

NAR Frequently Asked Questions

Health Insurance Reform

NEW MEDICARE TAX ON “UNEARNED” NET INVESTMENT INCOME

Q-1: Who will be subject to the new taxes imposed in the health legislation?

A: A new 3.8% tax will apply to the “unearned” income of “High Income” taxpayers. Another 0.9% tax will apply to the “earned” income of many of these same individuals. Both levies are referred to as “Medicare” taxes. (For a description of the new 0.9% tax, see separate Q&A entitled “NEW TAX ON EARNED INCOME: WAGES, SALARIES AND COMMISSIONS.”)

Q-2: Who is a “High Income” Taxpayer?

A: Those whose tax filing status is “single” will be subject to the new unearned income taxes if they have Adjusted Gross Income (AGI) of more than \$200,000. Married couples filing a joint return with AGI of more than \$250,000 will also be subject to the new tax. (The AGI threshold for married filing separate returns is \$125,000.)

Q-3: Are the \$200,000 and \$250,000 thresholds indexed for inflation?

A: No. Thus, over time, more individuals may become subject to this tax.

Q-4: When does the new 3.8% Medicare tax take effect?

A: The new Medicare tax on unearned income will take effect January 1, 2013.

Q-5: What is “unearned” net investment income?

A: Unearned income is the income that an individual derives from investing his/her capital. It includes capital gains, rents, dividends and interest income. It also comes from some investments in active businesses *if* the investor is not an active participant in the business.

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The portion of unearned income that is subject both to income tax and the new Medicare tax is the amount of income derived from these sources, *reduced* by any expenses associated with earning that income. (Hence the term “net” investment income.) Thus, in the case of rents, the taxable amount would be gross rents minus all expenses (including depreciation) incurred in operating the rental property. So if gross rents were \$100,000 with associated expenses of \$40,000, net rents of \$60,000 (\$100,000 minus \$40,000) would be included in Adjusted Gross Income (AGI).

Q-6: So the new tax will apply to rents from investment properties that I own?

A: Maybe. Remember that net investment income includes only *net* rental income. Thus, gross rents would not be subject to the tax. Rather, gross rents would be reduced (as they are under the income tax) by all allowable expenses, including depreciation, cost of repairs, property taxes and all other expenses related to the property. AGI includes net income from rent, so if your AGI is above the \$200,000/\$250,000 thresholds, then the rental income might be subject to the tax. For many investment real estate owners, the net rents will be the same as or similar to the amounts reported on their Schedule E, filed with their Form 1040 Income Tax Return. (For calculations, see Q-8, below. See also Q-9 through Q-12 related to capital gain from sale of principal residence, losses on sale and to vacation homes, below.)

Q-7: Does the tax apply to the yearly appreciation of an asset?

A: No. *Capital gains are subject to this new tax only in the year when the asset is sold.* The amount of the gain will be measured in the same way that it is for income tax purposes. This rule applies to real estate and all other appreciating capital assets. Net capital gains are taxable only in the year of sale.

Q-8: How is the new 3.8% Medicare tax calculated?

A: The new 3.8% Medicare tax is assessed *only* when Adjusted Gross Income (AGI) is more than \$200,000/\$250,000. (See Q-2 above.) AGI includes net income from interest, dividends, rents and capital gains, as well as earned compensation and several additional forms of income presented on a Form 1040 Income Tax Return.

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*The tax is NOT imposed on the total AGI, nor is it imposed solely on the investment income. Rather, the taxable amount will depend on the operation of a formula. The taxpayer will determine the **LESSER** of (1) net investment income **OR** (2) the excess of AGI over the \$200,000/\$250,000 AGI thresholds. Thus, if net investment income is the smaller amount, then the 3.8% tax is applied *only* to the net investment income amount. If the excess over the thresholds is the smaller amount, then the 3.8% tax would apply *only* to the excess amount.*

For example, if AGI for a single individual is \$275,000, then the excess over \$200,000 would be \$75,000 (\$275,000 minus \$200,000). Assume that this individual's net investment income is \$60,000. The new 3.8% tax applies to the smaller amount. In this example, \$60,000 of net investment income is less than the \$75,000 excess over the threshold. Thus, in this example, the 3.8% tax is applied to the \$60,000.

If this single individual had AGI of \$275,000 and net investment income of \$90,000, then the new tax would be imposed on the smaller amount: the \$75,000 of excess over \$200,000.

Rules of thumb for predicting the application of this tax year to year are not readily determinable, largely because the proportion of net investment income compared to AGI will vary from year to year and from individual to individual.

Q-9: Will the \$250,000/\$500,000 exclusion on the sale of a principal residence continue to apply?

A: Yes. Any gain from the sale of a principal residence that is less than \$250,000 (individual) or \$500,000 (joint return) will continue to be excluded from the income tax. The new 3.8% tax will **NOT** apply to this excluded amount of the gain.

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Q-10: Will the 3.8% tax apply to any part of the gain on the sale of a principal residence?

A: The new Medicare tax would apply only to any gain realized that is more than the \$250K/\$500K existing primary home exclusion (known as the “taxable gain”), and only if the seller has AGI above the \$200K/\$250K AGI thresholds.

So, for example, if the taxable gain was \$30,000 and a married couple had AGI (which would include the taxable gain) of \$180,000, the 3.8% tax would *not* apply because AGI is less than \$250,000. If that same couple had AGI of \$290,000, then the application of the 3.8% tax would be subject to the same formula described above. The \$30,000 taxable gain on the sale would be less than the \$40,000 excess above \$250,000 AGI, so the \$30,000 gain would be subject to the new 3.8% tax.

Q-11: Is rent from a vacation home subject to the 3.8% tax? And what about the gain on sale of a vacation or rental property?

A: The application of the tax will depend on whether the vacation home has been rented out, the period for which it has been rented and whether the property is solely for the enjoyment of the owner. If the owner has rented the home out to others, then the 14-day rent exclusion will continue to apply. Thus, if the owner rents the property to others (including family members) for 14 or fewer days, there would be no net investment tax. (Note that no deductions for expenses would be available, as under current law.)

If the home has been rented to others (including family members) for more than 14 days, then the rents (minus related expenses) would be considered as part of net investment income and could, depending on AGI and the calculations described above, be subject to the new tax.

If the vacation home has been used solely for personal enjoyment (i.e., there is no rental income and no associated expenses), then a gain on sale would be treated as net investment income and could be subject to the tax, depending on AGI. Similarly, if the property had generated rents, any net gain on sale could also be included in net investment income. The amount of the tax (if any) would depend on the calculation formula, above in Q-8.

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Q-12: My rental property generates a net loss each year. How will those losses be factored into the new tax? And what if I have net capital losses when I sell?

A: Net losses from rents and net capital losses reduce AGI. Thus, the losses themselves would not be subject to the tax. If, after losses, AGI still exceeds the High Income thresholds, the 3.8% tax would still apply if there were any interest or dividends income. (Capital losses reduce capital gains. If losses exceed gains, no more than \$3000 of capital losses may reduce other income in any year.)

