



# Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)

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## **Summary**

On March 23, President Obama signed health care reform legislation into law—the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), some provisions of which are amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). PPACA will, among other things, raise revenues to pay for expanded health insurance coverage by imposing excise taxes and fees on industries in the health care sector, limiting tax-advantaged health accounts, increasing the Medicare payroll tax on upper-income households and adding an additional tax on net investment income on upper-income households. The new law will also eliminate the tax deduction for expenses allocable to the Medicare Part D subsidy to employers.

This report summarizes the health-related revenue provisions in PPACA.

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## Introduction

On March 23, 2010, President Obama signed health reform legislation into law—the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148), some provisions of which were amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

PPACA includes a number of provisions to reform the private insurance market and expand health insurance coverage to the uninsured. Private health insurance provisions that take effect prior to 2014 (including some this year) include the following: ending lifetime and unreasonable annual limits on benefits, prohibiting rescissions of health insurance policies, requiring coverage of preventive services and immunizations, extending dependant coverage up to age 26, capping insurance companies' non-medical administrative expenditures, guaranteeing coverage for preexisting health conditions for enrollees under age 19, and providing assistance for those who are uninsured because of a preexisting condition.<sup>1</sup> Many of the other provisions will be fully implemented in 2014, when most individuals, large employers, and health plans are to meet certain coverage requirements. PPACA will restructure the private health insurance market, particularly for individuals purchasing coverage on their own (who may qualify for premium credits) and small businesses. The new law will also expand Medicaid coverage to families with incomes up to 133% of the federal poverty level.

To pay for expanded health insurance coverage, there are a number of health-related revenue provisions in PPACA. These include taxes and fees on firms in the health care sector and other employers as well as additional taxes on upper-income individuals. The new law also makes changes to tax-advantaged health care accounts such as flexible spending and health savings accounts. This report details the changes in tax law that will be made as a result of the health-related revenue provisions in PPACA.

## Health-Related Revenue Provisions

The health-related revenue provisions in PPACA include excise taxes and limitations on employer deductions that would impact health insurers, health plan sponsors, and health plan administrators. In addition, there are a number of revenue provisions that would affect workers through modifications to current tax-advantaged accounts and deductions used for health care spending and coverage.

**Table 1** shows the implementation date and preliminary revenue projections for PPACA as amended by the reconciliation bill. According the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), these laws are projected to raise \$391.7 billion in health-related provisions over 10 years. Other revenues would come from penalties on individuals and employers as well as other non-health related revenue provisions.<sup>2</sup> CBO projects that the deficit would be reduced by \$143 billion over the 10-year period 2010-2019 under PPACA as amended by the reconciliation bill. Of those savings, 63% (\$90 billion) is on-budget and the remaining

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<sup>1</sup> See CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act*, by Hinda Chaikind et al.

<sup>2</sup> For more information on penalties paid by employers who do not provide coverage see CRS Report R41159, *Summary of Potential Employer Penalties Under PPACA (P.L. 111-148)*, by Hinda Chaikind and Chris L. Peterson.

37% (\$53 billion) is off-budget, reflecting increases in the Medicare Hospital Insurance (HI), Supplementary Medical Insurance and Social Security Trust Funds.<sup>3</sup>

**Table I. Health-Related Revenue Provisions in PPACA as Amended by the Reconciliation Act of 2010**

	Effective Date, Taxable Years Beginning	Increase in Revenues (FY2010-FY2019)
<b>Provisions Affecting Firms</b>		
<b>Excise Taxes and Fees</b>		
40% Excise Tax on High-Cost Plans	2018	\$32.0 billion
Impose Annual Fee on Health Insurance Providers	2014	\$60.1 billion
Annual Fee on Manufacturers and Importers of Branded Drugs	2011	\$27.0 billion
Annual Fee/ Excise Tax on Manufacturers and Importers of Certain Medical Devices	2013	\$20.0 billion
10% Excise Tax on Indoor Tanning Services	July 1, 2010	\$2.7 billion
<b>Limitation on Employer Deductions</b>		
Eliminate Deductions for Expenses Allocable to Medicare Part D subsidy	2013	\$4.5 billion
Limit Deduction for Compensation to \$500,000 for Executives of Health Insurance Companies	2013	\$0.6 billion
<b>Provisions Affecting Individuals</b>		
<b>Medicare Tax</b>		
Medicare Payroll Tax	2013	\$86.8 billion
Medicare Contribution on Investment Income	2013	\$123.4 billion
<b>Modifications to Tax-Advantaged Accounts and Itemized Deductions</b>		
Limit Health Flexible Spending Accounts (FSAs) to \$2,500	2013	\$13.0 billion
Raise Penalty for Non-Qualified Health Savings Account (HSA) Withdrawals from 10% to 20%	2011	\$1.4 billion
Change the Definition of Medical Expenses for FSAs and HSAs	2011	\$5.0 billion
Raise 7.5% Floor for Itemized Medical Expenses to 10% for Those Under Age 65	2013	\$15.2 billion
<b>Total Revenues Relating to Health Care</b>	—	<b>\$391.7 billion</b>

