Effects of the Affordable Care Act on Jobs

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Chairman Pitts, members of the Committee, I am honored to be invited to testify before you today on the effects of the Affordable Care Act on jobs. The Act has employment effects on millions of Americans, and I thank you for holding this hearing.

I am a senior fellow at the Manhattan Institute. From 2003 until April 2005 I was chief economist at the U.S. Department of Labor. From 2001 until 2002 I served at the Council of Economic Advisers as chief of staff. I have served as Deputy Executive Secretary of the Domestic Policy Council under President George H.W. Bush and as an economist on the staff of President Reagan's Council of Economic Advisers. I am the author of a study entitled *The Effects of the Patient Protection and Affordable Care Act on the Franchise Industry*.

High unemployment tops of the list of concerns for Americans. In early March, the Labor Department announced that the February unemployment rate declined to 7.7 percent. That was good news, but the Department also announced that the labor force participation rate declined to 63.5 percent, equivalent to levels in September 1981. The civilian labor force declined by 130,000. Many workers left the labor force because they have not been able to find jobs.

It is normal in a recovery for the labor force participation rate to rise, not decline, as people move back into the labor force. This recovery, however, has been accompanied

by a shrinking workforce. Including discouraged and underemployed workers, the Labor Department's measure of unemployment is 14.3 percent.[1]

The $2,000 per worker penalty in the new health care law, effective 2014 and levied on employers who do not provide the right kind of health insurance, is discouraging hiring.

The Affordable Care Act of 2010 will raise the cost of employment when fully implemented in 2014. Companies with 50 or more workers will be required to offer a generous health insurance package, with no lifetime caps and no copayments for routine visits, or pay an annual penalty of $2,000 for each full-time worker.

This penalty raises significantly the cost of employing full-time workers, especially low-skill workers, because the penalty is a higher proportion of their compensation than for high-skill workers, and employers cannot take the penalty out of employee compensation packages.

To look at the effects of the requirement to offer health insurance, I suggest to the honorable Members of the Committee the following thought experiment. What if employers were required to provide food, clothing or housing—admittedly far more important than health insurance? Firms would hire fewer employees. They would hire

[1] Bureau of Labor Statistics, "The Employment Situation—February 2013," March 8, 2013, http://bls.gov/news.release/pdf/empsit.pdf.

employees with more skills. They would reduce the cash wage to compensate for the amount they had to spend on food, clothing, and housing.

The same is happening in a smaller scale with the requirement to provide a certain level of health insurance or pay a fine. Employers are not blind. They see these penalties coming, and they are adjusting their workforce accordingly.

The evidence that employers are economizing on workers is all around us. More supermarkets and drug stores have self-scanning machines at checkout. Large department stores have price-scanning machines scattered around the stores, so that shoppers can check prices without asking a clerk. Food trucks line the streets in New York and Washington, D.C., enabling restaurants to sell their food without waiters. These workforce adjustments are just one reason that employment growth has been slower than usual during this economic "recovery."

Hardest hit are workers with fewer jobs skills. The unemployment rate for adult workers with less than a high school diploma is 11.2 percent. Teens face an unemployment rate of 25.1 percent. The rate for African American teens is even higher, at 43.1 percent.[2]

Another group that is disproportionately affected is younger workers. Of the 1.4 million adults who found jobs over the past year, over 1 million are over 55 years old, and

[2] Bureau of Labor Statistics, ibid.

336,000 are between ages 25 and 55—even though the 25 to 55 group is over 50 percent larger than the 55 and older group. Younger workers have far fewer employment opportunities, which affects their lifetime expected earnings.

Suppose that a firm with 49 employees does not provide health benefits. Hiring one more worker will trigger an annual penalty of $2,000 per worker multiplied by the entire workforce, after subtracting the statutory exemption for the first 30 workers. In this case the penalty would be $40,000, or $2,000 times 20 (50 minus 30). Indeed, a firm in this situation might have a strong incentive not to hire a 50th worker, or to pay him off the books, thereby violating the law.

