

**TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS  
OF THE “RECONCILIATION ACT OF 2010,”  
AS AMENDED, IN COMBINATION WITH THE  
“PATIENT PROTECTION AND AFFORDABLE CARE ACT”**

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## INTRODUCTION

This document,<sup>1</sup> prepared by the staff of the Joint Committee on Taxation, provides a technical explanation of the revenue provisions contained in the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act.” Unless otherwise indicated, all section references are to the Internal Revenue Code of 1986, as amended. References to the “Senate amendment” refer to the Patient Protection and Affordable Care Act, an amendment to H.R. 3590, the engrossed amendment as agreed to by the Senate. References to the “Reconciliation bill” refer to the Health Care and Education Reconciliation Act of 2010, an amendment in the nature of a substitute to H.R. 4872, the Reconciliation Act of 2010, as amended.

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<sup>1</sup> This document may be cited as follows: Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as amended, in combination with the “Patient Protection and Affordable Care Act”* (JCX-18-10), March 21, 2010. This document can also be found on our website at [www.jct.gov](http://www.jct.gov).

## TITLE I – QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

### A. Tax Exemption for Certain Member-Run Health Insurance Issuers (sec. 1322<sup>2</sup> of the Senate amendment, new section 501(c)(29) of the Code, and section 6033 of the Code)

#### Present Law

##### In general

Although present law provides that certain limited categories of organizations that offer insurance may qualify for exemption from Federal income tax, present law generally does not provide tax-exempt status for newly established, member-run nonprofit health insurers that are established and funded pursuant to the Consumer Oriented, Not-for-Profit Health Plan program created under the bill and described below.

##### Taxation of insurance companies

###### Taxation of stock and mutual companies providing health insurance

Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Both mutual insurance companies and stock insurance companies are subject to Federal income tax under these rules. Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property and casualty insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.<sup>3</sup>

###### Life insurance companies

A life insurance company, whether stock or mutual, is taxed at regular corporate rates on its life insurance company taxable income (LICTI). LICTI is life insurance gross income reduced by life insurance deductions.<sup>4</sup> An alternative tax applies if a company has a net capital gain for the taxable year, if such tax is less than the tax that would otherwise apply. Life insurance gross income is the sum of (1) premiums, (2) decreases in reserves, and (3) other

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<sup>2</sup> Section 1322 of the Senate amendment as amended by section 10104.

<sup>3</sup> Sec. 816(a).

<sup>4</sup> Sec. 801.

amounts generally includible by a taxpayer in gross income. Methods for determining reserves for Federal income tax purposes generally are based on reserves prescribed by the National Association of Insurance Commissioners for purposes of financial reporting under State regulatory rules.

Because deductible reserves might be viewed as being funded proportionately out of taxable and tax-exempt income, the net increase and net decrease in reserves are computed by reducing the ending balance of the reserve items by a portion of tax-exempt interest (known as a proration rule).<sup>5</sup> Similarly, a life insurance company is allowed a dividends-received deduction for intercorporate dividends from nonaffiliates only in proportion to the company's share of such dividends.<sup>6</sup>

#### Property and casualty insurance companies

The taxable income of a property and casualty insurance company is determined as the sum of the amount earned from underwriting income and from investment income (as well as gains and other income items), reduced by allowable deductions.<sup>7</sup> For this purpose, underwriting income and investment income are computed on the basis of the underwriting and investment exhibit of the annual statement approved by the National Association of Insurance Commissioners.<sup>8</sup>

Underwriting income means premiums earned during the taxable year less losses incurred and expenses incurred.<sup>9</sup> Losses incurred include certain unpaid losses (reported losses that have not been paid, estimates of losses incurred but not reported, resisted claims, and unpaid loss adjustment expenses). Present law limits the deduction for unpaid losses to the amount of discounted unpaid losses, which are discounted using prescribed discount periods and a prescribed interest rate, to take account partially of the time value of money.<sup>10</sup> Any net decrease in the amount of unpaid losses results in income inclusion, and the amount included is computed on a discounted basis.

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<sup>5</sup> Secs. 807(b)(2)(B) and (b)(1)(B).

<sup>6</sup> Secs. 805(a)(4), 812. Fully deductible dividends from affiliates are excluded from the application of this proration formula (so long as such dividends are not themselves distributions from tax-exempt interest or from dividend income that would not be fully deductible if received directly by the taxpayer). In addition, the proration rule includes in prorated amounts the increase for the taxable year in policy cash values of life insurance policies and annuity and endowment contracts owned by the company (the inside buildup on which is not taxed).

<sup>7</sup> Sec. 832.

<sup>8</sup> Sec. 832(b)(1)(A).

<sup>9</sup> Sec. 832(b)(3). In determining premiums earned, the company deducts from gross premiums the increase in unearned premiums for the year (sec. 832(b)(4)(B)). The company is required to reduce the deduction for increases in unearned premiums by 20 percent, reflecting the matching of deferred expenses to deferred income.

<sup>10</sup> Sec. 846.

In calculating its reserve for losses incurred, a proration rule requires that a property and casualty insurance company must reduce the amount of losses incurred by 15 percent of (1) the insurer's tax-exempt interest, (2) the deductible portion of dividends received (with special rules for dividends from affiliates), and (3) the increase for the taxable year in the cash value of life insurance, endowment, or annuity contracts the company owns (sec. 832(b)(5)). This rule reflects the fact that reserves are generally funded in part from tax-exempt interest, from wholly or partially deductible dividends, or from other untaxed amounts.

## **Tax exemption for certain organizations**

### **In general**

Section 501(a) generally provides for exemption from Federal income tax for certain organizations. These organizations include: (1) qualified pension, profit sharing, and stock bonus plans described in section 401(a); (2) religious and apostolic organizations described in section 501(d); and (3) organizations described in section 501(c). Section 501(c) describes 28 different categories of exempt organizations, including: charitable organizations (section 501(c)(3)); social welfare organizations (section 501(c)(4)); labor, agricultural, and horticultural organizations (section 501(c)(5)); professional associations (section 501(c)(6)); and social clubs (section 501(c)(7)).<sup>11</sup>

### **Insurance organizations described in section 501(c)**

Although most organizations that engage principally in insurance activities are not exempt from Federal income tax, certain organizations that engage in insurance activities are described in section 501(c) and exempt from tax under section 501(a). Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary societies that provide for the payment of life,

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<sup>11</sup> Certain organizations that operate on a cooperative basis are taxed under special rules set forth in Subchapter T of the Code. The two principal criteria for determining whether an entity is operating on a cooperative basis are: (1) ownership of the cooperative by persons who patronize the cooperative (e.g., the farmer members of a cooperative formed to market the farmers' produce); and (2) return of earnings to patrons in proportion to their patronage. In general, cooperative members are those who participate in the management of the cooperative and who share in patronage capital. For Federal income tax purposes, a cooperative that is taxed under the Subchapter T rules generally computes its income as if it were a taxable corporation, with one exception -- the cooperative may deduct from its taxable income distributions of patronage dividends. In general, patronage dividends are the profits of the cooperative that are rebated to its patrons pursuant to a preexisting obligation of the cooperative to do so. Certain farmers' cooperatives described in section 521 are authorized to deduct not only patronage dividends from patronage sources, but also dividends on capital stock and certain distributions to patrons from nonpatronage sources.

Separate from the Subchapter T rules, the Code provides tax exemption for certain cooperatives. Section 501(c)(12), for example, provides that certain rural electric and telephone cooperative are exempt from tax under section 501(a), provided that 85 percent or more of the cooperative's income consists of amounts collected from members for the sole purpose of meeting losses or expenses, and certain other requirements are met.



sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than \$600,000 (\$150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals.<sup>12</sup> Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance.

#### Certain section 501(c)(3) organizations

Certain health maintenance organizations (HMOs) have been held to qualify for tax exemption as charitable organizations described in section 501(c)(3). In *Sound Health Association v. Commissioner*,<sup>13</sup> the Tax Court held that a staff model HMO qualified as a charitable organization. A staff model HMO generally employs its own physicians and staff and serves its subscribers at its own facilities. The court concluded that the HMO satisfied the section 501(c)(3) community benefit standard, as its membership was open to almost all members of the community. Although membership was limited to persons who had the money to pay the fixed premiums, the court held that this was not disqualifying, because the HMO had a subsidized premium program for persons of lesser means to be funded through donations and Medicare and Medicaid payments. The HMO also operated an emergency room open to all persons regardless of income. The court rejected the government's contention that the HMO conferred primarily a private benefit to its subscribers, stating that when the potential membership is such a broad segment of the community, benefit to the membership is benefit to the community.

In *Geisinger Health Plan v. Commissioner*,<sup>14</sup> the court applied the section 501(c)(3) community benefit standard to an individual practice association (IPA) model HMO. In the IPA model, health care generally is provided by physicians practicing independently in their own offices, with the IPA usually contracting on behalf of the physicians with the HMO. Reversing a Tax Court decision, the court held that the HMO did not qualify as charitable, because the community benefit standard requires that an HMO be an actual provider of health care rather than merely an arranger or deliverer of health care, which is how the court viewed the IPA model in that case.