Note that passive loss limitations will continue to apply to rental income and loss.

Q-13: All of my income is derived from real estate investments that I own and operate myself. Will my rents and gains be subject to the new tax?

A: No. If the ownership and operation of real estate you own is your sole occupation, then those activities are what's called your "trade or business." Income derived from a trade or business is not subject to the new 3.8% tax, but could be subject to the 0.9% tax on earned income.

If the owner of rental properties has a "day job," however, real estate investments are *not* considered as a trade or business, but are rather considered as investments, even if they are a major source of income. Note that many Realtors engage in business activities that are the "typical" selling, leasing and brokerage endeavors usually associated with the term "Realtor." If they also own real estate assets as part of their own personal investment portfolio, the rents from that portfolio could become subject to the new 3.8% tax on net investment income, depending on AGI.

Q-14: Is there a real estate "sales tax" or a transfer tax in the new health care bill?

A: No. There is neither a real estate "sales tax" nor a real estate transfer tax in the bill.

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Q-15: Will “High Income Filers” lose any portion of the Mortgage Interest they are allowed to deduct?

A: No. The mortgage interest deduction is unchanged. No cap was imposed on any itemized deductions.

Q-16: Why is this new tax called a “Medicare tax?”

A: The revenues generated from this tax will be allocated to the Medicare Trust Fund that is part of the Social Security System. That fund is currently on shaky financial footing. The additional revenues generated from the new earned income and unearned income taxes are intended to shore up the Medicare Trust Fund.

Q-17: How will this new tax affect marginal (the highest) tax rates when it is combined with existing law and with the possible expiration of the Bush tax cuts enacted in 2001?

A: Marginal tax rates are the tax rates assessed on the “last” dollars included in taxable income. If the Bush tax cuts are allowed to expire, then the marginal rates for upper income individuals will increase, particularly for capital gains income.

The chart on the next page reflects the impact of those changes, presented based on implementation of current law effective dates.

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MARGINAL TAX RATES - 2010 - 2013* (Marginal Tax Bracket is Rate Imposed on Last Dollar of Income)

Year Income Category	Maximum Marginal Rate without Medicare	Maximum Rate with Medicare (Employee Only - 1.45%)	Maximum Rate with Medicare (Self-employed - 2.9%)
2010 (Current Law)			
Ordinary Income	35%	36.45%	37.9%
Capital Gains, Dividends	15%	15%	15%
Rental Income, Interest	35%	35%	35%
2011 (Expiration of Bush Tax Cuts)			
Ordinary Income	39.6%	41.05%	42.5%
Capital Gains	20%	20%	20%
Dividends, Interest	39.6%	39.6%	39.6%
Rental Income	39.6%	39.6%	39.6%
2013 (Adds new Medicare Taxes)			
Ordinary Income (Adds 0.9% tax on Earned Income)	39.6%	41.95%	43.4%
Capital Gains (Adds 3.8% tax on Unearned Income)	20%	23.8%	23.8%
Dividends, Interest (Adds 3.8% tax on Unearned Income)	39.6%	43.4%	43.4%
Rental Income (Adds 3.8% tax on Unearned Income)	39.6%	43.4%	43.4%

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*Several special calculations actually increase the marginal tax rates of many upper income individuals. These include the loss of the personal exemption, loss of some itemized deductions and special self-employment tax deductions and rate adjustments. This chart does not reflect those special calculations because their impact will vary from taxpayer to taxpayer.

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NEW MEDICARE TAX ON EARNED INCOME: WAGES, SALARIES AND COMMISSIONS

Q-1: Who will be subject to the new taxes imposed in the health legislation?

A: A new 0.9% tax will apply to the “earned” income of “High Income” taxpayers. Another 3.8% tax will apply to the “unearned” income of many of these same individuals. Both are described as “Medicare” taxes. (For a description of the 3.8% tax on unearned income, see separate Q&A entitled “NEW MEDICARE TAX ON “UNEARNED” NET INVESTMENT INCOME.)

Q-2: Who is a “High Income” Taxpayer?

A: Those whose tax filing status is “single” will be subject to the new taxes on earned income *if* the earned income that is part of Adjusted Gross Income (AGI) is more than \$200,000. Married couples filing a joint return with earned income of more than \$250,000 will also be subject to the new tax. (The earned income threshold for married filing separate returns is \$125,000)

Q-3: Are the \$200,000 and \$250,000 thresholds indexed for inflation?

A: No. Thus, over time, more individuals could become subject to this tax.

Q-4: When does this tax go into effect?

A: Implementation will begin January 1, 2013.

Q-5: What is “earned” income?

A: The term “earned income” is essentially the income derived from an individual’s labor. It can take the form of wages, salaries, commissions or similar compensation arrangements. Employees of an organization and self-employed individuals are generally compensated for the work they do in some form of earned income.

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Q-6: Does the new 0.9% tax apply to all of an individual's earned income?

A: No. The 0.9% tax applies only to the portion of a high income taxpayer's earnings that exceed the \$200,000 or \$250,000 thresholds. Taxpayers with adjusted gross income below those amounts will experience no change in their Medicare taxes.

Q-7: Does the new tax apply to gross commissions?

A: No. The tax applies only to *net* commissions, i.e., gross commissions minus the expenses of earning the commission. For many Realtors, this will be the amount reflected in the Schedule C they file as part of their annual Form 1040 income tax filings.

Q-8: So will a self-employed person pay an additional tax of 1.8% (i.e., both the "employer" and "employee" portions of the Medicare tax) on the taxable portion of earnings?

A: No. There is no "employer" portion of this new tax. The rate for all individuals subject to the tax will be 0.9%, whether they are employees or they are self-employed. Real estate professionals who have employees would not be required to pay any portion of this tax for any of their employees who might become subject to it. (Note, however, that real estate professionals who have employees may have responsibility to withhold the new tax on behalf of employees who might be subject to it.) Independent contractor sales agents will always pay the full share of this tax they might owe on their earned income.

Q-9: How does the new tax on self-employment income interact with the current rules for the Self-employment Tax (SECA)?

A: Under current law, self-employed individuals must pay a Medicare tax (also known as Hospital Insurance tax, or HI) of 2.9 percent (1.45% "employer" and 1.45% on "employee") on ALL self-employment income. Generally, self-employment income is comprised of earnings from self-employment activities minus the expenses associated with generating those earnings.

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For example, a Realtor might have gross commissions of \$95,000 and expenses associated with that income of \$35,000. That individual's self-employment income would be \$60,000 (\$95,000 minus \$35,000). Assuming no other earned income sources, this Realtor would *not* be subject to the new tax.

By contrast, a high producer Realtor might have net self-employment income of \$280,000. If that Realtor were single, the tax would apply *only* to the \$80,000 that exceeds the \$200,000 AGI threshold. Thus, the additional new tax would be \$720. (\$280,000 minus \$200,000 = \$80,000) (\$80,000 x .009 = \$720). A married couple with earned income of \$280,000 would pay an additional new tax of \$270 (\$280,000 minus \$250,000 = \$30,000) (\$30,000 x .009 = \$270).