In addition, if an employer offers insurance, but an employee qualifies for subsidies under the new health care exchanges because the insurance premium exceeds 9.5 percent of his income, his employer must pay $3,000 per worker. This combination of penalties gives businesses a powerful incentive to downsize, replace full-time employees with part-timers, and contract out work to other firms or individuals. For example, a restaurant might outsource some of its food preparation versus paying employees to make it on-site.

What has been rarely discussed is that the franchise industry will be particularly hard-hit because the new law will make it harder for small businesses with 50 or more employees to compete with those with fewer than 50 employees.

Franchisors and franchisees, who often own groups of small businesses, such as stores, restaurants, hotels, and service businesses, will be at a comparative disadvantage relative to other businesses with fewer locations and fewer employees. This will occur when a franchisor or franchisee employs 50 or more persons at several locations and finds itself competing against independent establishments with fewer than 50.

An estimated 828,000 franchise establishments in the U.S. accounted for more than $468 billion of GDP and more than 9 million jobs, based on PricewaterhouseCoopers' report of 2007 Census data.[3] When factoring the indirect effects, these franchise businesses accounted for more than $1.2 trillion of GDP—or nearly 10 percent of total non-farm GDP. Of franchise businesses, an estimated 77 percent were franchisee-owned and 23 percent were franchisor-owned.

Franchise businesses can be organized in many ways. In some cases the franchisor, or parent company, will own and operate some locations while franchising others. In other cases, a franchisee will own a single location or "unit." In a third set of cases, a franchisee will own multiple locations, referred to as a "multi-unit franchisee." More than half of all franchise establishments are owned by multi-unit franchisees. In the

[3] PricewaterhouseCoopers (PwC), February 2011, *The Economic Impact of Franchised Businesses: Volume III, Results for 2007*, February 2011, http://www.buildingopportunity.com/download/National%20Views.pdf.

cases where the franchisor and the franchisee own and operate multiple locations, these firms are treated as one company for penalty and health care purposes.

The new health care law would put many franchise businesses at a disadvantage relative to non-franchise competitors by driving up their operating costs. Many of these businesses would be subject to the $2,000 health care penalty if they do not provide health insurance. The multi-unit franchisees will have a particularly difficult time operating in this uneven business environment.

Suppose a multi-unit franchisee owns four establishments with 15 full-time employees each. Under the new health care law, this multi-unit franchisee will be treated as a single firm with 60 full-time employees, and the employer will be required by law to provide healthcare benefits for all employees or pay a fine of $2,000 per full-time employee per year.

However, if these four establishments were owned and operated separately, they would be exempt from the requirement of providing healthcare benefits. Further, if these four separately-owned businesses choose to offer health insurance, they would in some cases be entitled to a penalty credit.

When the employer mandates are phased-in in 2014, many franchise businesses will be motivated to reduce the number of locations and move workers from full-time to part-

time status. This will reduce employment still further and curtail the country's economic growth. More than 3.2 million full-time employees in franchise businesses may be affected.

Industries that have traditionally offered the greatest opportunities to entry-level workers—leisure and hospitality, restaurant—will be particularly hard-hit by the new law. Many of these employers do not now offer health insurance to all of their employees, and employ large percentages of entry-level workers, whose cost of hiring will increase significantly.

The franchise industry has offered an entry point to low-skill workers, who have some of the highest unemployment rates in America. Adults without high school diplomas face an unemployment rate of 11.2 percent, nearly 3 times as high as rates for college graduates, and well above the national average of 7.7 percent.

Under the new law, for each block of 30 weekly hours of part-time work by one or more employees a business is deemed to have one full time equivalent employee. The penalty for full-time employees is $2,000 per worker after the first 30 employees.

Businesses with fewer than 50 employees will have an advantage. If they do not hire too many workers—another government-induced disincentive for hiring in this weak labor market—and stay within the 49-person limit, these firms will not have to provide health

insurance and will have a cost advantage over the others. Such businesses will be able to compete advantageously against businesses with multiple locations and 50 or more employees.

