Part IV: Health Reform Provisions That Have Been Repealed, Expired, or Not Implemented

Free Choice Vouchers – Repealed

99. What were free choice vouchers and what were they intended to do?

As originally enacted in 2010, the health reform law required certain employers to provide free choice vouchers to qualified employees to allow those employees to purchase a health plan through a state health insurance exchange, beginning in 2014.[[1]](#footnote-1) In the original law, employers offering health coverage and paying a portion of the costs of the plan were to provide vouchers to certain employees with a value equal to the contribution that the employer would have made to its own plan. If multiple plans were offered, the amount of the voucher would have been equal to the most generous employer contribution. The employer was to provide its share of self-only or dependent coverage at the worker’s choice. Employers providing these vouchers would not have been subject to the employer mandate tax penalty as to such employees.

Originally, employers that offered minimum essential coverage were required to offer vouchers beginning in 2014 to certain employees whose cost of coverage was more than 8 percent but less than 9.8 percent of household income. Those lower-income workers could then opt out of their employer's health insurance and purchase more affordable coverage on the insurance exchange, where they would have received a premium subsidy through an income tax credit if their income was below 400 percent of the federal poverty level.

The voucher would have permitted the employee to take the employer’s contribution toward health coverage and use it for a potentially cheaper exchange plan when the tax subsidy was taken into account. If the amount of the voucher exceeded the cost of the premium for the plan the worker bought through the exchange, the excess was to be paid to the employee. The money spent on health insurance would have been income-tax free, and any cash payment to the employee would have been taxed.

100. When was the provision for free choice vouchers repealed?

In 2011, appropriations legislation[[2]](#footnote-2) repealed the free choice voucher provisions. It is not clear why, but the motive may have been, at least in part, to save money because some of the individuals who would have received vouchers were not eligible for the premium subsidy. Additionally, it has been reported that certain groups, such as employers and unions, did not want workers to be able to buy health insurance on their own.

101. What is the impact of the repeal of free choice vouchers?

With free choice vouchers, Americans whose income fell below 400 percent of the federal poverty level and whose employer-sponsored health insurance premiums were between 8 percent and 9.8 percent of their total income would have been allowed to access the state insurance exchange and qualify for government assistance to buy insurance.

In 2014, if employees’ share of their employer-sponsored health insurance premiums rose to 9.9 percent of their total income, they would be allowed to shop for more affordable health insurance in the new health insurance exchanges, with a taxpayer-funded subsidy. But again, at 9.8 percent and below, their only options would be to pay for their employer-sponsored coverage or to go without health coverage.

Had Free Choice Vouchers survived, fewer Americans would have had to go without health insurance. Through the use of private subsidy dollars versus relying solely on taxpayer funded subsidies, arguably money would have been saved for taxpayers. If employer premiums continue to rise, more and more Americans would have become eligible for this option. More choice, and perhaps competition, would have been present in the health insurance market.

Some employers, especially small employers, had expressed interest in expanding the free choice voucher provision so that they would no longer need to pick their employees' health insurance. They liked the idea of giving their employees access to a health insurance system, much like the Federal Employee Health Benefits Plan, in which employers can essentially subsidize their employees’ ability to shop on the new health insurance exchanges.

Vouchers would be good for employees because they would be able to pick the plan that works best for them versus the plan that works best for their employer. Additionally, vouchers would likely have resulted in more Americans using the exchanges' risk pools, holding down costs for everyone.

Expanded 1099 Requirements – Repealed

102. What were the repealed 1099 requirements?

Under current tax law, a business making payments to a service provider (the “payee”), other than a corporation, aggregating $600 or more for services in the course of a trade or business in a year is required to send an information return (Form 1099) to the IRS (and to the service provider-payee) setting forth the amount, as well as name and address of the recipient of the payment (generally on Form 1099).[[3]](#footnote-3)

Expanded 1099 Requirements to Have Been Effective in 2012*.* The new law makes two changes to Code section 6041. First, businesses must issue the Forms 1099 to all persons and businesses, including corporations, for which aggregate annual payments are $600 or more. Second, the forms must be issued for payments made to “property” providers as well as service providers. The new law adds the phrase “amounts in consideration of property” as payments made to a provider that must be reported, but the law does not define the term “property.” Regulations will need to define this term, but it probably means all property, including the goods a business purchases for resale.[[4]](#footnote-4)