(Note that these examples are over-simplified. Determination of self-employment income requires more calculations than are presented here. The example is intended to illustrate that the new tax applies *only* to a portion of an individual's or couple's earned income.)

Q-10: Under current law, a self-employed Realtor deducts one-half of his/her SECA/HI payment for income tax purposes. Can all or some portion of this new tax be deducted?

A: NO AMOUNT of any payment of the new 0.9 percent HI tax on self-employment income will be deductible for income tax purposes.

Q-11: Why is this tax called a "Medicare" tax when it is structured so differently from SECA?

A: The revenues generated from this tax will be allocated to the Medicare Trust Fund that is part of the Social Security System. That fund is currently on shaky financial footing. The additional revenues generated from the new earned income and unearned income taxes are intended to shore up the Medicare Trust Fund.

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Q-12: Is there a real estate “sales tax” or a transfer tax in the new health care bill?

A: No. There is neither a real estate “sales tax” nor a real estate transfer tax in the bill.

Q-13. Will “High Income Filers” also see a reduction in the amount of Mortgage Interest they are allowed to deduct?

A: No. The mortgage interest deduction is unchanged. No cap was imposed on any itemized deductions.

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THE FINAL LEGISLATION

Q-1: Which bills approved by Congress and signed by the President reform health insurance markets and other health care matters?

A: HR 3590, “The Patient Protection and Affordable Care Act” is the primary health reform bill.

H.R. 4872, “The Reconciliation Act of 2010”, amended HR 3590 to reflect agreements made to incorporate provisions from the House’s health reform bill. The final version of the bill was approved by the House and Senate on March 25, 2010.

Q-2: When were these bills signed by the President?

A: H.R. 3590 was signed into law by President Obama on March 23, 2010.

H.R. 4872 was signed by the President on March 30, 2010.

Q-3: When were these bills approved by the House and Senate?

A. H.R. 3590 passed the Senate on December 24, 2009 and the House on March 21, 2010.

H.R. 4872 was approved by the House and Senate on March 25, 2010.

Q-4: How can I see how my Representative and Senators voted on these bills?

A. Access the links below for roll call votes on H.R. 3590 and H.R. 4872:

[View the House roll call votes on H.R. 3590](#)

[View the Senate roll call votes on H.R. 3590](#)

[View the House roll call votes on H.R. 4872](#)

[View the Senate roll call votes on H.R. 4872](#)

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Q-5: Where can I go to see the final text of each of these bills?

A: Access the links below for the final text of H.R. 3590 and H.R. 4872:

[H.R. 3590 as approved](#)

[H.R. 4872 as approved](#)

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NEED FOR REFORM – A REALTOR® PERSPECTIVE

Q-1: Why is health insurance reform being discussed in Congress?

A: Health insurance has become increasingly too costly and difficult to get for individuals, the self-employed, as well as small **and** large employers. Health insurance premiums have risen steadily and more rapidly than wages over the past decade, making it difficult for many to afford health coverage. At the same time, insurance companies often deny coverage to individuals who need it most. In some states, one or two health insurance companies have near-monopoly status, adding to the inefficiency and high costs of health insurance. The reform debate has sought to resolve these challenges.

Q-2: Even if there is a need for reform, why did NAR – a real estate association - get involved in the health reform debate?

A: NAR is a real estate association, but part of its portfolio is to work for the benefit of its members, as well. NAR has heard loud and clear from Realtor associations and the membership for more than seven years that the current healthcare system puts REALTORS® at a particular disadvantage. The overwhelming majority of NAR's 1.2 million members are self-employed. As independent contractors, their only access to medical insurance is through the individual insurance market--the most costly, selective and inefficient segment of the private insurance industry. This situation has left 28% of NAR's membership, as well as many of their dependents, uninsured; many others are underinsured.

Q-3: Why doesn't NAR just offer its members a group plan? With 1.2 million members certainly we're big enough to do so.

A: For most of NAR's existence, health insurance was something most members were able to purchase inexpensively in the individual market or obtain through a spouse's employer, a retirement benefit or a veteran's benefit program. Only in the last decade has demand for more accessible, affordable health insurance outstripped the insurance industry's capacity to provide it. While NAR's Member

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Benefits program has continued to explore the options available, a viable comprehensive health insurance option has not been found.

In today's current health insurance markets, premium costs have been a sizeable obstacle for a fully-insured Realtor health insurance program:

1. Demographics of the REALTORS® population: REALTORS® as a group tend to skew older; today, the average age of a NAR member is 54 years. Since older individuals tend to have more health needs, NAR has not found an insurer willing to offer an insurance program at a price that the membership would be willing or able to pay.
2. The structure of an association plan is also, by definition, very different than an employer provided plan. These differences have made insurers reluctant to offer a true group plan (guaranteed issue, uniform premiums, no health underwriting, etc.) to associations of independent individuals.

Employees enrolled in plans at work (a) pay only a small portion of the premium, (b) have the premium withdrawn by their employer from their paycheck, and (c) cannot enter and exit the plan freely. The sizable subsidy encourages very high rates of participation by young and healthy employees who enroll and stay enrolled.

Insurers argue that actuarial data demonstrates that independent individuals who personally pay the full premiums tend to move in and out of the insurance market based on their personal financial circumstances and, most importantly, their health status and/or perceived need for health services. This is especially true when a plan is a guaranteed issue policy, i.e. you can't be turned down. As a result, those most likely to enroll in a voluntary, unsubsidized group plan tend to be those individuals who are unhealthy (and most need coverage) and/or those who know that they need or want an elective procedure i.e. knee replacement, pregnancy, etc. Consequently, enrollees in this type of plan make claims at a much higher rate than is the case in an employer pool of a similar size. And as a result, insurers shy away from creating such plans.

3. 50 States and 50 Different Sets of State Insurance Regulations: Current law impedes associations from offering a plan that satisfies the requirements of all 50 States. We are aware of no insurance provider with sufficient geographic scope to cover the entire membership. The complexity of the fifty different sets of state insurance laws has encouraged many insurers to abandon many

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markets. As a result, there is not enough competition to help keep prices low for a group like our membership.

The alternative to a privately-insured product would be for NAR itself to get into the insurance business and devise its own self-insured plan. NAR has been unwilling to undertake such an enterprise due to the very significant financial risks that such a program would impose on the organization. In the past, a number of state associations - both large and small - have tried to offer their own self-insured products to their members. All of these enterprises have failed. These efforts have imposed significant financial burdens that have compromised core member services. For the present, NAR believes that, as an organization with no experience or expertise in the insurance business, it will not create its own self-insured program. If insurance professionals are unwilling to take on the risk associated with a national plan for Realtors, then NAR will not attempt to enter the marketplace.

Q-4: What has NAR done to help REALTORS® get affordable, effective health insurance coverage?