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<sup>12</sup> When section 501(c)(26) was enacted in 1996, the House Ways and Means Committee, in reporting out the bill, stated as its reasons for change: "The Committee believes that eliminating the uncertainty concerning the eligibility of certain State health insurance risk pools for tax-exempt status will assist States in providing medical care coverage for their uninsured high-risk residents." H.R. Rep. No. 104-496, Part I, "Health Coverage Availability and Affordability Act of 1996," 104<sup>th</sup> Cong., 2d Sess., March 25, 1996, 124. See also Joint Committee on Taxation, *General Explanation of Tax Legislation Enacted in the 104th Congress*, JCS-12-96, December 18, 1996, 351.

<sup>13</sup> 71 T.C. 158 (1978), *acq.* 1981-2 C.B. 2.

<sup>14</sup> 985 F.2d 1210 (3<sup>rd</sup> Cir. 1993), *rev'g* T.C. Memo. 1991-649.

More recently, in *IHC Health Plans, Inc. v. Commissioner*,<sup>15</sup> the court ruled that three affiliated HMOs did not operate primarily for the benefit of the community they served. The organizations in the case did not provide health care directly, but provided group insurance that could be used at both affiliated and non-affiliated providers. The court found that the organizations primarily performed a risk-bearing function and provided virtually no free or below-cost health care services. In denying charitable status, the court held that a health-care provider must make its services available to all in the community plus provide additional community or public benefits.<sup>16</sup> The benefit must either further the function of government-funded institutions or provide a service that would not likely be provided within the community but for the subsidy. Further, the additional public benefit conferred must be sufficient to give rise to a strong inference that the public benefit is the primary purpose for which the organization operates.<sup>17</sup>

#### Certain organizations providing commercial-type insurance

Section 501(m) provides that an organization may not be exempt from tax under section 501(c)(3) (generally, charitable organizations) or section 501(c)(4) (social welfare organizations) unless no substantial part of its activities consists of providing commercial-type insurance. For this purpose, commercial-type insurance excludes, among other things: (1) insurance provided at substantially below cost to a class of charitable recipients; and (2) incidental health insurance provided by an HMO of a kind customarily provided by such organizations.

When section 501(m) was enacted in 1986, the following reasons for the provision were stated: “The committee is concerned that exempt charitable and social welfare organizations that engaged in insurance activities are engaged in an activity whose nature and scope is so inherently commercial that tax exempt status is inappropriate. The committee believes that the tax-exempt status of organizations engaged in insurance activities provides an unfair competitive advantage to these organizations. The committee further believes that the provision of insurance to the general public at a price sufficient to cover the costs of insurance generally constitutes an activity that is commercial. In addition, the availability of tax-exempt status . . . has allowed some large insurance entities to compete directly with commercial insurance companies. For example, the Blue Cross/Blue Shield organizations historically have been treated as tax-exempt organizations described in sections 501(c)(3) or (4). This group of organizations is now among the largest health care insurers in the United States. Other tax-exempt charitable and social welfare organizations engaged in insurance activities also have a competitive advantage over commercial insurers who do not have tax-exempt status. . . .”<sup>18</sup>

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<sup>15</sup> 325 F.3d 1188 (10<sup>th</sup> Cir. 2003).

<sup>16</sup> *Ibid.* at 1198.

<sup>17</sup> *Ibid.*

<sup>18</sup> H.R. Rep. No. 99-426, “Tax Reform Act of 1985,” Report of the Committee on Ways and Means, 99<sup>th</sup> Cong., 1<sup>st</sup> Sess., December 7, 1985, 664. *See also* Joint Committee on Taxation, *General Explanation of the Tax Reform Act of 1986*, JCS-10-87, May 4, 1987, 584.

## Unrelated business income tax

Most organizations that are exempt from tax under section 501(a) are subject to the unrelated business income tax rules of sections 511 through 515. The unrelated business income tax generally applies to income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions. Certain types of income are specifically exempt from the unrelated business income tax, such as dividends, interest, royalties, and certain rents, unless derived from debt-financed property or from certain 50-percent controlled subsidiaries.

### **Explanation of Provision**

#### **In general**

The provision authorizes \$6 billion in funding for, and instructs the Secretary of Health and Human Services ("HHS") to establish, the Consumer Operated and Oriented Plan (the "program") to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans. Federal funds are to be distributed as loans to assist with start-up costs and grants to assist in meeting State solvency requirements.

Under the provision, the Secretary of HHS must require any person receiving a loan or grant under the program to enter into an agreement with the Secretary of HHS requiring the recipient of funds to meet and continue to meet any requirement under the provision for being treated as a qualified nonprofit health insurance issuer, and any requirements to receive the loan or grant. The provision also requires that the agreement prohibit the use of loan or grant funds for carrying on propaganda or otherwise attempting to influence legislation or for marketing.

If the Secretary of HHS determines that a grant or loan recipient failed to meet the requirements described in the preceding paragraph, and failed to correct such failure within a reasonable period from when the person first knew (or reasonably should have known) of such failure, then such person must repay the Secretary of HHS an amount equal to 110 percent of the aggregate amount of the loans and grants received under the program, plus interest on such amount for the period during which the loans or grants were outstanding. The Secretary of HHS must notify the Secretary of the Treasury of any determination of a failure that results in the termination of the grantee's Federal tax-exempt status.

#### **Qualified nonprofit health insurance issuers**

The provision defines a qualified nonprofit health insurance issuer as an organization that meets the following requirements:

1. The organization is organized as a nonprofit, member corporation under State law;
2. Substantially all of its activities consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans;

3. None of the organization, a related entity, or a predecessor of either was a health insurance issuer as of July 16, 2009;
4. The organization is not sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision;
5. Governance of the organization is subject to a majority vote of its members;
6. The organization's governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference;
7. The organization must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to its members, in accordance with regulations to be promulgated by the Secretary of HHS;
8. Any profits made must be used to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to its members;
9. The organization meets all other requirements that other issuers of qualified health plans are required to meet in any State in which it offers a qualified health plan, including solvency and licensure requirements, rules on payments to providers, rules on network adequacy, rate and form filing rules, and any applicable State premium assessments. Additionally, the organization must coordinate with certain other State insurance reforms under the bill; and
10. The organization does not offer a health plan in a State until that State has in effect (or the Secretary of HHS has implemented for the State), the market reforms required by part A of title XXVII of the Public Health Service Act ("PHSA"), as amended by the bill.

#### **Tax exemption for qualified nonprofit health insurance issuers**

An organization receiving a grant or loan under the program qualifies for exemption from Federal income tax under section 501(a) of the Code with respect to periods during which the organization is in compliance with the above-described requirements of the program and with the terms of any program grant or loan agreement to which such organization is a party. Such organizations also are subject to organizational and operational requirements applicable to certain section 501(c) organizations, including the prohibitions on private inurement and political activities, the limitation on lobbying activities, taxation of excess benefit transactions (section 4958), and taxation of unrelated business taxable income under section 511.

Program participants are required to file an application for exempt status with the IRS in such manner as the Secretary of the Treasury may require, and are subject to annual information reporting requirements. In addition, such an organization is required to disclose on its annual information return the amount of reserves required by each State in which it operates and the amount of reserves on hand.

#### **Effective Date**

The provision is effective on date of enactment.

**B. Tax Exemption for Entities Established Pursuant to Transitional Reinsurance Program for Individual Market in Each State (sec. 1341<sup>19</sup> of the Senate amendment)**

**Present Law**

Although present law provides that certain limited categories of organizations that offer insurance may qualify for exemption from Federal income tax, present law does not provide tax-exempt status for transitional nonprofit reinsurance entities created under the Senate bill and described below.

**Explanation of Provision**

In general, issuers of health benefit plans that are offered in the individual market would be required to contribute to a temporary reinsurance program for individual policies that is administered by a nonprofit reinsurance entity. Such contributions would begin January 1, 2014, and continue for a 36-month period. The provision requires each State, no later than January 1, 2014, to adopt a reinsurance program based on a model regulation and to establish (or enter into a contract with) one or more applicable reinsurance entities to carry out the reinsurance program under the provision. For purposes of the provision, an applicable reinsurance entity is a not-for-profit organization (1) the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first three years of operation of an exchange for such markets within the State, and (2) the duties of which are to carry out the reinsurance program under the provision by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program. A State may have more than one applicable reinsurance entity to carry out the reinsurance program in the State, and two or more States may enter into agreements to allow a reinsurer to operate the reinsurance program in those States.

An applicable reinsurance entity established under the provision is exempt from Federal income tax. Notwithstanding an applicable reinsurance entity's tax-exempt status, it is subject to tax on unrelated business taxable income under section 511 as if such entity were described in section 511(a)(2).

**Effective Date**

The provision is effective on the date of enactment.

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<sup>19</sup> Section 1341 of the Senate amendment as amended by section 10104.

**C. Refundable Tax Credit Providing Premium Assistance  
for Coverage Under a Qualified Health Plan  
(secs. 1401, 1411, and 1412<sup>20</sup> of the Senate amendment and new sec. 36B of the Code)**

**Present Law**

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance. Some individuals may be eligible for health coverage through State Medicaid programs which consider income, assets, and family circumstances. However, these Medicaid programs are not in the Code.

**Health coverage tax credit**

Certain individuals are eligible for the health coverage tax credit (“HCTC”). The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The HCTC is available for “qualified health insurance,” which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury, and the Treasury then pays the full premium (the individual’s portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized health plans, or with certain other specified health coverage are not eligible for the credit.

