes occur).

■ TAXES, PENALTIES AND OTHER CHANGES FOR INDIVIDUALS

The “shared responsibility penalty” will be charged to individuals who are required to maintain health insurance for themselves and their dependents and do not do so beginning in 2014. The amount of the penalty is the lesser of either a flat dollar amount or a percentage of household income (see chart). The penalty is reported and paid on individuals’ income tax returns.

Medicare payroll tax

The first new tax, effective in 2013, is the “*additional 0.9% Medicare payroll tax*” or “Medicare payroll tax,” which applies to compensation income in excess of the following thresholds:

- \$200,000 for single and head of household taxpayers
- \$250,000 for married taxpayers filing joint returns
- \$125,000 if married filing separately

These thresholds *will not* be adjusted for inflation. The new Medicare payroll tax is imposed on only those who earn compensation (workers), not those who pay it (employers), unlike the FICA, Medicare, and Self-Employment taxes that it resembles. The tax of 0.9% applies to the combined wages of married couples. Employers are required to withhold this tax from the amount of an employee’s wages that exceed \$200,000. The tax also applies to self-employment income exceeding the thresholds, except to the extent that the same individual is subject to this new tax on his or her wage income.

The cost of no insurance

Flat-dollar amounts

2014: \$95 per individual, not more than \$285 per family

2015: \$325 per individual, not more than \$975 per family

2016: \$695 per individual, not more than \$2,085 per family*

* After 2016, the \$695 and \$2,085 amounts will be adjusted for inflation.

Household income*

2014: 1%

2015: 2 %

2016 and thereafter: 2.5%

* Household income is comprised of both taxpayer and dependent income.

Unearned Income Medicare tax

Another tax is referred to as the “Unearned Income Medicare Contribution.” This tax, with a rate of 3.8%, applies to individuals, estates and trusts, and also begins in 2013. It is imposed on the lesser of net investment income (see chart for what’s considered net investment income) or modified adjusted gross income exceeding certain thresholds:

- \$200,000 for single and head of household taxpayers
- \$250,000 for married taxpayers filing joint returns
- \$125,000 if married filing separate returns

For estates and trusts, the 3.8% tax is applied to the lesser of undistributed net investment income or the amount by which the entity’s adjusted gross income exceeds the dollar amount at which the highest income tax bracket for estates and trusts begins. Based on the 2010 tax schedule, it would be \$11,200.

Changes to medical accounts

Fairly significant changes will affect flexible spending and health reimbursement accounts (FSAs and HRAs) and health savings accounts (HSAs and Archer MSAs) beginning in 2013. For HSAs and MSAs, the penalty for non-qualified withdrawals increases to 20% from 10%. Also, for FSAs, the maximum contribution is limited to \$2,500 beginning in 2013. Current law does not limit contributions, each individual plan imposes its own limits. Finally, for both FSAs and HRAs, beginning in 2013, the definition of qualified medical expenses will be narrowed to include only prescribed drugs and insulin. Prescribed drugs are not limited to those obtained only with a prescription but include over-the-counter drugs obtained under a prescription. Current law allows all over-the-counter drugs, vitamins and other health aids to be considered as medical expenses.

Beginning in 2013, the floor for determining deductible unreimbursed medical expenses increases from 7.5% of adjusted gross income to 10%. A special transition rule applies to those age 65 and over between the time period between 2013 through 2017 in which they will be allowed to use the 7.5% floor.

What’s “net investment income?”

Included

- Interest
- Dividends
- Capital gains
- Rental income
- Annuities
- Business income (if it’s an investment)

Excluded

- Tax-exempt income
- Certain home sale gains
- Income from wages
- Self-employment wages
- Social Security and payments from retirement plans and IRAs
- State tax refunds
- Prizes and awards

■ TAXES, PENALTIES AND OTHER CHANGES FOR INDIVIDUALS (continued)

Tanning tax

Individuals will also pay the new tanning service excise tax of 10% effective July 1, 2010. It may seem like “small potatoes” in the grand scheme of things, but the tax is expected to raise \$2.7 billion of tax revenue over the next 10 years. It will be collected by the sellers of tanning services, but phototherapy services performed by licensed medical professionals will not be taxed.