A: For at least seven years, and through periods of both Republican and Democratic congressional control, NAR has worked on four major pieces of health insurance reform legislation. The goal has been to devise bills that would allow small businesses and the self-employed to negotiate for improved health insurance products and have access to more affordable “group coverage.” NAR has been a leading player involved in the drafting and advocacy of both bipartisan and majority-only legislation including the Small Business Health Option Program (SHOP), Small Business Health Cooperatives (CHOICE), Small Business Health Plans (SBHPs), Association Health Plans (AHPs), as well as a number of health-related tax measures. The SHOP bill’s underwriting and rating reforms served as the basis for many of the underwriting and rating provisions contained in the final bill signed into law.

Throughout the comprehensive reform debate, NAR engaged in the legislative process by meeting regularly with Members of Congress and their staffs as well as the Obama Administration to voice our concerns about different aspects of proposed legislation. Additionally NAR testified and submitted statements at a number of congressional hearings, and sent letters to Congress outlining our position on various proposals.

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The healthcare issue has also been one of the top four issues that REALTORS® discussed with their Representatives and Senators during each NAR Midyear (Washington, DC) Meeting since 2003.

NAR's leadership has testified before both the House and Senate on the need for reform to address the problems faced by the Realtor community. The issue has also been the focus of Calls for Action urging Congress to enact the various bills that NAR has supported. In addition, our Issue Advocacy program has regularly put out both print and radio ads in the DC media market and in some Congressional districts, as well. These ads have called attention to the health insurance challenges that REALTORS® and other self-employed individuals face.

Copies of NAR's testimony and letters to Congress throughout the process can be found at www.realtor.org/healthreform under "NAR Takes Action."

In addition, NAR's Member Benefits program has continued to explore the policy options available in today's insurance markets. To date, a viable comprehensive health insurance option has not been found.

NAR has been able to put together a guaranteed issued, limited health insurance plan for members. The REALTORS® Core Health Insurance (RCHI) offers coverage for basic medical services. RCHI is available to NAR members aged 18-65. The program does not offer a comprehensive benefit package. More information on the program can be found at http://www.realtor.org/realtor_benefits/benefits_partners/core_health_insurance.

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ACCESS TO HEALTH INSURANCE

Q-1: How does the health care bill reform health insurance markets?

A: The Acts' health insurance provisions reform the nation's currently dysfunctional individual and small group health insurance markets. They do so by:

- Creating a mechanism – An exchange for individuals and a Small Business Health Options Program exchange (SHOP) for small employers - to create larger insurance pools and simplify the onerous task of shopping for the best insurance policy, whether you're an individual, a family or an employer; and
- Replacing the existing set of 50 different state laws governing health insurance with a uniform set of more consumer-protective underwriting and rating rules.

The Exchanges and SHOP will be "one-stop shops" for finding out what policies are available in a given community, comparing different policies and purchasing both private individual and small business insurance products. The Exchange and SHOP will be open to any insurer who offers a product that meets and abides by the underwriting and rating (i.e. pricing) rules set out by the legislation. In addition, the legislation spells out new underwriting and rating rules policies that would be more consumer-protective than is currently the case under state law. These new rules would be on par with what most people think of when they hear the term "group policy".

Q-2: Could I be denied coverage under the new rules?

A: No. The Acts' underwriting standards require all policies be "guaranteed issue." Insurers cannot turn anyone down for reasons related to pre-existing conditions, current health status, previous claims, age, type of employment, etc.

Q-3. Could my insurer decide to not renew my policy?

A: No. The Acts guarantee that your insurance provider must renew any policy that it has issued and for which you have paid.

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Q-4: Can an insurer rescind or cancel my insurance policy?

A: The Acts ban policy rescissions or cancellations without good cause, i.e. failure to pay premiums associated with a policy, fraud, etc. Health status or health claims are not a basis for cancellation or rescission.

Q-5: Would there be waiting periods to receive insurance coverage?

A: The Acts limit the length of any waiting period to 90 days. In many cases, there will be no waiting period.

Q-6: How will pre-existing conditions be handled?

A: The Acts bar the use of pre-existing conditions as an underwriting factor, so no one can be rejected because of those conditions. Moreover, pre-existing conditions may not be used as a factor in setting premium prices.

Q-7: How will premiums be determined?

A: The Acts reduces the number of factors that insurers can use to determine premium costs:

- Age (How old is the insured?),
- Location/geography (Where does the insured live?),
- Type of policy (What plan is the insured purchasing—individual, couple, parent/child, or family?), and
- Coverage level (How high are the plan's deductibles? How comprehensive is the plan's coverage?)

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HEALTH INSURANCE EXCHANGE AND SHOP

Q-1: How would people get health insurance in this reformed health insurance system?

A: Individuals and Very Small Businesses: Individuals, the self-employed and small businesses will buy policies from private insurance companies underwritten and rated using the new set of consumer-protective federal rules. These new policies will be available through state-based “Exchanges” and a “Small Business Health Option Programs” (SHOP) exchange. Individuals and small businesses can also choose to continue any insurance coverage that they already have. In the terms of the Act, those existing plans would be “grandfathered” and considered coverage that meets the terms of the Acts.

Larger Employers: Larger employers who purchase health insurance in the current small and large group market or who self-insure will continue to purchase coverage for their employees, dependents, and retirees in the existing state-regulated small and large group markets. Larger organizations who self-insure will continue to be bound by the federal ERISA statutes that have long governed self-insured plans.

Government Plans: Federal, state and local health insurance plans for employees, retirees, active duty military, veterans and other groups such as children (SCHIP), the elderly (Medicare) and low-income households (Medicaid) will continue to offer coverage to their covered participants.

Q-2: What is an “Exchange”?

A: A key provision of the Acts’ insurance reforms is the creation of “**Exchanges.**” The Exchanges will be state-based and serve as an aggregator of individual policies sold by private insurers and underwritten using the new federal underwriting and rating rules spelled out by the Acts. The Small Business Health Options Program (SHOP) exchange will serve a similar function for small employers and the self-employed. It should be noted that the self-employed independent contractor can choose to purchase coverage that best meets their needs in either the Exchange or in SHOP.

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The Exchanges and SHOP will act much like an “Expedia or Orbitz for Health Insurance” system. Both will allow individuals and small firms to obtain information, compare and purchase private health insurance plans. The Exchange/SHOP will also be the entities that will evaluate whether or not a particular insurance policy meets the criteria set out by the new federal rules for policies offered to individuals and very small employers in the Exchange or SHOP.

Q-3: What types of individuals and small employers will be eligible to participate in an Exchange or SHOP?

A: The Exchange will be open to those who currently purchase insurance in the individual market. This group will include, for example, early retirees (pre-Medicare eligible retirees), the self-employed, individuals whose employers do not provide insurance, or those who cannot afford their employer’s insurance. The SHOP will be open to the self-employed individual and the employees of firms with 100 or fewer employees. The bill grants the Administrator (or states) the authority to allow larger firms to participate in the Exchange or SHOP in the future and/or to merge the Exchange and SHOP into one larger pool.