**COBRA continuation coverage premium reduction**

The Consolidated Omnibus Reconciliation Act of 1985 (“COBRA”)<sup>21</sup> requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the “applicable premium” for such period and the premium must be payable, at the election of the payor, in monthly installments.

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<sup>20</sup> Sections 1401, 1411 and 1412 of the Senate amendment, as amended by sections 10104, 10105, 10107, are further amended by section 1001 of the Reconciliation bill.

<sup>21</sup> Pub. L. No. 99-272.

Section 3001 of the American Recovery and Reinvestment Act of 2009,<sup>22</sup> as amended by the Department of Defense Appropriations Act, 2010,<sup>23</sup> and the Temporary Extension Act of 2010<sup>24</sup> provides that, for a period not exceeding 15 months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct).<sup>25</sup> In addition, the qualifying event must occur during the period beginning September 1, 2008, and ending March 31, 2010.

The COBRA continuation coverage subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the subsidy. To the extent that the aggregate amount of the subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the COBRA continuation coverage subsidy. Taxpayers with modified adjusted gross income exceeding \$145,000 (or \$290,000 for joint filers), must repay any subsidy received by them, their spouse, or their dependant, during the taxable year. For taxpayers with modified adjusted gross incomes between \$125,000 and \$145,000 (or \$250,000 and \$290,000 for joint filers), the amount of the subsidy that must be repaid is reduced proportionately. The subsidy is also conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income

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<sup>22</sup> Pub. L. No. 111-5.

<sup>23</sup> Pub. L. No. 111-118.

<sup>24</sup> Pub. L. No. 111-144.

<sup>25</sup> TEA expanded eligibility for the COBRA subsidy to include individuals who experience a loss of coverage on account of a reduction in hours of employment followed by the involuntary termination of employment of the covered employee. For an individual entitled to COBRA because of a reduction in hours and who is then subsequently involuntarily terminated from employment, the termination is considered a qualifying event for purposes of the COBRA subsidy, as long as the termination occurs during the period beginning on the date following TEA's date of enactment and ending on March 31, 2010.

tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

### **Explanation of Provision**

#### **Premium assistance credit**

The provision creates a refundable tax credit (the “premium assistance credit”) for eligible individuals and families who purchase health insurance through an exchange.<sup>26</sup> The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an exchange.

Under the provision, an eligible individual enrolls in a plan offered through an exchange and reports his or her income to the exchange. Based on the information provided to the exchange, the individual receives a premium assistance credit based on income and the Treasury pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium tax credit amount and the total premium charged for the plan.<sup>27</sup> Individuals who fail to pay all or part of the remaining premium amount are given a mandatory three-month grace period prior to an involuntary termination of their participation in the plan. For employed individuals who purchase health insurance through a State exchange, the premium payments are made through payroll deductions. Initial eligibility for the premium assistance credit is based on the individual’s income for the tax year ending two years prior to the enrollment period. Individuals (or couples) who experience a change in marital status or other household circumstance, experience a decrease in income of more than 20 percent, or receive unemployment insurance, may update eligibility information or request a redetermination of their tax credit eligibility.

The premium assistance credit is available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved who do not received health insurance through an employer or a spouse’s employer.<sup>28</sup> Household income is defined as the sum of: (1) the taxpayer’s modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining that taxpayer’s family size (but only if such individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as

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<sup>26</sup> Individuals enrolled in multi-state plans, pursuant to section 1334 of the Senate amendment, are also eligible for the credit.

<sup>27</sup> Although the credit is generally payable in advance directly to the insurer, individuals may elect to purchase health insurance out-of-pocket and apply to the IRS for the credit at the end of the taxable year. The amount of the reduction in premium is required to be included with each bill sent to the individual.

<sup>28</sup> Individuals who are lawfully present in the United States but are not eligible for Medicaid because of their immigration status are treated as having a household income equal to 100 percent of FPL (and thus eligible for the premium assistance credit) as long as their household income does not actually exceed 100 percent of FPL.



adjusted gross income increased by: (1) the amount (if any) normally excluded by section 911 (the exclusion from gross income for citizens or residents living abroad), plus (2) any tax-exempt interest received or accrued during the tax year. To be eligible for the premium assistance credit, taxpayers who are married (within the meaning of section 7703) must file a joint return. Individuals who are listed as dependants on a return are ineligible for the premium assistance credit.

As described in Table 1 below, premium assistance credits are available on a sliding scale basis for individuals and families with household incomes between 100 and 400 percent of FPL to help offset the cost of private health insurance premiums. The premium assistance credit amount is determined by the Secretary of HHS based on the percentage of income the cost of premiums represents, rising from two percent of income for those at 100 percent of FPL for the family size involved to 9.5 percent of income for those at 400 percent of FPL for the family size involved. Beginning in 2014, the percentages of income are indexed to the excess of premium growth over income growth for the preceding calendar year (in order to hold steady the share of premiums that enrollees at a given poverty level pay over time). Beginning in 2018, if the aggregate amount of premium assistance credits and cost-sharing reductions<sup>29</sup> exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year. For purposes of calculating household size, individuals who are in the country illegally are not included. Individuals who are listed as dependants on a return are ineligible for the premium assistance credit.

Premium assistance credits, or any amounts that are attributable to them, cannot be used to pay for abortions for which federal funding is prohibited. Premium assistance credits are not available for months in which an individual has a free choice voucher (as defined in section 10108 of the Senate amendment).

### **The low income premium credit phase-out**

The premium assistance credit increases, on a sliding scale in a linear manner, as shown in the table below.

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<sup>29</sup> As described in section 1402 of the Senate amendment.

Household Income (expressed as a percent of poverty line)	Initial Premium (percentage)	Final Premium (percentage)
100% through 133%	2.0	3.0
133% through 150%	3.0	4.0
150% through 200%	4.0	6.3
200% through 250%	6.3	8.05
250% through 300%	8.05	9.5
300% through 400%	9.5	9.5

The premium assistance credit amount is tied to the cost of the second lowest-cost silver plan (adjusted for age) which: (1) is in the rating area where the individual resides, (2) is offered through an exchange in the area in which the individual resides, and (3) provides self-only coverage in the case of an individual who purchases self-only coverage, or family coverage in the case of any other individual. If the plan in which the individual enrolls offers benefits in addition to essential health benefits,<sup>30</sup> even if the State in which the individual resides requires such additional benefits, the portion of the premium that is allocable to those additional benefits is disregarded in determining the premium assistance credit amount.<sup>31</sup> Premium assistance credits may be used for any plan purchased through an exchange, including bronze, silver, gold and platinum level plans and, for those eligible,<sup>32</sup> catastrophic plans.

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<sup>30</sup> As defined in section 1302(b) of the Senate amendment.

<sup>31</sup> A similar rule applies to additional benefits that are offered in multi-State plans, under section 1334 of the Senate amendment.

<sup>32</sup> Those eligible to purchase catastrophic plans either must have not reached the age of 30 before the beginning of the plan year, or have certification or an affordability or hardship exemption from the individual responsibility payment, as described in new sections 5000A(e)(1) and 5000A(e)(5), respectively.

## **Minimum essential coverage and employer offer of health insurance coverage**

Generally, if an employee is offered minimum essential coverage<sup>33</sup> in the group market, including employer-provided health insurance coverage, the individual is ineligible for the premium tax credit for health insurance purchased through a State exchange.

If an employee is offered unaffordable coverage by his or her employer or the plan's share of provided benefits is less than 60 percent, the employee can be eligible for the premium tax credit, but only if the employee declines to enroll in the coverage and satisfies the conditions for receiving a tax credit through an exchange. Unaffordable is defined as coverage with a premium required to be paid by the employee that is 9.5 percent or more of the employee's household income, based on the type of coverage applicable (e.g., individual or family coverage).<sup>34</sup> The percentage of income that is considered unaffordable is indexed in the same manner as the percentage of income is indexed for purposes of determining eligibility for the credit (as discussed above). The Secretary of the Treasury is informed of the name and employer identification number of every employer that has one or more employees receiving a premium tax credit.

No later than five years after the date of the enactment of the provision the Comptroller General must conduct a study of whether the percentage of household income used for purposes of determining whether coverage is affordable is the appropriate level, and whether such level can be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided health coverage. The Secretary reports the results of such study to the appropriate committees of Congress, including any recommendations for legislative changes.

## **Procedures for determining eligibility**

For purposes of the premium assistance credit, exchange participants must provide information from their tax return from two years prior during the open enrollment period for coverage during the next calendar year. For example, if an individual applies for a premium assistance credit for 2014, the individual must provide a tax return from 2012 during the 2103 open enrollment period. The Internal Revenue Service ("IRS") is authorized to disclose to HHS limited tax return information to verify a taxpayer's income based on the most recent return information available to establish eligibility for the premium tax credit. Existing privacy and safeguard requirements apply. Individuals who do not qualify for the premium tax credit on the basis of their prior year income may apply for the premium tax credit based on specified changes in circumstances. For individuals and families who did not file a tax return in the prior tax year, the Secretary of HHS will establish alternative income documentation that may be provided to determine income eligibility for the premium tax credit.

The Secretary of HHS must establish a program for determining whether or not individuals are eligible to: (1) enroll in an exchange-offered health plan; (2) claim a premium

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<sup>33</sup> As defined in section 5000A(f) of the Senate amendment.