**Source:** Joint Committee on Taxation, March 20, 2010, JCX-17-10.

<sup>3</sup> Congressional Budget Office, Letter to Honorable Nancy Pelosi, March 20, 2010.

## **Provisions Affecting Health Care Firms and Other Employers**

PPACA will impose the following taxes and/or fees on health insurers, plan administrators, and health companies:

- an excise tax on high-cost employer-sponsored health insurance;
- an annual fee on health insurance providers;
- an annual fee on manufacturers and importers of brand name pharmaceuticals;
- an excise tax on manufacturers and importers of certain medical devices; and
- an excise tax on indoor tanning services.

The new law will also limit the deductibility of compensation for health insurance executives. While the provisions above are directly targeted toward firms in the health care sector, there is an additional provision that will affect all employers who provide prescription drug coverage to Medicare beneficiaries.

The following section describes the current law (where applicable), changes to the law as enacted in PPACA and amended by the reconciliation bill.

### **Excise Tax on Health Insurance Plans**

Under current law, an insurance company is subject to federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of reserves that are treated as life insurance reserves. Some non-profit insurers are exempt from federal income taxes.<sup>4</sup> Also, employees are not taxed on the value of health insurance coverage provided by employers.<sup>5</sup> PPACA will impose a 40% excise tax on health insurers and health plan administrators for coverage that exceeds certain thresholds in 2018. The thresholds are \$10,200 for single coverage and \$27,500 for family coverage, and would be indexed by growth in the CPI-U plus 1% in subsequent years. Coverage for individuals who are retired and ages 55 to 64, and workers engaged in high-risk professions, will be subject to higher thresholds (\$11,850 single and \$30,950 families). Also, employees in multi-employer (union) plans will only be subject to the family thresholds. Finally, there is also a provision to allow employers to adjust the cost of health insurance coverage (when compared with the thresholds) if the demographics of their workforce in terms of age and gender are different from that of a national risk pool.<sup>6</sup>

Health insurance coverage subject to the 40% excise tax in PPACA will be broadly defined to include not only the employer and employee premium payments for health insurance coverage (including self-insured plans), but also premiums paid by the employee and the employer for dental and vision coverage (if this supplemental coverage is not part of a stand-alone package). In addition, tax-advantaged health-related accounts such as flexible spending accounts (FSAs),

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<sup>4</sup> Joint Committee on Taxation, Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as Amended, in Combination with the “Patient Protection and Affordable Care Act,” JCX-18-10, March 21, 2010.

<sup>5</sup> See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Janemarie Mulvey.

<sup>6</sup> The national risk pool is based on the rates in the standard Blue Cross Blue Shield FEHBP health insurance plan.

health savings accounts (HSAs), health reimbursement accounts (HRAs) and medical savings accounts (MSAs) are also specified as health insurance coverage and included in the threshold calculation. For these tax-advantaged accounts, the plan administrator (which is often the employer) will be subject to the excise tax. The excise tax will be levied on each of these components (i.e., health insurance, dental and vision, FSAs) based on their share of the total. This share will then be applied to the amount of the total contribution that exceeds the applicable threshold to determine the excise tax imposed on each component.