Q-4: Would the larger firms that aren’t eligible to participate in the Exchange be impacted by the proposed reforms?

A: No and Yes. Those businesses that are not eligible to participate in the Exchange will continue to purchase insurance as they have in the past. The state-regulated small group and large group markets will continue to exist and operate much as they do now. The ERISA regulated market of self-insured employer plans will also continue to exist and operate as they do now.

The Acts will require all insurance policies, including those sold to larger firms, to adopt many of the reforms that will apply to Exchange/SHOP policies including elimination of pre-existing conditions exclusions for children, prohibiting rescissions, eliminating lifetime limits, and restricting the use of annual limits.

Q-5: Why create an Exchange or SHOP? What’s the purpose?

A: The Exchanges and SHOP serve a number of purposes. First, they create larger individual and small employer insurance pools with many of the advantages (lower

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costs, lower premiums, more policy choices) that a larger pool enjoys. Second, they provide individuals and very small employers with access to the new policies written using the new uniform set of national rules which are more consumer-friendly. Third, the Exchange/SHOP will also provide a “one-stop shop” for researching, comparing and purchasing health insurance coverage subject to the new rules, making the process of finding an appropriate health insurance policy easier and more efficient.

Some have drawn a comparison with Expedia.com or Orbitz.com, which provide a similar service for purchasing airline tickets. Just as these travel websites list the array of private airlines, flights and pricing, an Exchange/SHOP will list all of the private insurance policy options available to individuals and small employers in a given community, supply tools to compare these policies, and provide a means of purchasing a policy. The Exchange or SHOP, however, will not offer a government-run policy.

Q-6: When I compare the various plans offered in the Exchange or SHOP, can I compare them on an “apples to apples” basis?

A: Yes, that is the intent. Just as it is difficult to find a comprehensive listing of policies available in any given location, it is equally difficult for consumers and small business that lack a Human Resources department to make informed decisions on which plans best suit their needs. The Exchange/SHOP will not only provide access to the array of policies available in a given marketplace but will also provide assistance in identifying the policies that best fit an individual’s or family’s circumstances.

Q-7: Why would the new Exchange/SHOP underwriting and rating rules be any better than those that are already in place?

A: The Exchange/SHOP underwriting and rating rules in The Acts are much more consumer-protective than most, if not all, of the current state individual and very small group underwriting and rating rules they replace. Currently, most states have few or limited rules governing or restricting individual health insurance policy

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practices. As a result, those who are dependent upon today's individual can be denied coverage, subject to pre-existing exclusions and experience sharp year-to-year increases in premiums. These same practices will not be allowed by the new rules spelled out in the Act.

Q-8: Do the Acts create a new government-run plan, a public insurance option, or so-called "public plan"?

A: No. The Acts approved do not include a government-run policy. Earlier bills considered by the House and one Senate Committee did include a public plan but the final Acts do not.

Q-9: What is a health insurance co-operative/co-op?

A: The Acts authorize the creation of private health insurance co-operatives. A health insurance co-operative is a non-profit, non-government, consumer-driven health plan that would serve as an alternative to the private health insurance programs. A health insurance co-op would be owned and controlled by the people and small businesses that purchase health coverage from the co-operative – not by an insurance company or outside investors. As proposed, a health co-op will be subject to all exchange rules and state laws that apply to other insurance products, i.e. licensure, solvency, capitalization, and consumer protections. The co-op model has been successfully used by farmers, ranchers, utility providers and other businesses to provide services to their members.

Q-10: Do the Acts allow consumers to purchase health insurance plans across state lines?

A: Yes, within certain guidelines. The Acts authorize the creation of state compacts that would allow insurers to offer plans across state lines. In addition, the Act allows non-profit insurers to contract with the exchanges to offer multi-state plans.

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INDIVIDUAL MANDATES

Q-1: What's an "individual mandate"?

A: The Acts impose an "individual mandate" or directive that all individuals have health insurance coverage of some sort. An individual is also responsible for providing insurance both for himself/herself and any dependent family members.

Q-2: What's the purpose of or rationale for an individual mandate?

A: Health policy experts agree that the current system is fundamentally flawed, as it shifts the costs of providing care among both the insured and the uninsured. The insured, medical service providers and taxpayers "pay for" services provided to the uninsured since it is unlawful or unethical to refuse treatment in many situations. At the same time, the uninsured that have the financial resources to pay for services are charged higher prices for the services they receive as they have no power to negotiate a lower fee as the insurers can.

More importantly, the basic concept of insurance is to spread risk among the largest number of participants. Health care costs can be reduced *only* if the costs and the risks are spread among the largest possible populations. Thus, the mandate includes younger and healthy individuals who might otherwise choose to be uninsured. Increasing the size of the risk pool can reduce per capita claims costs, administrative costs and premiums.

Finally, an individual mandate is intended to keep individuals from "gaming the system" by waiting until they need medical care to purchase coverage for their unexpected health care costs.

Q-3: Isn't there some other option besides a mandate?

A. Probably not. A mandate is thought to be the sole *practical* mechanism for assuring that nearly all have insurance. A mandate is also perceived as the best way to assure that the private sector will continue to provide insurance and that there will be robust competition for it. The only other practical way to assure that all have coverage is to have a government program as the sole source of health coverage. Such a system is commonly referred to a "single payer" health care system. There

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was little political support for turning the entire health care system over to the government.

Q-4: How does one satisfy the mandate?

A: The mandate can be satisfied with health insurance obtained via the Exchanges/SHOPs, through an employer plan, through a spouse's employer-provided plan and an existing insurance policy. Coverage obtained through retiree plans, veterans programs, Medicare, Medicaid, SCHIP (Children's Health Insurance Program), and available to active duty military will also satisfy the mandate as will other designated types of government-sponsored health plans.

Q-5: What will be done about those individuals and families who cannot afford to purchase coverage, but are legally required by the individual mandate to do so?

A: The Act provides affordability enhancements. These enhancements take the form of credits that will be used to help pay premiums for lower and moderate income individuals and families. These credits will be distributed on a sliding scale based on income, meaning that the less money you earn, the more subsidy you would receive. Examples are provided below.

Q-6: Can you illustrate how the credits to enhance affordability will work?

A: The Act creates a credit that would be used to reduce health insurance premiums for low- and middle-income Americans who purchase coverage through the Exchange. The amount of a credit an individual or family might receive will depend on family size and household income. Family size and income will be compared with the Federal Poverty Level (FPL) and the credit computed based on those two factors.

As a rule of thumb, families can anticipate that the greater their income, the less the credit; the larger their family, the greater the credit. FPL rises based on size of family. Hence, the poorest, largest families will receive most premium credit. The credit will phase out at 400 percent of FPL. Under current law, an individual with

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income up to \$43,000 and a family of 4 with up to \$88,080 of income can receive some premium credit.