<sup>34</sup> The 9.5 percent amount is indexed for calendar years beginning after 2014.

assistance credit; and (3) establish that their coverage under an employer-sponsored plan is unaffordable. The program must provide for the following: (1) the details of an individual's application process; (2) the details of how public entities are to make determinations of individuals' eligibility; (3) procedures for deeming individuals to be eligible; and, (4) procedures for allowing individuals with limited English proficiency to have proper access to exchanges.

In applying for enrollment in an exchange-offered health plan, an individual applicant is required to provide individually identifiable information, including name, address, date of birth, and citizenship or immigration status. In the case of an individual claiming a premium assistance credit, the individual is required to submit to the exchange income and family size information and information regarding changes in marital or family status or income. Personal information provided to the exchange is submitted to the Secretary of HHS. In turn, the Secretary of HHS submits the applicable information to the Social Security Commissioner, Homeland Security Secretary, and Treasury Secretary for verification purposes. The Secretary of HHS is notified of the results following verification, and notifies the exchange of such results. The provision specifies actions to be undertaken if inconsistencies are found. The Secretary of HHS, in consultation with the Social Security Commissioner, the Secretary of Homeland Security, and the Treasury Secretary must establish procedures for appealing determinations resulting from the verification process, and redetermining eligibility on a periodic basis.

An employer must be notified if one of its employees is determined to be eligible for a premium assistance credit because the employer does not provide minimal essential coverage through an employer-sponsored plan, or the employer does offer such coverage but it is not affordable. The notice must include information about the employer's potential liability for payments under section 4980H and that terminating or discriminating against an employee because he or she received a credit or subsidy is in violation of the Fair Labor Standards Act.<sup>35</sup> An employer is generally not entitled to information about its employees who qualify for the premium assistance credit. Employers may, however, be notified of the name of the employee and whether his or her income is above or below the threshold used to measure the affordability of the employer's health insurance coverage.

Personal information submitted for verification may be used only to the extent necessary for verification purposes and may not be disclosed to anyone not identified in this provision. Any person, who submits false information due to negligence or disregard of any rule, and without reasonable cause, is subject to a civil penalty of not more than \$25,000. Any person who intentionally provides false information will be fined not more than \$250,000. Any person who knowingly and willfully uses or discloses confidential applicant information will be fined not more than \$25,000. Any fines imposed by this provision may not be collected through a lien or levy against property, and the section does not impose any criminal liability.

The provision requires the Secretary of HHS, in consultation with the Secretaries of the Treasury and Labor, to conduct a study to ensure that the procedures necessary to administer the determination of individuals' eligibility to participate in an exchange, to receive premium

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<sup>35</sup> Pub. L. No. 75-718.

assistance credits, and to obtain an individual responsibility exemption, adequately protect employees' rights of privacy and employers' rights to due process. The results of the study must be reported by January 1, 2013, to the appropriate committees of Congress.

### **Reconciliation**

If the premium assistance received through an advance payment exceeds the amount of credit to which the taxpayer is entitled, the excess advance payment is treated as an increase in tax. For persons whose household income is below 400% of the FPL, the amount of the increase in tax is limited to \$400. If the premium assistance received through an advance payment is less than the amount of the credit to which the taxpayer is entitled, the shortfall is treated as a reduction in tax.

The eligibility for and amount of premium assistance is determined in advance of the coverage year, on the basis of household income and family size from two years prior, and the monthly premiums for qualified health plans in the individual market in which the taxpayer, spouse and any dependent enroll in an exchange. Any advance premium assistance is paid during the year for which coverage is provided by the exchange. In the subsequent year, the amount of advance premium assistance is required to be reconciled with the allowable refundable credit for the year of coverage. Generally, this would be accomplished on the tax return filed for the year of coverage, based on that year's actual household income, family size, and premiums. Any adjustment to tax resulting from the difference between the advance premium assistance and the allowable refundable tax credit would be assessed as additional tax or a reduction in tax on the tax return.

Separately, the provision requires that the exchange, or any person with whom it contracts to administer the insurance program, must report to the Secretary with respect to any taxpayer's participation in the health plan offered by the Exchange. The information to be reported is information necessary to determine whether a person has received excess advance payments, identifying information about the taxpayer (such as name, taxpayer identification number, months of coverage) and any other person covered by that policy; the level of coverage purchased by the taxpayer; the total premium charged for the coverage, as well as the aggregate advance payments credited to that taxpayer; and information provided to the Exchange for the purpose of establishing eligibility for the program, including changes of circumstances of the taxpayer since first purchasing the coverage. Finally, the party submitting the report must provide a copy to the taxpayer whose information is the subject of the report.

### **Effective Date**

The provision is effective for taxable years ending after December 31, 2013.

#### **D. Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans (secs. 1402, 1411, and 1412 of the Senate amendment<sup>36</sup>)**

##### **Present Law**

Currently there is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance. Some individuals may be eligible for health coverage through State Medicaid programs which consider income, assets, and family circumstances. However, these Medicaid programs are not in the Code.

##### **Health coverage tax credit**

Certain individuals are eligible for the HCTC. The HCTC is a refundable tax credit equal to 80 percent of the cost of qualified health coverage paid by an eligible individual. In general, eligible individuals are individuals who receive a trade adjustment allowance (and individuals who would be eligible to receive such an allowance but for the fact that they have not exhausted their regular unemployment benefits), individuals eligible for the alternative trade adjustment assistance program, and individuals over age 55 who receive pension benefits from the Pension Benefit Guaranty Corporation. The HCTC is available for “qualified health insurance,” which includes certain employer-based insurance, certain State-based insurance, and in some cases, insurance purchased in the individual market.

The credit is available on an advance basis through a program established and administered by the Treasury Department. The credit generally is delivered as follows: the eligible individual sends his or her portion of the premium to the Treasury, and the Treasury then pays the full premium (the individual’s portion and the amount of the refundable tax credit) to the insurer. Alternatively, an eligible individual is also permitted to pay the entire premium during the year and claim the credit on his or her income tax return.

Individuals entitled to Medicare and certain other governmental health programs, covered under certain employer-subsidized health plans, or with certain other specified health coverage are not eligible for the credit.

##### **COBRA continuation coverage premium reduction**

COBRA<sup>37</sup> requires that a group health plan must offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment). A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the “applicable premium” for such period and the premium must be payable, at the election of the payor, in monthly installments.

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<sup>36</sup> Sections 1401, 1411 and 1412 of the Senate amendment, as amended by section 10104, is further amended by section 1001 of the Reconciliation bill.

<sup>37</sup> Pub. L. No. 99-272.

Section 3001 of the American Recovery and Reinvestment Act of 2009,<sup>38</sup> as amended by the Department of Defense Appropriations Act, 2010,<sup>39</sup> and the Temporary Extension Act of 2010<sup>40</sup> provides that, for a period not exceeding 15 months, an assistance eligible individual is treated as having paid any premium required for COBRA continuation coverage under a group health plan if the individual pays 35 percent of the premium. Thus, if the assistance eligible individual pays 35 percent of the premium, the group health plan must treat the individual as having paid the full premium required for COBRA continuation coverage, and the individual is entitled to a subsidy for 65 percent of the premium. An assistance eligible individual generally is any qualified beneficiary who elects COBRA continuation coverage and the qualifying event with respect to the covered employee for that qualified beneficiary is a loss of group health plan coverage on account of an involuntary termination of the covered employee's employment (for other than gross misconduct).<sup>41</sup> In addition, the qualifying event must occur during the period beginning September 1, 2008, and ending March 31, 2010.

The COBRA continuation coverage subsidy also applies to temporary continuation coverage elected under the Federal Employees Health Benefits Program and to continuation health coverage under State programs that provide coverage comparable to continuation coverage. The subsidy is generally delivered by requiring employers to pay the subsidized portion of the premium for assistance eligible individuals. The employer then treats the payment of the subsidized portion as a payment of employment taxes and offsets its employment tax liability by the amount of the subsidy. To the extent that the aggregate amount of the subsidy for all assistance eligible individuals for which the employer is entitled to a credit for a quarter exceeds the employer's employment tax liability for the quarter, the employer can request a tax refund or can claim the credit against future employment tax liability.

There is an income limit on the entitlement to the COBRA continuation coverage subsidy. Taxpayers with modified adjusted gross income exceeding \$145,000 (or \$290,000 for joint filers), must repay any subsidy received by them, their spouse, or their dependant, during the taxable year. For taxpayers with modified adjusted gross incomes between \$125,000 and \$145,000 (or \$250,000 and \$290,000 for joint filers), the amount of the subsidy that must be repaid is reduced proportionately. The subsidy is also conditioned on the individual not being eligible for certain other health coverage. To the extent that an eligible individual receives a subsidy during a taxable year to which the individual was not entitled due to income or being eligible for other health coverage, the subsidy overpayment is repaid on the individual's income

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<sup>38</sup> Pub. L. No. 111-5.

<sup>39</sup> Pub. L. No. 111-118.

<sup>40</sup> Pub. L. No. 111-144.