■ TAXES, PENALTIES AND CHANGES FOR BUSINESS

Prompting the greatest hue and cry, so far, is the limitation on the deductions of employers for Medicare Part D expenses. Prior law allowed plan sponsors to deduct in full the cost of employment-based retiree prescription drug plans even though the subsidy payments they received from the government for providing this benefit were considered tax exempt. Although not effective until 2013, some effects of this change have already been disclosed by publicly traded companies in their recent earnings reports.

Beginning in 2011, employers will be required to report the cost of employer-sponsored health coverage on employees' Forms W-2. The value to be reported is the amount the employer would charge for COBRA continuation coverage.

Dependent coverage expanded

Group insurance coverage of dependents is expanded and goes into effect for plan years that begin after September 23, 2010. That means for some this rule will be effective this year. Some plans have voluntarily adopted the new provision and are currently covering these young adults. If the plan allows coverage of dependents, then dependents who are under age 26 *must* be eligible for coverage at the same price and level as any other dependent covered by the plan. (Note: group plans *are not required* to include dependents, this change only applies if they do.) Once the rule goes into effect, the penalty on those providing the coverage, usually insurance companies, for failing to include these young adults is \$100 per day of noncompliance per individual affected. This expansion is mandatory for group plans. It is not clear whether it applies to other plans that may include health insurance benefits for dependents.

Small business impacts

Effective January 1, 2010 (yes, this is already effective), certain small employers are eligible for up to a 35% tax credit for health coverage expenses in tax years beginning in 2010. Eligible employers are those who employ no more than 25 full-time-equivalent employees (FTEs) during the tax year, and their employees' annual full-time-equivalent wages must average \$50,000 or less. The employer must contribute at least 50% of the cost of premiums to be eligible for the credit. The full 35% tax credit, however, is only available to employers with fewer than 11 FTEs whose annual full-time-equivalent wages average \$25,000 or less.

■ TAXES, PENALTIES AND CHANGES FOR BUSINESS (continued)

Basing the credit on FTEs requires employers to count the hours of their employees as part of qualifying for the credit -- 2,080 hours is considered full-time employment for one employee. A FTE could be two employees each working 1,040 hours.

The credit is reduced for the years 2010 through 2013 for employers with more than 10 but not more than 25 employees or those whose employees' average annual wages are more than \$25,000 but less than \$50,000.

Beginning in 2014, the credit is 50% for all small (fewer than 26 employees) employers but coverage must be purchased through an insurance exchange. Also for years beginning after 2013, the credit is available only for two consecutive years.

Tax-exempt small employers are also eligible for a refundable credit on the same basis and terms as the small-employer credit. They can receive the lesser of the amount of the credit under this provision or the amount of payroll taxes for the year. These tax-exempt employers are eligible for a lesser credit: 25% instead of 35% and 35% instead of 50%.

What about large companies?

Large employers have a "shared responsibility" to provide access to health insurance coverage for their employees under the health care acts. For years beginning after 2013, large employers, defined as having at least 50 FTEs, will be penalized for not offering affordable minimum essential coverage for all FTEs if their employees obtain subsidized premiums or cost-sharing reductions.

Even those employers who do offer acceptable coverage will be penalized if their employees obtain subsidized coverage unless the employer provides those employees with the means (via free choice vouchers) to purchase coverage themselves.

■ TAXES FOR INSURANCE, DRUG AND MEDICAL DEVICE COMPANIES

A number of targeted excise taxes provide some of the revenue to offset the costs of the health care acts. These taxes are imposed on insurance companies; manufacturers, producers and importers of certain medical devices; and those who manufacture or import "branded prescription drugs." It is difficult to believe that these taxes will not eventually be passed on as costs to consumers.

■ CONCLUSION

While the new health care law expands coverage to millions of Americans, it comes at a cost. The law imposes higher taxes on wealthy families and individuals, and businesses will foot part of the bill, as well.

The legislation also changes some rules related to how employer-based health insurance functions, adding some complexity and another layer of reporting for business operations. It's not all that hard to understand why people have called the health care acts "complicated." Much of the law's vagueness will need to be clarified over the next few years as more pieces of it are put into motion. As those muddier areas of the law are interpreted, we will keep you informed on how they may affect your family and your assets.

■ ABOUT THE AUTHOR

Kristi Mathisen serves as Laird Norton Tyee's in-house expert on tax and estate planning issues. She provides advice on philanthropic strategies to the firm's client service team and to clients directly. She is a CPA and has more than 20 years of finance-related experience, much of it in accounting.

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