More specifically, taking the affordability credits into consideration, the maximum proportion of income that individuals will pay for health insurance increases with income, on a sliding scale:

Up to 133% FPL	→	2% of income
133 - 150%	→	3% - 4%
150% - 200%	→	4% - 6.3%
200% - 250%	→	6.3% - 8.05%
250% - 300%	→	8.05% - 9.5%
300% - 400%	→	9.5%

Information about the FPL can be found at <http://aspe.hhs.gov/poverty/index.shtml>.

Note that individuals will pay a penalty if, even with this premium credit, they do not acquire health insurance. (See below, "How would an individual mandate be enforced?")

Q-7: Are there any exceptions to the individual mandate?

A. Yes. The approved measure provides hardship exceptions for those individuals and families whose incomes are too small to be able to afford the premiums required to pay for a basic insurance policy. More specifically, individuals or families who find that the least expensive policy available requires more than 8% of household income would be exempted from the mandate.

Q-8: Are insurance mandates something new?

A. Yes and No. While a health insurance mandate is a new application of a mandate, mandates currently exist for other forms of insurance. For example, state and local governments commonly require all car owners/licensed drivers to have liability insurance. While not a statutory requirement, hazard insurance is usually a condition of obtaining a mortgage. Federal flood insurance is required by statute for

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federally-related mortgages in federally-designated flood zones. Part of the monthly payment for a loan backed by the Federal Housing Administration is an insurance premium that FHA requires.

Q-9: How would an individual mandate be enforced?

A: Mandates will be enforced by requiring individuals to provide proof of insurance when filing their federal tax returns. Federal guidelines will specify the format for the proof of insurance. It can also be expected that the Exchanges/SHOPs will provide the proof required for those enrolled in Exchange/SHOP plans and that employers who provide insurance to their workers will confirm the insurance as an information item on the IRS Form W-2 provided each year to their employees.

In addition, tax penalties will be imposed on those who cannot prove coverage. These penalties will be phased in over time as follows:

2014 - greater of a flat fee of	\$95	or	0.5% of taxable income
2015 - greater of a flat fee of	\$325	or	1.0% of taxable income
2016 - greater of a flat fee of	\$695	or	2.0% of taxable income

The maximum for a family without insurance when fully phased in will be the greater of \$2,085 or 2.5% of household income.

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EMPLOYER MANDATES/RESPONSIBILITY PROVISIONS

Q-1: What's an "employer mandate"?

A: An "employer mandate" is a requirement that most employers provide and contribute to the cost of health insurance for their employees.

Q-2: Does the Act contain an employer mandate?

A: Yes. While the Acts do not include an employer mandate in the strictest sense of the term, the Acts do stipulate that employers with more than 50 employees:

- Who do not offer insurance coverage and have at least one Full Time Employee (FTE) that receives a premium tax credit or cost-sharing subsidy will be subject to a penalty of \$2000 times the number of FTE;
- Who *offer coverage* but have at least one FTE that enrolls in the Exchange and receives a premium tax credit pay penalties of \$3,000 per employee receiving a premium credit.

In both cases the first 30 workers employed by the employer are disregarded in calculating the amount of any penalty.

Q-3: What's the purpose or rationale of an employer mandate?

A. In today's market, most health insurance coverage is provided by employers. Rather than create the upheaval that would accompany abandoning this model, Congress chose to 'maintain and, where possible, build upon the nation's employer-employee system of health insurance. Employers, particularly larger employers, are able to negotiate better prices and spread risks more broadly than individuals. Thus, the employer mandate is another mechanism that can create pressure to keep health care costs as low as possible. The mandate is also a means of ensuring that employers that offer employee coverage currently do not "dump" their employees into the Exchange, or if they do, that the additional cost imposed on the federal government is repaid.

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Q-4: Are all employers subject to the employer mandate?

A: No. Firms with 50 or fewer employees are not subject to the employer mandate.

Q-5: Are independent contractors affiliated with a firm considered employees for purposes of the employer mandate?

A: No.

Q-6: Is any assistance available if my small business simply can't afford to provide and contribute to the cost of insurance for its employees?

A: Yes. The Act includes a new tax credit of up to 50% of the employer's contribution for small employers who provide coverage and contribute to their employees' health insurance premiums. Firms with 10 or fewer employees and an average annual per-employee wage less than \$50,000 would be eligible for the full tax credit. Employers with no more than 25 employees would be eligible for a partial credit.

The amount of the credit to a firm will be based on a complex formula that provides the largest amount of credit to the smallest firms with the lowest wages. The credit could be claimed for a maximum of six years (the four years between 2010-2013, plus two years from 2014 and thereafter).

Q-7: How would an employer mandate be enforced?

A: Like individuals, employers will have to provide proof of coverage and contributions when filing their tax returns. Employers will be required to make an affirmative election that they *will* provide health insurance coverage and to disclose that election to employees.

The Administrator of the health insurance program will specify the format and rules for providing proof of coverage. Any penalties would be paid in conjunction with the employer's income tax filings for the year.

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IF YOU ALREADY HAVE OR PROVIDE COVERAGE

Q-1: What if I like the insurance I purchase for myself and/or my family in the individual market? Will I have to change?

A: If you are an individual who buys your own coverage and have a policy you like, you can keep it. Your coverage would be “grandfathered” and will be considered “qualified coverage” that satisfies the individual mandate. However, if you choose to drop your policy, you will be required to purchase a new plan through the new Exchange unless you are eligible for a financial hardship exception to the individual mandate. Adding a spouse or other new dependent to a policy will not jeopardize the grandfather status of your current plan.

Q-2: What will be the impact on those who are currently covered under a spouse's plan?

A: Obviously, the possible effects on any existing coverage will depend upon the spouse’s employer’s decisions regarding employee coverage, just as they do now. If the employer is a medium or large employer, they will continue to purchase state-regulated or ERISA-regulated coverage just as he does now. If the employer is a small employer who likes the coverage he currently offers, they can also continue to offer their existing plan. If the firm is small and eligible to participate in the Exchange, the employer will have the option to look for a new plan that might offer more affordable and/or better coverage.

Should an employer decide to stop offering coverage to its employees or their spouses, those affected will then be eligible to purchase insurance from the Exchange and perhaps qualify for the affordability credits.

One final possible impact may also depend on how generous the employer provided coverage is. The approved measure includes a tax on insurers who offer so-called “Cadillac” employer-provided health insurance plans beginning in 2018 as one of the “pay-fors” in the new legislation. As approved, the bill imposes a tax on insurers offering policies costing more than \$10,200 and family plans in excess of \$27,500. (These thresholds do not include premiums for vision and dental coverage and would be indexed for inflation.) While the tax will be imposed on insurers as a means of encouraging them to moderate costs and offer plans that do not encourage

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overconsumption of health services, it is reasonable to expect that the cost will be passed along to employers, and potentially to employees.

Q-3: Will I get to keep my doctor?

A: The reform proposals do not impact a physician's ability to pick and choose the insurance programs in which they will participate. If you choose to keep your existing plan or choose a new plan in which your physician participates, you can keep your doctor.

Q-4: If I'm self-employed, will I still be able to deduct the cost of my health insurance premiums?