<sup>41</sup> TEA expanded eligibility for the COBRA subsidy to include individuals who experience a loss of coverage on account of a reduction in hours of employment followed by the involuntary termination of employment of the covered employee. For an individual entitled to COBRA because of a reduction in hours and who is then subsequently involuntarily terminated from employment, the termination is considered a qualifying event for purposes of the COBRA subsidy, as long as the termination occurs during the period beginning on the date following TEA's date of enactment and ending on March 31, 2010.

tax return as additional tax. However, in contrast to the HCTC, the subsidy for COBRA continuation coverage may only be claimed through the employer and cannot be claimed at the end of the year on an individual tax return.

### **Explanation of Provision**

#### **Cost-sharing subsidy**

A cost-sharing subsidy is provided to reduce annual out-of-pocket cost-sharing for individuals and households between 100 and 400 percent of FPL (for the family size involved). The reductions are made in reference to the dollar cap on annual deductibles for high deductible health plans in section 223(c)(2)(A)(ii) (currently \$5,000 for self-only coverage and \$10,000 for family coverage). For individuals with household income of more than 100 but not more than 200 percent of FPL, the out-of-pocket limit is reduced by two-thirds. For those between 201 and 300 percent of FPL by one-half, and for those between 301 and 400 percent of FPL by one-third.

The cost-sharing subsidy that is provided must buy out any difference in cost-sharing between the qualified health insurance purchased and the actuarial values specified below. For individuals between 100 and 150 percent of FPL (for the family size involved), the subsidy must bring the value of the plan to not more than 94 percent actuarial value. For those between 150 and 200 percent of FPL, the subsidy must bring the value of the plan to not more than 87 percent actuarial value. For those between 201 and 250 percent of FPL, the subsidy must bring the value of the plan to not more than 73 percent actuarial value. For those between 251 and 400 percent of FPL, the subsidy must bring the value of the plan to not more than 70 percent actuarial value. The determination of cost-sharing subsidies will be made based on data from the same taxable year as is used for determining advance credits under section 1412 of the Senate amendment (and not the taxable year used for determining premium assistance credits under section 36B). The amount received by an insurer as a cost-sharing subsidy on behalf of an individual, as well as any out-of-pocket spending by the individual, counts towards the out-of-pocket limit. Individuals enrolled in multi-state plans, pursuant to section 1334 of the Senate amendment, are eligible for the subsidy.

In addition to adjusting actuarial values, plans must further reduce cost-sharing for low-income individuals as specified below. For individuals between 100 and 150 percent of FPL (for the family size involved) the plan's share of the total allowed cost of benefits provided under the plan must be 94 percent. For those between 151 and 200 percent of FPL, the plan's share must be 87 percent, and for those between 201 and 250 percent of FPL the plan's share must be 73 percent.

The cost-sharing subsidy is available only for those months in which an individual receives an affordability credit under new section 36B.<sup>42</sup>

As with the premium assistance credit, if the plan in which the individual enrolls offers benefits in addition to essential health benefits,<sup>43</sup> even if the State in which the individual resides

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<sup>42</sup> Section 1401 of the Senate amendment.



requires such additional benefits, the reduction in cost-sharing does not apply to the additional benefits. In addition, individuals enrolled in both a qualified health plan and a pediatric dental plan may not receive a cost-sharing subsidy for the pediatric dental benefits that are included in the essential health benefits required to be provided by the qualified health plan. Cost-sharing subsidies, and any amounts that are attributable to them, cannot be used to pay for abortions for which federal funding is prohibited.

The Secretary of HHS must establish a program for determining whether individuals are eligible to claim a cost-sharing credit. The program must provide for the following: (1) the details of an individual's application process; (2) the details of how public entities are to make determinations of individuals' eligibility; (3) procedures for deeming individuals to be eligible; and, (4) procedures for allowing individuals with limited English proficiency proper access to exchanges.

In applying for enrollment, an individual claiming a cost-sharing subsidy is required to submit to the exchange income and family size information and information regarding changes in marital or family status or income. Personal information provided to the exchange is submitted to the Secretary of HHS. In turn, the Secretary of HHS submits the applicable information to the Social Security Commissioner, Homeland Security Secretary, and Treasury Secretary for verification purposes. The Secretary of HHS is notified of the results following verification, and notifies the exchange of such results. The provision specifies actions to be undertaken if inconsistencies are found. The Secretary of HHS, in consultation with the Treasury Secretary, Homeland Security Secretary, and Social Security Commissioner, must establish procedures for appealing determinations resulting from the verification process, and redetermining eligibility on a periodic basis.

The Secretary notifies the plan that the individual is eligible and the plan reduces the cost-sharing by reducing the out-of-pocket limit under the provision. The plan notifies the Secretary of cost-sharing reductions and the Secretary makes periodic and timely payments to the plan equal to the value of the reductions in cost-sharing. The provision authorizes the Secretary to establish a capitated payment system with appropriate risk adjustments.

An employer must be notified if one of its employees is determined to be eligible for a cost-sharing subsidy. The notice must include information about the employer's potential liability for payments under section 4980H and explicit notice that hiring, terminating, or otherwise discriminating against an employee because he or she received a credit or subsidy is in violation of the Fair Labor Standards Act.<sup>44</sup> An employer is generally not entitled to information about its employees who qualify for the premium assistance credit or the cost-sharing subsidy. Employers may, however, be notified of the name of an employee and whether his or her income is above or below the threshold used to measure the affordability of the employer's health insurance coverage.

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<sup>43</sup> As defined in section 1302(b) of the Senate amendment.

<sup>44</sup> Pub. Law No. 75-718.

The Secretary of the Treasury is informed of the name and employer identification number of every employer that has one or more employee receiving a cost-sharing subsidy.

The provision implements special rules for Indians (as defined by the Indian Health Care Improvement Act) and undocumented aliens. The provision prohibits cost-sharing reductions for individuals who are not lawfully present in the United States, and such individuals are not taken into account in determining the family size involved.

The provision defines any term used in this section that is also used by section 36B as having the same meaning as defined by the latter. The provision also denies subsidies to dependents, with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which the individual's taxable year begins. Further, the provision does not permit a subsidy for any month that is not treated as a coverage month.

#### **Effective Date**

The provision is effective on date of enactment.

**E. Disclosures to Carry Out Eligibility Requirements for Certain Programs  
(sec. 1414<sup>45</sup> of the Senate amendment and sec. 6103 of the Code)**

**Present Law**

Section 6103 provides that returns and return information are confidential and may not be disclosed by the IRS, other Federal employees, State employees, and certain others having access to such information except as provided in the Internal Revenue Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances. For example, section 6103 provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B premium subsidy adjustment.

Section 6103(p)(4) requires, as a condition of receiving returns and return information, that Federal and State agencies (and certain other recipients) provide safeguards as prescribed by the Secretary of the Treasury by regulation to be necessary or appropriate to protect the confidentiality of returns or return information. Unauthorized disclosure of a return or return information is a felony punishable by a fine not exceeding \$5,000 or imprisonment of not more than five years, or both, together with the costs of prosecution.<sup>46</sup> The unauthorized inspection of a return or return information is punishable by a fine not exceeding \$1,000 or imprisonment of not more than one year, or both, together with the costs of prosecution.<sup>47</sup> An action for civil damages also may be brought for unauthorized disclosure or inspection.<sup>48</sup>

**Explanation of Provision**

Individuals will submit income information to an exchange as part of an application process in order to claim the cost-sharing reduction and the tax credit on an advance basis. The Department of HHS serves as the centralized verification agency for information submitted by individuals to the exchanges with respect to the reduction and the tax credit to the extent provided on an advance basis. The IRS is permitted to substantiate the accuracy of income information that has been provided to HHS for eligibility determination.

Specifically, upon written request of the Secretary of HHS, the IRS is permitted to disclose the following return information of any taxpayer whose income is relevant in determining the amount of the tax credit or cost-sharing reduction, or eligibility for participation in the specified State health subsidy programs (i.e., a State Medicaid program under title XIX of the Social Security Act, a State's children's health insurance program under title XXI of such Act, or a basic health program under section 2228 of such Act): (1) taxpayer identity; (2) the filing status of such taxpayer; (3) the modified adjusted gross income (as defined in new sec.

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<sup>45</sup> Section 1414 of the Senate amendment is amended by section 1004 of the Reconciliation bill.

<sup>46</sup> Sec. 7213.

<sup>47</sup> Sec. 7213A.

<sup>48</sup> Sec. 7431.

36B of the Code) of such taxpayer, the taxpayer's spouse and of any dependants who are required to file a tax return; (4) such other information as is prescribed by Treasury regulation as might indicate whether such taxpayer is eligible for the credit or subsidy (and the amount thereof); and (5) the taxable year with respect to which the preceding information relates, or if applicable, the fact that such information is not available. HHS is permitted to disclose to an exchange or its contractors, or to the State agency administering the health subsidy programs referenced above (and their contractors) any inconsistency between the information submitted and IRS records.

The disclosed return information may be used only for the purposes of, and only to the extent necessary in, establishing eligibility for participation in the exchange, verifying the appropriate amount of the tax credit, and cost-sharing subsidy, or eligibility for the specified State health subsidy programs.

Recipients of the confidential return information are subject to the safeguard protections and civil and criminal penalties for unauthorized disclosure and inspection. Special rules apply to the disclosure of return information to contractors.

The IRS is required to make an accounting for all disclosures.

#### **Effective Date**

The provision is effective on date of enactment.