The $2,000 penalty will amount to 10.9 percent of average annual earnings in the food and beverage industry and 9.3 percent in retail trade.[4] This is a cost in addition to the employer's share of Social Security and Medicare taxes (7.65 percent, equal to what the employee pays), as well as workers' compensation and unemployment insurance.

When the government requires firms to offer benefits, employers will generally prefer to hire part-time workers, who will not be subject to the penalty. Even though the Act counts part-time workers by aggregating their hours to determine the size of a firm, part-time workers are not subject to the $2,000 penalty. Hence, there will be fewer opportunities open for full-time work. Many workers who prefer to work full-time will have an even harder time finding jobs.

In February over 8 million people were working part-time because they could not find full-time jobs. The new health care law would exacerbate this problem.

In addition to hiring more part-time workers, firms will have an added incentive to

[4] Bureau of Labor Statistics, Current Employment Statistics, March 8, 2013, http://www.bls.gov/web/empsit/ceseeb8b.htm.

become more automated, or machinery-intensive—and employ fewer workers. Fast food restaurants could ship in more precooked food and reheat it, rather than cook it on the premises. Something analogous is already gaining momentum in industries such as DVD rental, where manual labor at retail outlets is being replaced by customer-activated DVD checkout. Supermarkets, drugstores and large-chain hardware stores also are introducing do-it-yourself customer checkout.

Some employers will be allowed to keep existing plans, a term known as "grandfathering." However, restrictions on "grandfathering" could force up to 80 percent of small businesses to drop their current health insurance plans within three years and either replace them with more expensive new plans or go without insurance altogether and pay the penalty, according to government estimates.

The restaurant industry, which represents 23 percent of franchise businesses by number and 50 percent of franchise business employment, provides an example of how firms with seasonal, part-time employees, competitive environments, and low profit margins will face new challenges in connection with the provision of health insurance. Some restaurant owners are likely to drop existing coverage that no longer meets the requirements of the Act. Several restaurants received waivers from the Department of Health and Human Services in 2011, but these waivers will not continue into 2014, once the Act is fully phased in. Many restaurants will be penalized because their low-wage workers will choose to get subsidized coverage on the state exchanges.

The disincentive in the Act to hire additional workers is illustrated in Table 1. If a business does not offer health insurance, then, beginning 2014, it will be subject to a penalty if it employs more than 49 workers in all its establishments. For 49 workers, the penalty is 0. For 50 workers, the penalty is $40,000; for 75 workers, it is $90,000; and for 150 workers, the penalty is $240,000. Each time a business adds another employee, the penalty rises.

On the other hand, as is shown in Table 2, businesses can reduce costs by hiring part-time workers instead of full-time workers. A firm with 85,000 full-time workers and 7,000 part-time workers that does not offer health insurance would pay a penalty of $170 million. By keeping the number of hours worked the same, and gradually reducing full-time workers and increasing part-time workers, until the firm reaches 17,000 full-time workers and 92,000 part-time workers, the penalty is reduced to $34 million. If the firm abandons full-time workers altogether, admittedly an unlikely option, but useful for illustration, the penalty is reduced to zero.

Some businesses, single-unit franchisees and others, could minimize cost by increasing part-time hourly workers, reducing the number of full-time workers, and dropping employer-provided health insurance. Even if businesses choose to offer health insurance to their full-time employees, the Act gives them an incentive to employ more part-time hourly workers than full-time workers in an effort to maximize penalty

benefits. If Congress leaves these incentives in place, the reduction in full-time employment would be costly to the economy.

Table 3, with data taken from the International Franchise Association Educational Foundation, shows the costs of the new health care law to the multi-unit franchise business. Multi-unit franchisees would face more than $3.5 billion in penalties—penalties that could be reduced if firms switched from full-time to part-time workers. Costs would be highest in the quick service restaurant industry, with total penalties of more than $1.6 billion. More than 1.7 million full-time jobs are at risk in multi-unit franchisee businesses, with 820,000 jobs in the quick service industry.