A: Yes. The reform proposals do not alter the rules governing the deductibility of health insurance premiums by the self-employed.

Q-5: If I already offer my salaried workers health insurance, will I be impacted by the proposed changes?

A: Yes and No. If you are an employer who already offers health insurance to your salaried workers, you may continue to offer the plan you have. Your existing plan is "grandfathered" and you are deemed in compliance with the new employer mandate. You may continue to enroll new employees and terminate those employees who leave the firm without jeopardizing this grandfathered status.

If you are a moderate-sized or large firm with more than 50 employees, you still need to comply with the employer mandate. Hence you will need to offer a policy that meets the definition of what constitutes "qualified coverage" and pay a specified portion of employee premiums. If you drop your coverage or fail to contribute to the cost of employee premiums, you will be required to pay a penalty.

If you are a small employer with 50 or fewer employees, you are not required to offer health coverage. If you purchase your coverage through the SHOP and your business meets certain criteria the firm will be eligible to receive a tax credit for up to six years (four years between 2010-2013, plus two years for years 2014 and after).

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**Q-6: How might current legislative proposals affect those who are retired?
How will these proposals affect Medicare?**

A: Medicare is a federal government insurance program that is available to those over the age of 65. While there are changes designed to deal with rising Medicare costs and future shortfalls, NAR has maintained a focus on changes to the private insurance market, where the vast majority of REALTORS® seek insurance coverage. For more information on possible changes to Medicare and effects on retirees, it may prove helpful to look to organizations with more experience and expertise on these matters, such as the American Association of Retired Persons (www.aarp.org).

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PLAN DETAILS

**Q-1: What type of health services will be available under these new plans?
Will I lose access to types of services I have now?**

A: Insurance policies will be required to cover a comprehensive range of health services in order to satisfy the new requirements. The list is more inclusive than current state benefit mandate laws. Required covered benefits include:

- hospitalization
- physician/other health professional services
- prescription drugs
- preventive services
- maternity care
- well baby/child care
- pediatric and non-pediatric dental, vision and hearing services and equipment
- outpatient hospital services
- outpatient clinic services
- emergency room services
- rehabilitation services
- mental health services
- substance abuse disorder services

Q-2: Will there only be one type of insurance plan available through the Exchange?

A: No. The approved Acts spell out an array of insurance policies that participating insurers may offer via the Exchange.

Insurers who choose to participate in the Exchange can offer four levels of coverage – a Bronze, Silver, Gold and Platinum plan - that all offer the same types of coverage but that vary in terms of their deductibles or co-pays.

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Q-3: What will my policy cost? Who determines the cost?

A: The price of a policy will be determined just as it is today by the insurer who offers the policy. Premiums will be subject to the new rating rules and all pricing will remain subject to the review/approval of the state insurance commissioners.

As under current practice, policy premiums will depend upon a number of individualized factors. These include the number and ages of individuals covered the type of policy chosen, deductible levels, and the community where the covered individuals reside. Tobacco users may be subject to an additional surcharge on top of premiums. Thus, it is impossible to determine the cost of a policy at this time. A major goal of the reform effort is to reduce costs for consumers, health care providers and the insurance providers (including Medicare).

The Acts pursue the goal of reducing costs for consumers by making rating rules (i.e. pricing rules) more consumer-protective and merging the individual and small group insurance markets into one pool where risks could be spread across larger numbers of participants. Larger risk pools should lead to greater administrative efficiency and reduced costs, as well. Even the individual and employer mandates, while potentially burdensome during the transition to the new rules, are designed to reduce costs over the long term. In theory, as more individuals and families have health insurance, those with insurance will not be subsidizing those without insurance but to whom health care providers are often required to provide uncompensated care as is now the case. This phenomenon, known as “cost-shifting”, will be eliminated. The Acts also provide for credits for low and moderate income individuals and families, as well as small employers, which will help make coverage more affordable.

Q-4: How do the Acts handle prescription costs?

A: Prescription drug coverage is specifically listed as one of the “essential benefits” that must be covered by a “qualified” insurance policy both within the Exchange and by any new traditional market policy within five years after enactment (House). The size or amount of any deductibles or co-pays will depend on the policy option chosen. Out of pocket prescription costs would be counted as part of a plan’s limitations on annual out of pocket expenses.

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Q-5: Will healthy lifestyle discounts/incentives or higher premiums for unhealthy choices such as smoking be allowed?

A: The Acts allow insurers to offer incentives for healthy lifestyles, wellness programs and other preventive measures. In fact, wellness and health lifestyle incentives are seen as a key means of incentivizing healthy behavior. Under the Reconciliation Act, tobacco users can be assessed a \$200 annual surcharge on their premiums. Like many issues, incentives, discounts or higher premiums would depend on the insurance coverage plan an individual selects.

Q-6: Will health savings accounts (HSAs) still be available?

A: For the most part, the Acts are silent on the treatment of existing health savings accounts but do acknowledge HSA policies as acceptable coverage. (A health savings account allows individuals who purchase some types of high deductible health insurance to also set aside tax-free amounts to cover the cost of routine health care.)

Q-7: Will the government decide what medical procedures/treatments would be allowed? Wouldn't there be rationing?

A. No. The bill does not give the federal government any authority to decide what treatments would be allowed. Decisions as to whether a particular covered benefit is an appropriate one for a patient are left to the policy holder and his/her health care professional.

The only role the federal government has is to spell out what services insurers are required to include in policies, just as state law spells out what services must be covered by state-regulated policies.

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PAYING FOR HEALTH REFORM

Q-1: What is health reform likely to cost?

A: Projecting the costs of a change as substantial as what's being proposed is exceptionally difficult. The Acts are estimated by the non-partisan Congressional Budget Office to cost \$848 Billion and reduce the deficit by \$134 Billion over 10 years.

Q-2: What does the government currently spend on health care?

A: According to the Office of Management and Budget, the government spent \$386 Billion on Medicare and \$201 Billion on Medicaid in Fiscal Year 2008. (Total is \$587 Billion.) The projected costs for FY 2010 for these two items will be \$452 Billion and \$290 Billion, respectively. (The total would be \$742 Billion.)

Q-3: How will a reformed healthcare system be paid for?

A: The "costs" for reform will be shared by changes to current health care programs and the collection of new revenues (aka tax increases). The cuts will be comprised of changes intended to bring new efficiencies to the delivery of medical services, including Medicare and Medicaid. In seeking new revenues, Congress chose to pursue a few big-ticket items rather than make dozens of smaller changes to current law.

The Acts impose taxes on health providers (hospitals, drug companies, medical device manufacturers, etc.) The Acts impose a tax on insurers who offer high value employer-provided health insurance plans. This tax on high-cost plans would not be imposed on individual plans.

In addition, the Acts impose new Medicare taxes on the "net investment income" of high income households, i.e. households with adjusted gross income (AGI) in excess of \$200,000 for individuals and \$250,000 for couples. Since high-income households

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who own property could receive rental income and/or realize capital gains on the sale of properties, the new Medicare tax could impact these households.