**F. Premium Tax Credit and Cost-Sharing Reduction Payments  
Disregarded for Federal and Federally Assisted Programs  
(sec. 1415 of the Senate amendment)**

**Present Law**

There is no tax credit that is generally available to low or middle income individuals or families for the purchase of health insurance.

**Explanation of Provision**

Any premium assistance tax credits and cost-sharing subsidies provided to an individual under the Senate amendment are disregarded for purposes of determining that individual's eligibility for benefits or assistance, or the amount or extent of benefits and assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds. Specifically, any amount of premium tax credit provided to an individual is not counted as income, and cannot be taken into account as resources for the month of receipt and the following two months. Any cost sharing subsidy provided on the individual's behalf is treated as made to the health plan in which the individual is enrolled and not to the individual.

**Effective Date**

The provision is effective on date of enactment.

**G. Small Business Tax Credit**  
**(sec. 1421<sup>49</sup> of the Senate amendment and new sec. 45R of the Code)**

**Present Law**

The Code does not provide a tax credit for employers that provide health coverage for their employees. The cost to an employer of providing health coverage for its employees is generally deductible as an ordinary and necessary business expense for employee compensation.<sup>50</sup> In addition, the value of employer-provided health insurance is not subject to employer-paid Federal Insurance Contributions Act (“FICA”) tax.

The Code generally provides that employees are not taxed on the value of employer-provided health coverage under an accident or health plan.<sup>51</sup> That is, these benefits are excluded from gross income. In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents generally is excluded from gross income.<sup>52</sup> Active employees participating in a cafeteria plan may be able to pay their share of premiums on a pre-tax basis through salary reduction.<sup>53</sup> Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

**Explanation of Provisions**

**Small business employers eligible for the credit**

Under the provision, a tax credit is provided for a qualified small employer for nonelective contributions to purchase health insurance for its employees. A qualified small business employer for this purpose generally is an employer with no more than 25 full-time equivalent employees (“FTEs”) employed during the employer’s taxable year, and whose employees have annual full-time equivalent wages that average no more than \$50,000. However, the full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual fulltime equivalent wages from the employer of less than \$25,000. These wage limits are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) for years beginning in 2014.

Under the provision, an employer’s FTEs are calculated by dividing the total hours worked by all employees during the employer’s tax year by 2080. For this purpose, the maximum number of hours that are counted for any single employee is 2080 (rounded down to the nearest whole number). Wages are defined in the same manner as under section 3121(a) (as

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<sup>49</sup> Section 1421 of the Senate amendment is amended by section 10105 of the Senate amendment.

<sup>50</sup> Sec. 162. However, see special rules in sections 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

<sup>51</sup> Sec 106.

<sup>52</sup> Sec. 105(b).

<sup>53</sup> Sec. 125.

determined for purposes of FICA taxes but without regard to the dollar limit for covered wages) and the average wage is determined by dividing the total wages paid by the small employer by the number of FTEs (rounded down to the nearest \$1,000).

The number of hours of service worked by, and wages paid to, a seasonal worker of an employer is not taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year. For purposes of the credit the term ‘seasonal worker’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by 29 CFR sec. 500.20(s)(1) and retail workers employed exclusively during holiday seasons.

The contributions must be provided under an arrangement that requires the eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in certain defined qualifying health insurance offered to employees by the employer equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualifying health plan.

The credit is only available to offset actual tax liability and is claimed on the employer’s tax return. The credit is not payable in advance to the taxpayer or refundable. Thus, the employer must pay the employees’ premiums during the year and claim the credit at the end of the year on its income tax return. The credit is a general business credit, and can be carried back for one year and carried forward for 20 years. The credit is available for tax liability under the alternative minimum tax.

### **Years the credit is available**

Under the provision, the credit is initially available for any taxable year beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage within the meaning of section 9832, which is generally health insurance coverage purchased from an insurance company licensed under State law.

For taxable years beginning in years after 2013, the credit is only available to a qualified small employer that purchases health insurance coverage for its employees through a State exchange and is only available for a maximum coverage period of two consecutive taxable years beginning with the first year in which the employer or any predecessor first offers one or more qualified plans to its employees through an exchange.<sup>54</sup>

The maximum two-year coverage period does not take into account any taxable years beginning in years before 2014. Thus a qualified small employer could potentially qualify for this credit for six taxable years, four years under the first phase and two years under the second phase.

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<sup>54</sup> Sec. 1301 of the Senate amendment provides the requirements for a qualified health plan purchased through the exchange.

## **Calculation of credit amount**

The credit is equal to the applicable percentage of the small business employer's contribution to the health insurance premium for each covered employee. Only nonelective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 is not treated as an employer contribution for purposes of this credit. The credit is equal to the lesser of the following two amounts multiplied an applicable tax credit percentage: (1) the amount of contributions the employer made on behalf of the employees during the taxable year for the qualifying health coverage and (2) the amount of contributions that the employer would have made during the taxable year if each employee had enrolled in coverage with a small business benchmark premium. To calculate such contributions under the second of these two amounts, the benchmark premium is multiplied by the number of employees enrolled in coverage and then multiplied by the uniform percentage that applies for calculating the level of coverage selected by the employer. As discussed above, this tax credit is only available if this uniform percentage is at least 50 percent.

For the first phase of the credit (any taxable years beginning in 2010, 2011, 2012, or 2013), the applicable tax credit percentage is 35 percent. The benchmark premium is the average total premium cost in the small group market for employer-sponsored coverage in the employer's State. The premium and the benchmark premium vary based on the type of coverage provided to the employee (i.e., single, adult with child, family or two adults).

For taxable years beginning in years after 2013, the applicable tax credit percentage is 50 percent. The benchmark premium is the average total premium cost in the small group market for employer-sponsored coverage in the employer's State. The premium and the benchmark premium vary based on the type of coverage being provided to the employee (e.g. single or family).

The credit is reduced for employers with more than 10 FTEs but not more than 25 FTEs. The credit is also reduced for an employer for whom the average wages per employee is between \$25,000 and \$50,000. The amount of this reduction is equal to the amount of the credit (determined before any reduction) multiplied by a fraction, the numerator of which is the average annual wages of the employer in excess of \$25,000 and the denominator is \$25,000. For an employer with more than 10 FTEs, the percentage is reduced in proportion to the number of FTEs in excess of 10. For an employer with both more than 10 FTEs and average annual wages in excess of \$25,000, the reduction is the sum of the amount of the two reductions.

## **Tax exempt organizations as qualified small employers**

Any organization described in section 501(c) which is exempt under section 501(a) that otherwise qualifies for the small business tax credit is eligible to receive the credit. However, for tax-exempt organizations, the applicable percentage for the credit during the first phase of the credit (any taxable year beginning in 2010, 2011, 2012, or 2013) is limited to 25 percent and the applicable percentage for the credit during the second phase (taxable years beginning in years after 2013) is limited to 35 percent. The small business tax credit is otherwise calculated in the same manner for tax-exempt organizations that are qualified small employers as the tax credit is



calculated for all other qualified small employers. Tax-exempt organizations are eligible to apply the tax credit against the organization's liability as an employer for payroll taxes for the taxable year to the extent of: (1) the amount of income tax withheld from its employees under section 3401(a); (2) the amount of hospital insurance tax withheld from its employees under section 3101(b); (3) and the amount of the hospital tax imposed on the organization under section 3111(b). However, the organization is not eligible for a credit in excess of the amount of these payroll taxes.

### **Special rules**

The employer is entitled to a deduction under section 162 equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if a qualified small employer pays 100 percent of the cost of its employees' health insurance coverage and the tax credit under this provision is 50 percent of that cost, the employer is able to claim a section 162 deduction for the other 50 percent of the premium cost.

The employer is determined by applying the employer aggregations rules in section 414(b), (c), and (m). In addition, the definition of employee includes a leased employee within the meaning of section 414(n).<sup>55</sup>

Self-employed individuals, including partners and sole proprietors, two percent shareholders of an S Corporation, and five percent owners of the employer (within the meaning of section 416(i)(1)(B)(i)) are not treated as employees for purposes of this credit. Any employee with respect to a self-employed individual is not an employee of the employer for purposes of this credit if the employee is not performing services in the trade or business of the employer. Thus, the credit is not available for a domestic employee of a sole proprietor of a business. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for any contribution to the purchase of health insurance for these individuals and the individual is not taken into account in determining the number of FTEs or average full-time equivalent wages.

The Secretary of is directed to prescribe such regulations as may be necessary to carry out the provisions of new section 45R, including regulations to prevent the avoidance of the two-year limit on the credit period for the second phase of the credit through the use of successor entities and the use of the limit on the number of employees and the amount of average wages through the use of multiple entities. The Secretary of Treasury, in consultation with the Secretary of Labor, is directed to prescribe such regulations, rules, and guidance as may be necessary to

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<sup>55</sup> Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common are treated under regulations as employed by a single employer, and, in section 414(m), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(n) provides that leased employees, as defined in that section, are treated as employees of the service recipient for specified purposes. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the certain requirement under section 414(m) and 414(n).

determine the hours of service of an employee for purposes of determining FTEs, including rules for the employees who are not compensated on an hourly basis.

**Effective Date**

The provision is effective for taxable years beginning after December 31, 2009.