The $2,000 and $3,000 per worker tax payments are the most visible taxes under the new health care law, but they are not the only taxes. The U.S. Government Accountability Office has published a list of 47 different tax provisions in the new law. This list is reproduced in Table 4.

Despite the broad new array of taxes, the Act is structured so as to give the Internal Revenue Service limited enforcement to collect the tax, so that most individuals will be able to avoid paying individual penalties altogether. This will leave the burden of the tax to be paid by employers.

In a June 25, 2012 article in *Tax Notes,* law professors Jordon Barry of the University of San Diego School of Law and Bryan Camp of the Texas Tech University School of Law describe precisely how the Act limits the collection of the tax penalties by the Internal Revenue Service.

Under Section 5000A, the Act does not allow the IRS to use prosecution or criminal penalties to collect the health insurance tax penalty. Further, the IRS is not allowed to place a levy on a person's property, or file a notice of lien to collect the tax. This is completely at odds with other methods of collecting federal taxes, Barry and Camp explain.

The IRS could collect the tax penalty if taxpayers were entitled to a refund of overpaid federal income taxes. The agency could then subtract the health insurance penalty from the refund. But if taxpayers underpaid their income taxes, and were not entitled to a refund, collection would be most difficult.

Barry and Camp conclude, "The restrictions placed on the IRS's ability to collect the tax penalty make it unlikely the IRS can effectively enforce the individual mandate.…Thus, many taxpayers who neglect or refuse to pay the tax penalty could structure their

affairs in such a way as to avoid being subject to legal consequences of any sort for years to come, if ever."[5]

Although individuals will be able to avoid paying the tax, employers will not. Increased hiring costs will cause them to reduce hiring by substituting skilled for unskilled employees in some cases, and machines for employees in others. Placing a tax on hiring will only further reduce the growth of employment.

[5] Barry, Jordan M. and Bryan Camp, *Is the Individual Mandate Really Mandatory?* Tax Notes, Vol. 135, p. 1633, June 25, 2012.

Table 1: Disincentives for Growth

	Avg. Annual Wage
Full-time Employees	$40,000

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
Full-Time Employees	49	50	75	100	150
2014 Penalty	$0	$40,000	$90,000	$140,000	$240,000
Change in Cost per Employee (2014)	$0	$800	$1,200	$1,400	$1,600
Percent Cost Increase Per Employee (2014)	0.0%	2.0%	3.0%	3.5%	4.0%

Source: Author calculations based on new health care law.
Note: Scenario 1 assumes that there are no part-time employees and therefore the employer mandate does not apply.

Table 2: Cost Savings from Moving Workers from Full-time to Part-time

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6
Full-time Employees	85,000	68,000	51,000	34,000	17,000	0
Part-time Hourly Employees	7,000	28,250	49,500	70,750	92,000	113,250
2014 Employer Mandate Penalty	$169,940,000	$135,940,000	$101,940,000	$67,940,000	$33,940,000	0
Change in Total Cost (2014)	$169,940,000	-$113,593,500	-$397,135,500	-$680,653,000	-$964,231,000	- $1,247,679,750
Percent Change in Cost per Employee	6.64%	-8.66%	-22.67%	-35.55%	-47.42%	-58.40%
Assumed Cost Per Labor Hour (2011)	$19.60	$19.60	$19.60	$19.60	$19.60	$19.60
Cost Per Labor Hour (2014)	$20.91	$18.73	$16.56	$14.39	$12.21	$10.04

Source: Author calculations based on new health care law.
Note: The calculation is full-time employees minus the exempted 30 full-time employees, and then multiplied by the $2,000 employer mandate penalty.