Exceptions*.* The report of the Joint Committee on Taxation, beginning at page 113, provided for exceptions to the expanded 1099 requirement for a payee that is a tax-exempt corporation under Code section 501 and other specific provisions in the Code that except certain payments from reporting, such as securities or broker transactions as defined under Code section 6045(a). This includes items reported under Code sections 6042(a)(1), 6044(a)(1), 6047(e), 6049(a), or 6050N(a), other than payments with respect to which a statement is required under the authority of Code sections 6042(a)(2), 6044(a)(2), or 6045.[[5]](#footnote-5)

103. When and how were the expanded 1099 requirements repealed?

The Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011[[6]](#footnote-6) repealed both the expanded Form 1099 information reporting requirements mandated by the 2010 health reform law and also the new 1099 reporting requirements imposed on taxpayers with rental income enacted by the 2010 Small Business Jobs Act.[[7]](#footnote-7)

The Small Business Jobs Act enacted a requirement that individuals who receive rental income issue Forms 1099 to service providers for payments of $600 or more. It did this by specifying that “a person receiving rental income from real estate shall be considered to be engaged in a trade or business of renting property.” The 1099 Act strikes Code section 6041(h), retroactively and effective for payments made after December 31, 2010, the original effective date of Code section 6041(h).

As a result of the repeal, the 1099 reporting rules continue unchanged. “All persons engaged in a trade or business and making payment in the course of such trade or business to another person” of $600 or more must report the amount and the name and address of the recipient to the IRS and to the recipient.[[8]](#footnote-8) The Code applies this requirement to payments of “rent, salaries, wages, premiums, annuities, compensations, remunerations, emoluments, or other fixed or determinable gains, profits, and income.” Treasury regulations add “commissions, fees, and other forms of compensation for services rendered aggregating $600 or more,” as well as interest (including original issue discount), royalties, and pensions.[[9]](#footnote-9)

104. Did the repeal of the expanded 1099 reporting repeal the penalties for 1099 failures that were increased in 2010?

No. The 2011 repeal did not repeal the expanded penalties for 1099 reporting failures enacted by the 2010 Small Business Jobs Act. The first-tier penalty under Code section 6721 for failure to timely file an information return was increased from $15 to $30, and the calendar-year maximum from $75,000 to $250,000. The second-tier penalty was increased from $30 to $60, and the calendar-year maximum from $150,000 to $500,000. The third-tier penalty was increased from $50 to $100, and the calendar-year maximum from $250,000 to $1,500,000. For small-business filers, the calendar-year maximum increased from $25,000 to $75,000 for the first-tier penalty; from $50,000 to $200,000 for the second-tier penalty; and from $100,000 to $500,000 for the third-tier penalty. The minimum penalty for each failure due to intentional disregard increased from $100 to $250.

105. Why were the expanded 1099 requirements repealed?

The expanded 1099 reporting requirements would have created significant burdens for businesses and many property owners by dramatically increasing the number of 1099 filings. Payments by any method were included, such as check, credit card, etc. Consider the airlines, hotels, rental cars, and restaurants that appear on a proprietor's or business credit card bill. Under the repealed law, 1099s would have been required if annual payments were more than $600. Additionally, any business that pays a person – for example, a plumber – more than $600 would be sending that person a Form 1099.

In addition, affected businesses and property owners would have been responsible for obtaining taxpayer identification numbers from every payee that required a Form 1099. If a business was unable to obtain this information, it would have been required to withhold federal income taxes from payments to that payee (“backup withholding”) and forward them to the government.

Absent the repeal, a huge increase in the paperwork burden would have ensued. It was not simply a matter of completing the forms, but also the work and time involved in obtaining the proper tax identification numbers and dealing with backup withholding requirements. Businesses are on different tax years, and some use cash-basis tax reporting while others use accrual accounting. As a result, the IRS would not have been able to match 1099s and tax returns in any meaningful way. Congress understood this, and both the House and Senate passed the repeal by very small bipartisan margins. President Obama also supported the repeal.[[10]](#footnote-10)

Early Retiree Reinsurance Program (ERRP) – Expired

106. How was the Early Retiree Reinsurance Program (ERRP) intended to work?

Health reform provided for the Early Retiree Reinsurance Program (ERRP).[[11]](#footnote-11) The statute and regulations required that reimbursements be used to lower plan sponsor and employee costs for the medical plan in various ways. Plan sponsors, including employers, unions, and other organizations, participating in health reform’s ERRP were required to explain how they would use funds received under the program. HHS has stated that this program will be a major audit target over the next six years. Thus, plan sponsors must decide on how the funds will be used and develop a sustainable plan. Plan sponsors that deviate from their stated use run the risk of having their funds reclaimed after an HHS audit.