**Table 2. The 40% Excise Tax on Health Insurance Coverage**  
In PPACA

	Provisions
General Threshold Amounts	\$10,200 single \$27,500 family
Insurance Coverage Subject to the Thresholds	Health Insurance Coverage (excluding stand alone dental and vision plans) FSAs, HSAs, Archer MSAs, and HRAs.
Alternative Thresholds	Applicable to high-risk professions and retirees ages 55 to 64  \$11,850 single \$30,950 family
Multi-Employer Plans (Unions)	Only subject to general threshold for family coverage (even for self-only coverage)
Implementation Date	2018

**Source:** Compiled by CRS.

PPACA will also impose additional reporting requirements on employers providing health insurance coverage. Specifically, employers would be responsible for

- determining the aggregate amount of health insurance coverage subject to the excise tax,
- estimating the share of the tax allocated to the insurer and the plan administrator,
- reporting these amounts to the insurer, plan administrator and the Internal Revenue Service, and
- reporting the total value of health insurance coverage subject to the excise tax on the worker's W2 form.

Employers who under-report the amount of the excise tax to be paid by insurers and plan administrators would be subject to a penalty. The amount of the excise tax would not be deductible from federal income taxes. According to the JCT, the 40% excise tax is projected to raise \$32 billion over a 10-year period (see **Table 1**).

## **Annual Fee on Health Insurance Plans**

As noted earlier, under current law, there are special rules for determining the taxable income of insurance companies.<sup>7</sup> The rules differ depending on whether the company is a life insurance or a property and casualty insurer. PPACA will impose a fee on all health insurers based on their market share of net premiums written and will be effective beginning in 2014.<sup>8</sup> The share of net premiums written subject to the fee will vary by the size of net premiums of an insurer. For example, there will be no fee on the first \$25 million of net premiums of covered entities. For net premiums greater than \$25 million and less than \$50 million, 50% will be taken into account, and 100% of net premiums written in excess of \$50 million will be subject to the fee. The fee will not apply to self-insured plans and federal, state, or other government entities. There are also additional provisions for tax-exempt insurance providers. Only 50% of net premiums for tax-exempt insurer will be taken into account when calculating the fee. The law would also exempt Voluntary Employee Benefit Associations and nonprofit providers for whom more than 80% of revenues are received from public programs that target low-income, elderly, or disabled populations.

The aggregate fee collected across all health insurers will equal \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. After 2018, the fee amount is indexed to the rate of growth in premiums. According to the JCT, this fee is projected to raise about \$60 billion over a 10-year period (see **Table 1**).

## **Annual Fee On Pharmaceutical Companies and Excise Tax on Medical Device Manufacturers**

Under current law, there are excise taxes on sales by manufacturers of certain products. Certain sales are exempt from this tax.<sup>9</sup> PPACA will impose an annual fee on certain manufacturers and importers of branded prescription drugs (including biological products and excluding orphan drugs). The fee structure will be based on annual sales and will be set to reach a certain revenue target each year. Annual revenues collected by the fee would total \$2.5 billion for 2011, \$2.8 billion per year for 2012 and 2013, \$3.0 billion 2014 through 2016, \$4.0 billion for 2017, \$4.1 billion for 2018, and \$2.8 billion for 2019 and thereafter. PPACA specifies that these additional revenues should be transferred to the Federal Medicare Supplementary Insurance (Part B) Trust Fund. According to the JCT, this fee is projected to raise \$27 billion over a 10-year period (see **Table 1**).

Also under PPACA, a new excise tax of 2.3% will be imposed on the sale of medical devices by manufacturers, producers, or importers.<sup>10</sup> This provision will exempt eyeglasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use. The tax will apply to sales made after December 31, 2012. According to the JCT, this excise tax is projected to raise \$20 billion over a 10-year period (see **Table 1**).

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<sup>7</sup> Subchapter L of the Internal Revenue Code.

<sup>8</sup> See CRS Report R40834, *The Market Structure of the Health Insurance Industry*, by D. Andrew Austin and Thomas L. Hungerford, for information on market share of individual health insurance companies.

<sup>9</sup> See Internal Revenue Code Chapter 32.