Table 3: Estimated Effect of Healthcare Reform on Multi-Unit Franchise Businesses

Business Category	Jobs	Establishments	Employer Mandate Penalty	Full-time Jobs at risk
Quick service restaurants	1,174,957	62,404	$1,631,664,898	820,057
Table/Full Service restaurant	350,648	12,467	$557,958,133	279,746
Business services	306,658	49,474	$228,654,370	113,692
Lodging	318,159	11,976	$501,453,723	250,048
Personal services	294,945	66,584	$166,025,405	90,595
Retail food	159,901	19,961	$129,928,679	65,043
Real Estate	189,104	48,429	$102,037,036	52,421
Retail products and services	150,626	40,618	$80,171,475	40,025
Commercial and residential services	124,603	35,004	$65,120,442	32,619
Automotive	72,398	13,453	$42,741,404	21,360
All Multi-Unit Franchisees	3,141,999	360,371	$3,505,755,565	1,765,607

Source: U.S. Bureau of the Census, 2007 Economic Census; International Franchise Association, member data; and author calculations.

Table 4: Tax Provisions in the Affordable Care Act

	Legislation section	Internal Revenue Code (IRC) section	Provision description	Internal Revenue Service's (IRS) role	Effective date
1	1001		Prohibits group health plans from discriminating in favor of highly compensated individuals.	Issued notice inviting public comment on application to group health plans.	9/23/2010
2	1102		Establishes a temporary reinsurance program to provide reimbursement for a portion of the cost of providing health insurance coverage to early retirees.	Ensure payments received for submission of claims for health coverage to early retirees are not included in the gross income of the employment-based plan.	3/23/2010 Until 1/1/2014
3	1104		Imposes a penalty on health plans identified in an annual Department of Health and Human Services (HHS) penalty fee report, which is to be collected by the Financial Management Service after notice by the Department of the Treasury (Treasury).	Draft guidance or regulations, according to IRS.	3/23/2010
4	1311		Requires state exchanges to send to Treasury a list of the individuals exempt from having minimum essential coverage, those eligible for the premium assistance tax credit, and those who notified the exchange of change in employer or who ceased coverage of a qualified health plan.	Coordinate with HHS on drafting guidance or regulations, according to IRS.	3/23/2010

5	1322	501(c)(29)	Provides tax exemption for nonprofit health insurance companies receiving federal start-up grants or loans to provide insurance to individuals and small groups.	Ensure tax exemption for certain nonprofit health insurers receiving loans or grants under the Consumer Operated and Oriented Plan as established by HHS to provide insurance in the individual and small-group market.	3/23/2010
6	1341		Provides tax exemption for entities providing reinsurance for individual policies during first 3 years of state exchanges.	Ensure tax exemption for entities providing reinsurance for individual health insurance policies during the first 3 years of state exchanges.	3/23/2010
7	1401	36B	Provides premium assistance refundable tax credits for applicable taxpayers who purchase insurance through a state exchange, paid directly to the insurance plans monthly or to individuals who pay out-of-pocket at the end of the taxable year.	Prescribe regulations governing the reconciliation of advance payment amounts with authorized credits and where taxpayer's filing status differs from what was used to determine credit eligibility.	01/01/2014
8	1402		Provides a cost-sharing subsidy for applicable taxpayers to reduce annual out-of-pocket deductibles.	Prescribe regulations with the Secretary of HHS on calculating family size and household income.	3/23/2010
9	1411	36B	Outlines the procedures for determining eligibility for exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.	Verify household income and family size for purposes of eligibility for the tax credit and cost-sharing reduction.	3/23/2010

10	1412	36B	Allows advance determinations and payment of premium tax credits and cost-sharing reductions.	Make advance tax credit payments directly to issuer of a qualified plan on a monthly basis. Collect information from exchanges on individuals' participation, including the plan purchased and amounts advanced.	3/23/2010
11	1414	6103	Authorizes IRS to disclose certain taxpayer information to HHS for purposes of determining eligibility for premium tax credit, cost-sharing subsidy, or state programs including Medicaid, including (1) taxpayer identity; (2) the filing status of such taxpayer; (3) the modified adjusted gross income of taxpayer, spouse, or dependents; and (4) tax year of information.	Disclose certain taxpayer information to HHS officers, employees, and contractors on any taxpayer whose income is relevant to determining their eligibility for the premium tax credit, cost-sharing subsidy, Medicaid, state Children's Health Insurance Program, or a basic state health program established under PPACA.	3/23/2010
12	1421	45R	Provides nonrefundable tax credits for qualified small employers (no more than 25 full-time equivalents (FTE) with annual wages averaging no more than $50,000) for contributions made on behalf of its employees for premiums for qualified health plans.	Administer tax credit for small employers who contribute to health insurance premiums for their employees.	1/1/2010