ERRP was a temporary program for sponsors of employment-based health plans that provide retiree health benefits to retirees who are over age fifty-five and not yet eligible for the Medicare program. The program provides an 80 percent subsidy for retiree claims of between $15,000 and $90,000 for plan sponsors that applied to and were accepted by HHS. Congress appropriated $5 billion for the program, which was effective June 1, 2010. The subsidy was to be available through the earlier of January 1, 2014, or the date when the funds were exhausted, which was at the end of 2011.[[12]](#footnote-12) An HHS report stated that almost 5,500 plan sponsors have been approved to participate in the ERRP and that $535 million in ERRP reimbursement payments were made by December 31, 2010.[[13]](#footnote-13) On December 9, 2011, the Centers for Medicare & Medicaid Services (CMS) and HHS announced that ERRP would not reimburse any claims incurred after December 31, 2011. As of December 2, 2011, HHS had reimbursed $4.5 billion of the program’s total funds.

Funds Use Requirements. Plan sponsors had to explain how they would meet the two primary requirements and then follow-through and continue to use the funds in that prescribed fashion.

Reduce Overall Costs. Plan sponsors were required to use reimbursements to reduce overall costs to the Plan. This could include:

* Using the funds to pay any increases in health benefit (or health benefit premium) costs for the plan sponsor (i.e. to offset increases in those costs);
* Reducing individuals’ premium contributions, copayments, deductibles, coinsurance, or other out-of-pocket costs (or some combination of these costs); or
* Providing a combination of these two options.

An “employment-based plan” qualifying for ERRP reimbursements also was required to implement programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions. Health benefit claims that qualified for ERRP reimbursement were only those for medical services that would be covered by the Medicare program.[[14]](#footnote-14) The HHS guidance also described specific items and services that would not be covered. HHS issued a document providing a list of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes excluded under Medicare, which could not be credited toward the ERRP cost threshold or reimbursed as part of the ERRP claims submission process.[[15]](#footnote-15) Further, the HHS guidance stated that sponsors must comply with applicable state and federal requirements regarding benefits. Even though an item or service would not be reimbursed under the ERRP, a sponsor could cover the item or service in its health benefits plan.

Offset Future Increases.Plan sponsors that elected to use the reimbursements (or a portion of the reimbursements) to offset future increases to the plan sponsor would have to summarize how the reimbursements would relieve the organization of using its own funds to subsidize the increases and instead use its own funds to maintain current contributions. A plan sponsor had to explain how long it would continue to maintain its current level of financial support to the plan.

Federal Long-Term Care Benefit – Not Implemented

107. What was the federal long-term care benefit for which employees could have elected to pay?

The health reform law contained a provision whereby individuals could elect to purchase long-term care coverage from the federal government.[[16]](#footnote-16) By January 1, 2012, the Department of Health and Human Services (HHS) was to determine eligibility requirements for a federal long-term care program. By October 1, 2012, plan design and development was to have been completed. However, HHS asked Congress to de-fund the program, although its provisions remain in the law. These provisions provide that employees of companies that choose to participate will be automatically enrolled in the long-term care program, and they may elect to opt out. This part of the health reform law was called the Community Living Assistance Services and Support (CLASS) Act. The employee, not the employer, who does not opt out would pay for this coverage through payroll deductions. Other workers and the self-employed would have been able to enroll on their own. Retirees were not eligible.

After paying premiums for five years, is the employee would be eligible for a cash benefit of about $50 per day if he or she would have been unable to perform two or three activities of daily living, such as walking, bathing or dressing, or if he or she would have been cognitively impaired. In order to qualify for benefits, the employee was required to work for three of the five years during which he or she paid the premiums.

Under the CLASS Act, a person could not have been rejected for coverage because of health problems. It would have helped people with medical conditions that do not qualify for private long-term-care insurance or are subject to very high rates for the coverage. Additionally, it would have covered services that are not eligible for benefits under some long-term-care plans, including homemaker services, home modifications, and transportation, which could help a person stay out of a nursing home.

108. Why was the federal long-term care program cancelled by HHS?

On September 21, 2011, the Senate Appropriations Committee deleted the $120 million that was earmarked for the annual design and marketing of CLASS policies from the 2012 HHS budget, and HHS disbanded the CLASS program. On October 14, 2011, HHS Secretary Kathleen Sebelius told Congress by letter[[17]](#footnote-17) that HHS did not see a viable fiscal future for the CLASS program.[[18]](#footnote-18) (Implementation of the program was contingent on HHS determining that the program was fiscally sustainable and on not using any other funds to pay benefits. The administration determined that the program would be too costly over the long run.