<sup>10</sup> CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by C. Stephen Redhead and Erin D. Williams



## **Limitation on Deduction for Executive Compensation of Health Insurers**

PPACA will impose limits on the amount of executive compensation that is deductible by health insurers. Specifically, health insurance providers where at least 25% of their gross premium income is derived from health insurance plans that meet the minimum creditable coverage requirements (i.e., covered health insurance provider) will not be able to deduct compensation above \$500,000 per year. This income threshold will include deferred compensation. This provision will be effective for compensation paid in taxable years beginning after 2012 with respect to services performed after 2009. According to the JCT, this limitation on executive compensation is projected to raise \$600 million over a 10-year period (see **Table 1**).

## **Eliminate Employer Deduction for Retiree Prescription Drug Plans Eligible for Federal Subsidy**

Under current law, employers who provide their Medicare-eligible retirees with prescription drug coverage that meets or exceeds federal standards are eligible for subsidy payments from the federal government.<sup>11</sup> The subsidies were equal to 28% of their actual spending for prescription drug cost in excess of \$250 and not to exceed \$5,000 (in 2006 dollars). These qualified retiree prescription drug plan subsidies are excluded from the employer's gross income for the purposes of corporate income tax. Employers are also allowed to claim a business deduction for retiree prescription drug expenses even though they also receive the federal subsidy to cover a portion of those expenses. PPACA will require employers to coordinate the subsidy and the deduction for retiree prescription drug coverage beginning in 2013. The amount allowable as a deduction for retiree prescription drug coverage would be reduced by the amount of the federal subsidy received. According to the JCT, this provision is projected to raise \$4.5 billion over a 10-year period (see **Table 1**).

## **Provisions Affecting Individuals**

### **Medicare Payroll Tax**

Under current law, employers and employees each pay a payroll tax of 1.45% to finance Medicare Hospital Insurance (Part A). PPACA includes additional hospital insurance taxes on high-income taxpayers. Specifically, PPACA would impose an additional payroll tax of 0.9% on high-income workers with wages over \$200,000 for single filers and \$250,000 for joint filers effective for taxable years after December 31, 2012. Married taxpayers filing separately are subject to a \$125,000 threshold. The additional payroll tax only applies to wages above these thresholds. Thus, the HI portion of the payroll tax will increase from 1.45% to 2.35% for wage income over the threshold amounts. Additional revenues from this provision are transferred to the Medicare Hospital Insurance Trust Fund (Part A). According to the JCT, the increase in the Medicare payroll tax is projected to raise \$86.8 billion over a 10-year period (see **Table 1**).

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<sup>11</sup> Medicare Modernization Act of 2003.

## **Unearned Income Medicare Contribution**

A provision that was not part of the PPACA but was later added by the reconciliation bill (Section 1402) is an additional tax on net investment income. The new law defines net investment income to be interest, dividends, non-qualified annuities, royalties, rents, and taxable net capital gains. It excludes distributions from a qualified annuity from a pension plan.<sup>12</sup> Households with modified adjusted gross income (MAGI) under these thresholds will not be subject to the investment income tax. Specifically, effective for taxable years after December 31, 2012, the bill will impose a tax equal to 3.8% of the *lesser* of (1) net investment income for such taxable year or (2) the excess of MAGI<sup>13</sup> over \$250,000 for joint filers (\$125,000 for married filing separately and \$200,000 for all other returns).

While this tax is also applicable to income from estates and trusts, the active income from trade for self-employed and S-corporations would not be subject to the tax.<sup>14</sup> For these entities, the tax would apply only to passive income and income related to commodity trading. There is also a special provisions for the application of the tax to S-Corporations who sell their businesses.

As shown in **Table 1**, the investment income provision is projected to raise \$123.4 billion in revenues over a 10-year period.

## **Tax-Advantaged Accounts and Itemized Deductions Used to Pay for Health Care Expenses**

There are a number of tax-advantaged accounts and tax deductions for health care spending and coverage that will be affected by the revenue provisions in Title IX of PPACA (as amended by the reconciliation bill). The following discusses these in greater detail.

### ***Modifications to Tax-Advantaged Accounts***

Under current law, flexible spending accounts (FSAs), health savings accounts (HSAs), health reimbursement accounts (HRAs), and Medical Saving Accounts (MSAs) allow workers under varying circumstances to exclude a certain portion of qualified medical expenses from income taxes.<sup>15</sup> Health FSAs are employer-established benefit plans that reimburse employees for specified health care expenses (e.g., deductibles, co-payments, and non-covered expenses) as they are incurred on a pre-tax basis.<sup>16</sup> About one-third of workers in 2007 had access to an FSA.<sup>17</sup> Each employer may set their limits on FSA contributions. In 2008, the average FSA contribution

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<sup>12</sup> As defined in IRC Sec. 401(a), 403(a), 403(b), 408, 408A, or 457(b).