## **H. Excise Tax on Individuals Without Essential Health Benefits Coverage (sec. 1501<sup>56</sup> of the Senate amendment and new sec. 5000A of the Code)**

### **Present Law**

Federal law does not require individuals to have health insurance. Only the Commonwealth of Massachusetts, through its statewide program, requires that individuals have health insurance (although this policy has been considered in other states, such as California, Maryland, Maine, and Washington). All adult residents of Massachusetts are required to have health insurance that meets “minimum creditable coverage” standards if it is deemed “affordable” at their income level under a schedule set by the board of the Commonwealth Health Insurance Connector Authority (“Connector”). Individuals report their insurance status on State income tax forms. Individuals can file hardship exemptions from the mandate; persons for whom there are no affordable insurance options available are not subject to the requirement for insurance coverage.

For taxable year 2007, an individual without insurance and who was not exempt from the requirement did not qualify under Massachusetts law for a State income tax personal exemption. For taxable years beginning on or after January 1, 2008, a penalty is levied for each month an individual is without insurance. The penalty consists of an amount up to 50 percent of the lowest premium available to the individual through the Connector. The penalty is reported and paid by the individual with the individual’s Massachusetts State income tax return at the same time and in the same manner as State income taxes. Failure to pay the penalty results in the same interest and penalties as apply to unpaid income tax.

### **Explanation of Provision**

#### **Personal responsibility requirement**

Beginning January, 2014, non-exempt U.S. citizens and legal residents are required to maintain minimum essential coverage. Minimum essential coverage includes government sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and other coverage as recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. Government sponsored programs include Medicare, Medicaid, Children’s Health Insurance Program, coverage for members of the U.S. military,<sup>57</sup> veterans health care,<sup>58</sup> and health care for Peace Corps volunteers.<sup>59</sup> Eligible employer-sponsored plans include: governmental plans,<sup>60</sup> church plans,<sup>61</sup> grandfathered plans

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<sup>56</sup> Section 1501 of the Senate amendment, as amended by section 10106, is further amended by section 1002 of the Reconciliation bill.

<sup>57</sup> 10 U.S.C. 55 and 38 U.S.C. 1781.

<sup>58</sup> 38 U.S.C. 17.

<sup>59</sup> 22 U.S.C. 2504(e).

<sup>60</sup> ERISA Sec. 3(32), U.S.C. 5: Chapter 89, except a plan described in paragraph (1)(A).

and other group health plans offered in the small or large group market within a State. Minimum essential coverage does not include coverage that consists of certain HIPAA excepted benefits.<sup>62</sup> Other HIPAA excepted benefits that do not constitute minimum essential coverage if offered under a separate policy, certificate or contract of insurance include long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance.<sup>63</sup>

Individuals are exempt from the requirement for months they are incarcerated, not legally present in the United States or maintain religious exemptions. Those who are exempt from the requirement due to religious reasons must be members of a recognized religious sect exempting them from self employment taxes<sup>64</sup> and adhere to tenets of the sect. Individuals residing<sup>65</sup> outside of the United States are deemed to maintain minimum essential coverage. If an individual is a dependent<sup>66</sup> of another taxpayer, the other taxpayer is liable for any penalty payment with respect to the individual.

### **Penalty**

Individuals who fail to maintain minimum essential coverage in 2016 are subject to a penalty equal to the greater of: (1) 2.5 percent of household income in excess of the taxpayer's household income for the taxable year over the threshold amount of income required for income tax return filing for that taxpayer under section 6012(a)(1);<sup>67</sup> or (2) \$695 per uninsured adult in the household. The fee for an uninsured individual under age 18 is one-half of the adult fee for an adult. The total household penalty may not exceed 300 percent of the per adult penalty (\$2,085). The total annual household payment may not exceed the national average annual premium for bronze level health plan offered through the Exchange that year for the household size.

This per adult annual penalty is phased in as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016. For years after 2016, the \$695 amount is indexed to CPI-U, rounded to the next

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<sup>61</sup> ERISA sec. 3(33).

<sup>62</sup> U.S.C. 42 sec. 300gg-91(c)(1). HIPAA excepted benefits include: (1) coverage only for accident, or disability income insurance; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers' compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

<sup>63</sup> 42 U.S.C. 300gg-91(c)(2-4).

<sup>64</sup> Sec. 1402(g)(1).

<sup>65</sup> Sec. 911(d)(1).

<sup>66</sup> Sec. 152.

<sup>67</sup> Generally, in 2010, the filing threshold is \$9,350 for a single person or a married person filing separately and is \$18,700 for married filing jointly. IR-2009-93, Oct. 15, 2009.

lowest \$50. The percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015. If a taxpayer files a joint return, the individual and spouse are jointly liable for any penalty payment.

The penalty applies to any period the individual does not maintain minimum essential coverage and is determined monthly. The penalty is assessed through the Code and accounted for as an additional amount of Federal tax owed. However, it is not subject to the enforcement provisions of subtitle F of the Code.<sup>68</sup> The use of liens and seizures otherwise authorized for collection of taxes does not apply to the collection of this penalty. Non-compliance with the personal responsibility requirement to have health coverage is not subject to criminal or civil penalties under the Code and interest does not accrue for failure to pay such assessments in a timely manner.

Individuals who cannot afford coverage because their required contribution for employer-sponsored coverage or the lowest cost bronze plan in the local Exchange exceeds eight percent of household income for the year are exempt from the penalty.<sup>69</sup> In years after 2014, the eight percent exemption is increased by the amount by which premium growth exceeds income growth. If self-only coverage is affordable to an employee, but family coverage is unaffordable, the employee is subject to the mandate penalty if the employee does not maintain minimum essential coverage. However, any individual eligible for employer coverage due to a relationship with an employee (e.g. spouse or child of employee) is exempt from the penalty if that individual does not maintain minimum essential coverage because family coverage is not affordable<sup>70</sup> (i.e., exceeds eight percent of household income). Taxpayers with income below the income tax filing

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<sup>68</sup> IRS authority to assess and collect taxes is generally provided in subtitle F, “Procedure and Administration” in the Code. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and pay their taxes as well as their rights. It also establishes the duties and authority of the IRS to enforce the Code, including civil and criminal penalties.

<sup>69</sup> In the case of an individual participating in a salary reduction arrangement, the taxpayer's household income is increased by any exclusion from gross income for any portion of the required contribution to the premium. The required contribution to the premium is the individual contribution to coverage through an employer or in the purchase of a bronze plan through the Exchange.

<sup>70</sup> For example, if an employee with a family is offered self-only coverage costing five percent of income and family coverage costing 10 percent of income, the employee is not eligible for the tax credit in the Exchange because self-only coverage costs less than 9.5 percent of household income. The employee is not exempt from the individual responsibility penalty on the grounds of an affordability exemption because the self-only plan costs less than eight percent of income. Although family coverage costs more than 9.5 percent of income, the family does not qualify for a tax credit regardless of whether the employee purchases self-only coverage or does not purchase self-only coverage through the employer. However, if the family of the employee does not maintain minimum essential benefits coverage, the employee's family is exempt from the individual mandate penalty because while self-only coverage is affordable to the employee, family coverage is not considered affordable.

threshold<sup>71</sup> shall also be exempt from the penalty for failure to maintain minimum essential coverage. All members of Indian tribes<sup>72</sup> are exempt from the penalty.

No penalty is assessed for individuals who do not maintain health insurance for a period of three months or less during the taxable year. If an individual exceeds the three month maximum during the taxable year, the penalty for the full duration of the gap during the year is applied. If there are multiple gaps in coverage during a calendar year, the exemption from penalty applies only to the first such gap in coverage. The Secretary of the Treasury shall provide rules when a coverage gap includes months in multiple calendar years. Individuals may also apply to the Secretary of HHS for a hardship exemption due to hardship in obtaining coverage.<sup>73</sup> Residents of the possessions<sup>74</sup> of the United States are treated as being covered by acceptable coverage.

Family size is the number of individuals for whom the taxpayer is allowed a personal exemption. Household income is the sum of the modified adjusted gross incomes of the taxpayer and all individuals accounted for in the family size required to file a tax return for that year. Modified adjusted gross income means adjusted gross income increased by all tax-exempt interest and foreign earned income.<sup>75</sup>

#### **Effective Date**

The provision is effective for taxable years beginning after December 31, 2013.

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<sup>71</sup> Generally, in 2010, the filing threshold is \$9,350 for a single person or a married person filing separately and is \$18,700 for married filing jointly. IR-2009-93, Oct. 15, 2009.

<sup>72</sup> Tribal membership is defined in section 45A(c)(6).

<sup>73</sup> Sec. 1311(d)(4)(H).

<sup>74</sup> Sec. 937(a).

<sup>75</sup> Sec. 911.

**I. Reporting of Health Insurance Coverage**  
**(sec. 1502 of the Senate amendment and new sec. 6055 of the Code**  
**and sec. 6724(d) of the Code)**

**Present Law**

**Insurer reporting of health insurance coverage**

No provision.

**Penalties for failure to comply with information reporting requirements**

Present law imposes a variety of information reporting requirements on participants in certain transactions.<sup>76</sup> These requirements are intended to assist taxpayers in preparing their income tax returns and help the IRS determine whether such returns are correct and complete. Failure to comply with the information reporting requirements may result in penalties, including: a penalty for failure to file the information return,<sup>77</sup> a penalty for failure to furnish payee statements,<sup>78</sup> and a penalty for failure to comply with various other reporting requirements.<sup>79</sup>

The penalty for failure to file an information return generally is \$50 for each return for which such failure occurs. The total penalty imposed on a person for all failures during a calendar year cannot exceed \$250,000. Additionally, special rules apply to reduce the per-failure and maximum penalty where the failure is corrected within a specified period.