13	1501	5000A	Requires all U.S. citizens and legal residents and their dependents to maintain minimum essential insurance coverage unless exempted starting in 2014 and imposes a fine on those failing to maintain such coverage.	Collect penalties incurred by individuals who do not have minimum essential health insurance coverage, using limited collection methods including offsetting penalty amounts against refunds or credits.	1/1/2014
14	1502	6055, 6724(d)	Requires every person who provides minimum essential coverage to file an information return with the insured individuals and with IRS.	Prescribe the form and manner of the information return required to be filed by January 31 by all insurers, including employers that provided minimum essential health coverage to individuals in the preceding year. Apply penalties where an insurer does not file the information return. Notify individuals filing tax returns who do not have minimum essential health coverage that they can be penalized and provide information on the individual's state exchange.	1/1/2014

15	1513	4980H	Imposes a penalty on large employers (50+ FTEs) who (1) do not offer coverage for all of their full-time employees, offer unaffordable minimum essential coverage, or offer plans with high out-of-pocket costs and (2) have at least one full-time employee certified as having purchased health insurance through a state exchange and was eligible for a tax credit or subsidy.	Collect penalties assessed annually, monthly, or periodically and repay any penalty including interest where the premium credit or cost sharing is subsequently disallowed.	1/1/2014
16	1514	6056, 6724(d)	Requires information reporting of health insurance coverage information by large employers (subject to IRC 4980H) and certain other employers.	Prescribe the form of the information return to be filed by large employers and other employers offering minimum essential health coverage certifying that coverage was offered and providing information on the individuals covered, and impose penalties on those failing to submit returns.	1/1/2014
17	1515	125(f)(3)	Offers tax exclusion for reimbursement of premiums for small-group exchange-participating health plans offered by small employers to all full-time employees as part of a cafeteria plan.	Ensure tax exclusion for employers offering exchange-participating health plan in an employee cafeteria plan.	1/1/2014
18	1563	9815	Subjects new group health plans to certain Public Health Service Act requirements and imposes the excise tax on plans that fail to meet those requirements. (conforming amendment)	Impose the excise tax for failure to meet Public Health Service Act requirements on new group health plans under PPACA.	3/23/2010

19	3308	6103	Authorizes IRS to disclose certain taxpayer information to the Social Security Administration (SSA) regarding reduction in the subsidy for Medicare Part D for high-income beneficiaries. (conforming amendment)	Disclose certain taxpayer return information to SSA under IRC 6103.	3/23/2010
20	5605		Requires the independent institute partnering with the National Academy of Sciences (NAS) to implement a key national indicator system to be a nonprofit entity under section 501(c)(3).	Enable the independent private organization partnering with NAS to create the key national indicator system to be a nonprofit entity under IRC 501(c)(3).	3/23/2010
21	6301	4375, 4376, 4377, 9511	Imposes a fee through 2019 on specified health insurance policies and applicable self-insured health plans to fund the Patient-Centered Outcomes Research Trust Fund to be used for comparative effectiveness research.	Administer fee on insured and self-insured health plans equal to $2 per individual insured ($1 in plan years ending during fiscal year 2013) to be used by Patient-Centered Outcomes Research Trust Fund for comparative effectiveness research.	10/1/2012
22	9001	4980I	Imposes a 40 percent excise tax on high cost employer-sponsored health insurance coverage on the aggregate value of certain benefits that exceeds the threshold amount.	Administer excise tax on high-cost employer-sponsored health insurance coverage and impose penalties on employers, or the plan sponsor for multiemployer plans, for failure to properly calculate amount of the excess benefit subject to the tax.	1/1/2018
23	9002	6051	Requires employers to disclose the value of the employee's health insurance coverage sponsored by the employer on the annual Form W-2.	Administer change to W-2 reporting to include the value of employer-sponsored health coverage excluding any flexible health spending arrangements.	1/1/2011