<sup>13</sup> Modified adjusted gross income is defined as adjusted gross income increased by the excess of foreign earned income (defined in IRC Sec. 911(a)(1)) over the amount of any deductions or exclusions disallowed under IRC Sec. 911(d)(6) when determining foreign earned income.

<sup>14</sup> Corporations may elect S-corporation status if they meet a number of Internal Revenue Code requirements. Among other things, they cannot have more than 100 shareholders or more than one class of stock. S-corporations are tax-reporting rather than tax-paying entities, in contrast to C-corporations, which are subject to the corporate income tax.

<sup>15</sup> See CRS Report RL33505, *Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation*, by Janemarie Mulvey.

<sup>16</sup> See CRS Report RL32656, *Health Care Flexible Spending Accounts*, by Janemarie Mulvey.

<sup>17</sup> Bureau of Labor Statistics, *Table 24. Pretax benefits: Access, private industry workers*, National Compensation Survey, March 2007.

was \$1,350.<sup>18</sup> PPACA will limit the amount of annual FSA contributions to \$2,500 per FSA beginning in 2013. According to JCT, this provision is projected to increase revenues by \$13 billion over 10 years (see **Table 1**).

HSAs are also tax-advantaged accounts that allow individuals to fund unreimbursed medical expenses (deductibles, copayments, and services not covered by insurance) on a pre-tax basis.<sup>19</sup> Eligible individuals can establish and fund accounts when they have a qualifying high deductible health plan and no other health plan (with some exceptions). Unlike FSAs, HSAs may be rolled over and the funds accumulated over time. Distributions from an HSA that are used for qualified medical expenses are not included in taxable income. While distributions that are not used for qualified medical expenses are taxable as ordinary income and, under current law, an additional 10% penalty tax is imposed for those under the age of 65. PPACA will raise this penalty on non-qualified distributions from 10% to 20% of the disbursed amount. According to the JCT, this provision would raise \$1.3 billion over 10 years (see **Table 1**).

PPACA will also modify the definition of qualified medical expenses. Under current law, qualified medical expenses for FSAs, HSAs, and HRAs can include over-the-counter medications. The bill would restrict this practice and exclude over-the-counter medications (except those prescribed by a physician) as a qualified medical expense. According to the JCT, this provision would increase revenues by \$5 billion over 10 years (see **Table 1**).

### ***Modify Itemized Deduction for Medical Expenses***

Currently, taxpayers who itemize their deductions may deduct unreimbursed medical expenses that exceed 7.5% of adjusted gross income (AGI). Medical expenses include health insurance premiums paid by the taxpayer, but also can include certain transportation and lodging expenses related to medical care as well as qualified long-term care costs, and long-term care premiums that do not exceed a certain amount. About 7% of tax returns for tax year 2007 reported a deduction for medical expenses.<sup>20</sup> Taxpayers with AGI below \$50,000 accounted for 52% of those taking this itemized deduction for medical expenses.<sup>21</sup> PPACA will increase the threshold to 10% of AGI for taxpayers who are under the age of 65, this effectively further limits the amount of medical expenses that can be deducted. Taxpayers over the age of 65 will be temporarily excluded from this provision and still be subject to the 7.5% limit from 2013 through 2016.

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<sup>18</sup> Mercer Human Resources Consulting, *National Survey of Employer-Sponsored Health Plans 2008*.

<sup>19</sup> See CRS Report RL33257, *Health Savings Accounts: Overview of Rules for 2010*, by Janemarie Mulvey.

<sup>20</sup> Internal Revenue Service, Statistics of Income, *Table 1.3: All Returns: Source of Income, Adjustments, Deductions, Credits and Tax Items, by Marital Status, Tax Year 2007*.

<sup>21</sup> Joint Committee on Taxation, *Tax Expenditures: Compendium of Background Material on Individual Provisions*, December 2008.

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