Certain Republicans and Democrats had claimed that the program would eventually become a source of federal deficits. The nonpartisan Congressional Budget Office found the long-term care program would generate tens of billions of dollars between 2012 and 2021, when it was taking in premiums and paying out little in claims. However, the federal actuary for Medicare and Medicaid warned that, in subsequent years, the program would pay out more than it received.

MAXIMUM DEDUCTIBLE LIMITS FOR

SMALL MARKET PLANS REPEALED

Q 108.1 Why was the maximum deductible limit repealed?

As originally enacted, starting in 2014, healthcare reform limited annual deductibles to $2,000 for a plan covering a single individual and $4,000 for any other plan. In the preamble to final regulations, HHS limited this requirement solely to the small group insurance market, thus exempting self-insured plans and the large group insurance market. Under the Protecting Access to Medicare Act of 2014,[[19]](#footnote-19) this annual deductible limit was eliminated retroactively. The repeal occurred due to the desire by small businesses to offer high deductible plans paired with HSAs, HRAs, or health FSAs.

1. . PPACA §10108(a); IRC Sec. 4980H(b)(3). [↑](#footnote-ref-1)
2. . Department of Defense and Full-Year Continuing Appropriations Act, 2011, Pub. L. No. 112-10 (2011). [↑](#footnote-ref-2)
3. . Congressional Research Service Report: http://www.pppnet.org/pdf/crs.\_1099.pdf (last accessed May 27, 2011). [↑](#footnote-ref-3)
4. . Congressional Research Service Report: http://www.pppnet.org/pdf/crs.\_1099.pdf (last accessed May 27, 2011). [↑](#footnote-ref-4)
5. . PPACA §9006, amending IRC Sec. 6041(a) and adding IRC Secs. 6041(h) and (i). [↑](#footnote-ref-5)
6. . P.L. 112-9. [↑](#footnote-ref-6)
7. . P.L. 111-240. [↑](#footnote-ref-7)
8. . IRC Sec. 6041(a). [↑](#footnote-ref-8)
9. . Treas. Reg. §1.6041-1(a)(1)(i). [↑](#footnote-ref-9)
10. . See The White House Blog at http://www.whitehouse.gov/blog/2011/04/14/repealing-1099-reporting-requirement-big-win-small-business. [↑](#footnote-ref-10)
11. . PPACA §1102; 45 C.F.R. Part 149. See also 75 Fed. Reg. 24,450 (May 5, 2010). [↑](#footnote-ref-11)
12. . Employee Benefit Research Institute – see http://www.ebri.org/pdf/notespdf/EBRI\_Notes\_07-July10.Reins-Early.pdf. [↑](#footnote-ref-12)
13. . HHS, “Report on Implementation and Operation of the Early Retiree Reinsurance Program During Calendar Year 2010” (Mar. 2, 2011), available at http://www.healthcare.gov/center/reports/retirement03022011a.pdf. The largest share of 2010 reimbursements went to state and local governments, including school districts and other local agencies, for their early retirees, but approved sponsors also included for-profit companies, unions, religious organizations, and other nonprofits. [↑](#footnote-ref-13)
14. . This requirement is not specified in the law or regulations. See “Common Questions, Costs and Reimbursement,” available at http://www.errp.gov/faq\_costs.shtml. A question, originally posted on August 31, 2010, and updated on December 2, 2010, asked, “For what types of health benefit items and services can a sponsor receive reimbursement?” The answer states: “A sponsor can receive reimbursement for health benefit items and services for which Medicare would reimburse under Parts A, B, and D. For general reference as to what items and services are covered by Medicare Parts A and B, please refer to the Centers for Medicare & Medicaid Services’ (CMS) Medicare & You 2010 and Your Medicare Benefits publications, which are available on the Medicare.gov website.” [↑](#footnote-ref-14)
15. . HHS, “Claims Ineligible for Reimbursement under the Early Retiree Reinsurance Program, Coding Details for Ineligible Services under Medicare which will apply to ERRP” (Oct. 18, 2010), available at http://www.errp.gov/download/cpt/ProcedureCodesIneligibleForReimbursement.pdf. [↑](#footnote-ref-15)
16. . PPACA §8002. [↑](#footnote-ref-16)
17. . U.S. Department of Health and Human Services. Secretary Sebelius’ Letter to Congress about CLASS. (October 14, 2011) at http://www.hhs.gov/secretary/letter10142011.html. [↑](#footnote-ref-17)
18. . In September 2011, HHS foreshadowed the administration's decision by terminating the CLASS program's chief actuary and reassigning other staff. [↑](#footnote-ref-18)
19. Section 213, Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93 (Apr. 1, 2014), amending both PPACA § 1302(c) and PHSA § 2707(b). [↑](#footnote-ref-19)