Q-4. Did NAR oppose this new tax on capital gains and rents?

A. Yes. Despite the fact this provision was a last minute addition to HR 4872, the Budget Reconciliation Act that amended the underlying Senate health bill, NAR expressed its opposition to the new tax provision to tax committee staffs and sent a strongly worded letter to Congress opposing the new revenue raiser.

Q-5. How can I find out more about this tax?

A: To read more about this new tax and the impact it will have on high income households who receive net investment income i.e. income from capital gains, rents, interest, dividends, and business income earned by shareholders or partners not active in the business minus any allowable deductions, please see the next section of this Q&A entitled "[Medicare Tax on Net Investment Income](#)".

Q-6: Is the mortgage interest deduction going to be used to pay for these reforms?

A: No. While the Administration proposed some limits on the mortgage interest deduction (MID) to "pay for" health reform, the idea never got any traction in Congress.

NAR was adamant in its ongoing communication with Congress that *any* change or limitation to the current MID rules was unacceptable. Moreover, the current real estate market is far too fragile to absorb any changes to the tax rules for homeownership.

Q-7: Is Congress going to tax my health benefits when the insurance company honors my claims?

A: No. When an insurance company honors a claim, it is simply fulfilling its contractual obligation. The reimbursement is not a form of income and is not taxable.

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Q-8: What does it mean when news accounts talk about “taxing health benefits”?

A: The discussion about taxing health benefits arises in the context of employer-paid health insurance premiums. Under current law, any amount of health insurance premium that an employer pays is outside the tax system. The employer can deduct the cost of the premium as a compensation cost. Even though the premium payment is a form of compensation, however, the employee is not required to recognize that amount as income. Similarly, the employer-paid premium is not subject to Social Security taxes. Thus, health insurance is a tax-free employee benefit, often referred to as “the exclusion.”

Under current law, self-employed workers such as the overwhelming percentage of REALTORS® would not have been affected by this debate. Provisions of this sort were not included in the final reform law.

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NAR ADVOCACY POSITIONS

Q-1: Did NAR support the health reform bills?

A: NAR did not take a formal position, for or against, the comprehensive health reform bills debated over the past two years.

Throughout the health care debate, however, NAR met regularly with Members of Congress and their staffs, as well as The Administration, to voice our concerns about the insurance underwriting, rating, mandate and coverage components different of proposed legislation. Additionally NAR testified and submitted testimony at congressional reform hearings, and submitted letters outlining our position on various proposals.

Copies of NAR's testimony and letters to Congress throughout the process can be found at www.realtor.org/healthreform under "NAR Takes Action."

Q-2: Did NAR support an individual mandate?

A: NAR had reservations about the individual mandate and has communicated those concerns to both the House and Senate throughout the reform debate. As self-employed individuals and small business owners, NAR's members have experienced first-hand how difficult it is in today's world to find affordable health insurance. Consequently, NAR worked hard to educate members of Congress on the potential unintended consequences of an individual mandate that does not take into account the fact that even with tax credit assistance, many individuals and families will not be able to afford the required coverage. Polling of NAR's members showed that members were split on the question of individual mandates, so NAR's Board of Directors took no formal position.

Q-3: Did NAR support an employer mandate?

A: No. NAR's Board of Directors adopted formal policy opposing the creation of a mandate for employers to provide health insurance for their employees. An employer mandate creates burdensome new costs for small businesses that are already strained in today's economy. An "employer mandate" could affect REALTOR® sales agents who employ assistants and broker/owners who employ

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salaried workers such as receptionists, bookkeepers, office managers, secretarial staff, transaction coordinators and the like. However, the Acts exempt small employers (under 50 employees) from the employer mandate.

Q-4. Did NAR oppose this new tax on capital gains and rents?

A. Yes. Despite the fact this provision was a last minute addition to HR 4872, the Budget Reconciliation Act, NAR expressed its opposition to the new tax provision to tax committee staffs and sent a strongly worded letter to Congress opposing the new revenue raiser.

Q-5: Did NAR support a health insurance Exchange?

A: Yes. Realtors® and the other self-employed workers know how difficult it is to find objective and comprehensive information that enables them to make informed decisions on the health insurance plan best suited to their needs. An Exchange will provide a one-stop shop where consumers could find a complete list and description of health insurance policies available in a given area. The Exchange is directed to make “apples to apples” comparisons of policies. It will also provide individual assistance to help Exchange participants find policies that best fit their particular circumstances.

An Exchange should reduce the administrative overhead and inefficiencies that presently contribute to the high cost of health insurance premiums in the individual and small group markets. To maximize the cost savings, NAR had suggested that the number of Exchanges be limited to one national Exchange or a limited number of regional Exchanges, rather than a system of 50 or more mini-Exchanges.

The Acts do set up a system of 50 state exchanges, but also allow for states to join together in compacts to allow for interstate pooling, and insurers to offer multi-state plans as NAR has advocated for in the past. The Acts also provide for a federal “backup” exchange, should states not create their own.

Q-6: Did NAR support the so-called public plan option?

A: No. NAR raised a number of concerns with a public plan option in its letters and other communications to the House and Senate. NAR’s correspondence pointed out

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that (1) markets function best when there is a level playing field between all providers of a given service, (2) it is extremely difficult, if not impossible, for private firms to compete with the federal government and (3) the potential for “crowding out” privately-provided insurance plans is a major concern to Realtors. We also stressed that the debate over a public plan option had the potential to derail much needed underwriting, rating and administrative reforms.

The Acts passed do not contain a public option.

Q-7: Did NAR support efforts to allow the federal government to determine what benefits would be required for the new Exchange insurance plans?

A: NAR recognized the problems created by 50 very different sets of state rules and supported the creation of a uniform, set of benefit mandates that would create efficiencies and encourage insurance companies to re-enter markets and thereby increase competition.

NAR strongly believes that care must be taken to ensure that benefit coverage requirements are crafted so that products are affordable and designed to meet the needs of a population that varies in its need for covered services.

NAR believes, given the proposed individual and employer mandates, any decisions as to what benefits are required must be made with input from those who will be required to purchase the product, i.e. individuals, the self-employed, as well as small and large employers. Without an affordable option, the best reform plan will fail to meet the needs of households for accessible coverage. For this reason, we believe that the self-employed and small employers must be included in body that would determine what benefits must be covered.

Q-8: Did NAR support “single payer” healthcare?

A: No. NAR does not support a “single payer” approach to healthcare. NAR has formal policy opposing a single payer approach and communicated that opposition to members of both the House and Senate. Single payer is a system in which the government manages all insurance regulation, utilization and payments. Under

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some single payer systems doctors themselves are employees of the system. Other single payer systems are more like a public-private operation in which doctors remain private practitioners but the government manages and regulates health care delivery. Medicare is a single payer system.

The Acts do not create a “single payer” system.

Q-9: Where can I go to get more information?

A: For more information and copies of all of NAR’s letters and statements to the Hill, please go to REALTOR.org’s Health Insurance Reform webpage, located at www.realtors.org/healthreform.