24	9003	105, 106, 220, 223	Repeals the tax exclusion for over-the-counter medicines under a Health Flexible Spending Arrangement (FSA), Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), or Archer Medical Savings Account (MSA), unless the medicine is prescribed by a physician.	Administer change to qualified expenses that can be reimbursed by a health FSA or HSA to include only prescription drugs and insulin.	1/1/2011
25	9004	220, 223	Increases tax on distributions from HSAs and Archer MSAs not used for medical expenses.	Administer increase to tax on distributions from HSAs and Archer MSAs that are not used for qualified medical expenditures.	1/1/2011
26	9005	125	Limits health FSAs under cafeteria plans to a maximum of $2,500 adjusted for inflation.	Administer reduction in health FSA amounts to a maximum of $2,500 adjusted for inflation.	1/1/2013
27	9007	501(c)(29), 4959, 6033	Imposes additional reporting requirements for charitable hospitals to qualify as tax-exempt under IRC 501(c)(3) and requires hospitals to conduct a community health needs assessment at least once every 3 years and to adopt a financial assistance policy and policy relating to emergency medical care.	Ensure compliance with additional requirements for charitable hospitals to qualify as 501(c)(3) organization, review community benefit activities at least once every 3 years, impose penalties for failing to conduct community needs assessment, issue guidance on what constitutes reasonable efforts to determine patient eligibility for financial assistance under the hospital's policy, and annually report to Congress on levels of charity care provided and costs of care incurred.	3/23/2010 Community assessment: 03/23/13

28	9008		Imposes a fee on each covered entity engaged in the business of manufacturing or importing branded prescription drugs.	Calculate the fee amount and collect fee on manufacturers of branded prescription drugs sold to Medicare Parts B and D; Medicaid; Department of Veterans Affairs (VA); TRICARE; or other Department of Defense or VA programs.	1/1/2011
29	9010		Imposes an annual fee on any entity that provides health insurance for any U.S. health risk with net premiums written during the calendar year that exceed $25 million.	Calculate and collect annual fee on certain health insurance providers and administer penalties for entities who fail to report the amount of their net premiums for the calendar year, or report inaccurately.	1/1/2014
30	9012	139A	Allows the deduction for retiree prescription drug expenses only after the deduction amount is reduced by the amount of the excludable subsidy payments received.	Ensure amount of deduction for retiree prescription drug expenses has been reduced by any subsidy payments received.	1/1/2013
31	9013	213	Increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5 percent of Adjusted Gross Income (AGI) to 10 percent of AGI (unless taxpayer turns 65 during 2013-2016 and then threshold remains at 7.5 percent).	Ensure itemized deductions for unreimbursed medical expenses by taxpayers meet the 10 percent AGI threshold.	1/1/2013

32	9014	162	Denies the business expenses deductions for wage payments made to individuals for services performed for certain health insurance providers if the payment exceeds $500,000.	Ensure deductions for remuneration exceeding $500,000 are not allowed for certain insurance providers.	01/01/13: For services performed after 12/31/09
33	9015	1401, 3101, 3102	Imposes an additional Hospital Insurance (Medicare) Tax of 0.9 percent on wages over $200,000 for individuals and over $250,000 for couples filing jointly.	Collect additional Hospital Insurance Tax to remit to the hospital insurance trust fund.	1/1/2013
34	9016	833	Limits eligibility for deductions under section 833 (treatment of Blue Cross and Blue Shield) unless the organizations meet a medical loss ratio standard of at least 85 percent for the taxable year.	Issue guidance on determining medical loss ratio and ensure that proper deductions are allowed under IRC 833.	1/1/2010
35	9021	139D	Allows an exclusion from gross income for the value of specified Indian tribe health care benefits.	Ensure that the value of specified Indian tribe health care benefits is not included in gross income.	3/23/2010
36	9022	125	Allows small businesses to offer simple cafeteria plans—plans that increase employees' health benefit options without the nondiscrimination requirements of regular cafeteria plans.	Ensure compliance with requirements of "simple cafeteria plans" for small businesses.	1/1/2011

37	9023	48D	Establishes a 50 percent nonrefundable investment tax credit for qualified therapeutic discovery projects.	Award certifications with HHS for qualified investments and distribute the $1 billion provided for 2009 and 2010 as tax credits or grants.	1/1/2009
38	10108	139D	Requires employers to provide free choice vouchers to certain employees who contribute over 8 percent but less than 9.8 percent of their household income to the employer's insurance plan to be used by employees to purchase health insurance though the exchange.	Ensure that taxpayers receiving vouchers do not get the premium assistance tax credit or cost sharing subsidy and do not include the amount of the free choice voucher in calculating gross income, and allow employers to deduct cost of voucher as a business expense.	1/1/2014
39	10907	5000B	Imposes a tax on any indoor tanning service equal to 10 percent of amount paid for service.	Ensure tax is collected and remitted to IRS at time and in manner specified.	7/1/2010
40	10908	108(f)(4)	Excludes from gross income amounts received by a taxpayer under any state loan repayment or loan forgiveness program that is intended to provide for the increased availability of health care services in underserved or health professional shortage areas.	Ensure that student loan repayments or forgiveness for certain health care professionals working in certain areas are excluded from gross income.	1/1/2009
41	10909	23, 137	Increases the maximum adoption tax credit and the maximum exclusion for employer-provided adoption assistance for 2010 and 2011 to $13,170 per eligible child.	Facilitate the expansion of the already established adoption credit and exclusion for the adoption assistance program.	1/1/2010

Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010)					
42	1004	105, 162, 401, 501	Extends the exclusion from gross income for reimbursements for medical expenses under an employer-provided accident or health plan to employees' children under 27 years.	Ensure that taxpayers properly exclude (or deduct, in the case of self-employed taxpayers) amounts paid by employers for health insurance for employees' older children.	3/30/2010
43	1402	1411	Imposes an unearned income Medicare contribution tax of 3.8 percent on individuals, estates, and trusts on the lesser of net investment income or the excess of modified adjusted gross income (AGI + foreign earned income) over a threshold of $200,000 (individual) or $250,000 (joint).	Ensure collection of unearned income Medicare contribution tax on net investment income or modified adjusted income of certain individuals, trusts, or estates.	1/1/2013
44	1405	4191	Imposes a tax of 2.3 percent on the sale price of any taxable medical device on the manufacturer, producer, or importer.	Ensure payment by manufacturers, producers, or importers of a 2.3 percent sales tax on certain medical devices (does not include eyeglasses, contact lenses, hearing aids or other devices excluded by IRS).	1/1/2013

45	1408	40	Amends the cellulosic biofuel producer credit (nonrefundable tax credit of about $1.01 for each gallon of qualified fuel production of the producer) to exclude fuels with significant water, sediment, or ash content (such as black liquor).	Ensure that tax credits for cellulosic biofuel are not allowed for fuels with significant water, sediment, or ash content.	1/1/2010
46	1409	6662, 6662A, 6664, 6676, 7701	Clarifies and enhances the applications of the economic substance doctrine and imposes penalties for underpayments attributable to transaction lacking economic substance.	Impose penalties for underpayments, nondisclosed transactions, and erroneous claims for refund or credit relating to non-economic-substance transactions.	3/30/2010
47	1410	6655	Increases the required payment of corporate estimated tax due in the third quarter of 2014 by 15.75 percent for corporations with more than $1 billion in assets, and reduces the next payment due by the same amount.	Ensure payment of estimated taxes by certain corporations is increased for the filing in July, August, or September 2014.	3/30/2010

Source: GAO summary of PPACA and Reconciliation Act provisions affecting IRS.