The penalty for failure to provide a correct payee statement is \$50 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed \$100,000. Special rules apply that increase the per-statement and total penalties where there is intentional disregard of the requirement to furnish a payee statement.

**Explanation of Provision**

Under the provision, insurers (including employers who self-insure) that provide minimum essential coverage<sup>80</sup> to any individual during a calendar year must report certain health insurance coverage information to both the covered individual and to the IRS. In the case of coverage provided by a governmental unit, or any agency or instrumentality thereof, the

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<sup>76</sup> Secs. 6031 through 6060.

<sup>77</sup> Sec. 6721.

<sup>78</sup> Sec. 6722.

<sup>79</sup> Sec. 6723. The penalty for failure to comply timely with a specified information reporting requirement is \$50 per failure, not to exceed \$100,000 for a calendar year.

<sup>80</sup> As defined in section 5000A of the Senate amendment, as amended by section 10106, as further amended by section 1002 of the Reconciliation bill.

reporting requirement applies to the person or employee who enters into the agreement to provide the health insurance coverage (or their designee).

The information required to be reported includes: (1) the name, address, and taxpayer identification number of the primary insured, and the name and taxpayer identification number of each other individual obtaining coverage under the policy; (2) the dates during which the individual was covered under the policy during the calendar year; (3) whether the coverage is a qualified health plan offered through an exchange; (4) the amount of any premium tax credit or cost-sharing reduction received by the individual with respect to such coverage; and (5) such other information as the Secretary may require.

To the extent health insurance coverage is through an employer-provided group health plan, the insurer is also required to report the name, address and employer identification number of the employer, the portion of the premium, if any, required to be paid by the employer, and any other information the Secretary may require to administer the new tax credit for eligible small employers.

The insurer is required to report the above information, along with the name, address and contact information of the reporting insurer, to the covered individual on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS.

The provision amends the information reporting provisions of the Code to provide that an insurer who fails to comply with these new reporting requirements is subject to the penalties for failure to file an information return and failure to furnish payee statements, respectively.

The IRS is required, not later than June 30 of each year, in consultation with the Secretary of HHS, to provide annual notice to each individual who files an income tax return and who fails to enroll in minimum essential coverage. The notice is required to include information on the services available through the exchange operating in the individual's State of residence.

#### **Effective Date**

The provision is effective for calendar years beginning after 2013.



**J. Shared Responsibility for Employers**  
**(sec. 1513<sup>81</sup> of the Senate amendment and new sec. 4980H of the Code)**

**Present Law**

Currently, there is no Federal requirement that employers offer health insurance coverage to employees or their families. However, as with other compensation, the cost of employer-provided health coverage is a deductible business expense under section 162 of the Code.<sup>82</sup> In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.<sup>83</sup>

Employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.<sup>84</sup> Such salary reduction contributions are treated as employer contributions for purposes of the Code, and are thus excluded from gross income.

One way that employers can offer employer-provided health insurance coverage for purposes of the tax exclusion is to offer to reimburse employees for the premiums for health insurance purchased by employees in the individual health insurance market. The payment or reimbursement of employees' substantiated individual health insurance premiums is excludible from employees' gross income.<sup>85</sup> This reimbursement for individual health insurance premiums can also be paid through salary reduction under a cafeteria plan.<sup>86</sup> However, this offer to reimburse individual health insurance premiums constitutes a group health plan

The Employee Retirement Income Security Act of 1974 ("ERISA")<sup>87</sup> preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

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<sup>81</sup> Section 1513 of the Senate amendment, as amended by section 10106, is further amended by section 1003 of the Reconciliation bill.

<sup>82</sup> Sec. 162. However see special rules in sections 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

<sup>83</sup> Sec. 106.

<sup>84</sup> Sec. 125.

<sup>85</sup> Rev. Rul. 61-146 (1961-2 CB 25).

<sup>86</sup> Proposed Treas. Reg. sec.1.125-1(m).

<sup>87</sup> Pub. L. 93-406

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. There are other Federal requirements for health plans which include, for example, rules for health care continuation coverage.<sup>88</sup> The Code imposes an excise tax on group health plans that fail to meet these other requirements.<sup>89</sup> The excise tax generally is equal to \$100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan.

Under Medicaid, States may establish “premium assistance” programs, which pay a Medicaid beneficiary’s share of premiums for employer-sponsored health coverage. Besides being available to the beneficiary through his or her employer, the coverage must be comprehensive and cost-effective for the State. An individual’s enrollment in an employer plan is considered cost-effective if paying the premiums, deductibles, coinsurance and other cost-sharing obligations of the employer plan is less expensive than the State’s expected cost of directly providing Medicaid-covered services. States are also required to provide coverage for those Medicaid-covered services that are not included in the private plans. A 2007 analysis showed that 12 States had Medicaid premium assistance programs as authorized under current law.

### **Explanation of Provision**

An applicable large employer that does not offer coverage for all its full-time employees, offers minimum essential coverage that is unaffordable, or offers minimum essential coverage that consists of a plan under which the plan’s share of the total allowed cost of benefits is less than 60 percent, is required to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a state exchange with respect to which a tax credit or cost-sharing reduction is allowed or paid to the employee.

### **Applicable large employer**

An employer is an applicable large employer with respect to any calendar year if it employed an average of at least 50 full-time employees during the preceding calendar year. For purposes of the provision, “employer” includes any predecessor employer. An employer is not treated as employing more than 50 full-time employees if the employer’s workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year and the employees that cause the employer’s workforce to exceed 50 full-time employees are seasonal workers. A seasonal worker is a worker who performs labor or services on a seasonal basis (as defined by the Secretary of Labor), including retail workers employed exclusively during the holiday season and workers whose employment is, ordinarily, the kind exclusively performed at certain seasons

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<sup>88</sup> These rules were added to ERISA and the Code by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272).

<sup>89</sup> Sec. 4980B.

or periods of the year and which, from its nature, may not be continuous or carried on throughout the year.<sup>90</sup>

In counting the number of employees for purposes of determining whether an employer is an applicable large employer, a full-time employee (meaning, for any month, an employee working an average of at least 30 hours or more each week) is counted as one employee and all other employees are counted on a pro-rated basis in accordance with regulations prescribed by the Secretary. The number of full-time equivalent employees that must be taken into account for purposes of determining whether the employer exceeds the threshold is equal to the aggregate number of hours worked by non-full-time employees for the month, divided by 120 (or such other number based on an average of 30 hours of service each week as the Secretary may prescribe in regulations).

The Secretary, in consultation with the Secretary of Labor, is directed to issue, as necessary, rules, regulations and guidance to determine an employee's hours of service, including rules that apply to employees who are not compensated on an hourly basis.

The aggregation rules of section 414(b), (c), (m), and (o) apply in determining whether an employer is an applicable large employer. The determination of whether an employer that was not in existence during the preceding calendar year is an applicable large employer is made based on the average number of employees that it is reasonably expected to employ on business days in the current calendar year.

### **Penalty for employers not offering coverage**

An applicable large employer who fails to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month is subject to a penalty if at least one of its full-time employees is certified to the employer as having enrolled in health insurance coverage purchased through a State exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees. The penalty for any month is an excise tax equal to the number of full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) multiplied by one-twelfth of \$2,000. In the case of persons treated as a single employer under the provision, the 30-employee reduction in full-time employees is made from the total number of full-time employees employed by such persons (i.e., only one 30-person reduction is permitted per controlled group of employers) and is allocated among such persons in relation to the number of full-time employees employed by each such person.

For example, in 2014, Employer A fails to offer minimum essential coverage and has 100 full-time employees, ten of whom receive a tax credit for the year for enrolling in a State exchange-offered plan. For each employee over the 30-employee threshold, the employer owes

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<sup>90</sup> Section 500.20(s)(1) of title 29, Code of Federal Regulations. Under section 5000.20(s)(1), a worker who moves from one seasonal activity to another, while employed in agriculture or performing agricultural labor, is employed on a seasonal basis even though he may continue to be employed during a major portion of the year.

\$2,000, for a total penalty of \$140,000 (\$2,000 multiplied by 70 ((100-30))). This penalty is assessed on a monthly basis.

For calendar years after 2014, the \$2,000 dollar amount is increased by the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary of HHS no later than October 1 of the preceding calendar year) exceeds the average per capita premium for 2013 (as determined by the Secretary of HHS), rounded down to the nearest \$10.

### **Penalty for employees receiving premium credits**

An applicable large employer who offers, for any month, its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan is subject to a penalty if any full-time employee is certified to the employer as having enrolled in health insurance coverage purchased through a State exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to such employee or employees.

The penalty is an excise tax that is imposed for each employee who receives a premium tax credit or cost-sharing reduction for health insurance purchased through a State exchange. For each full-time employee receiving a premium tax credit or cost-sharing subsidy through a State exchange for any month, the employer is required to pay an amount equal to one-twelfth of \$3,000. The penalty for each employer for any month is capped at an amount equal to the number of full-time employees during the month (regardless of how many employees are receiving a premium tax credit or cost-sharing reduction) in excess of 30, multiplied by one-twelfth of \$2,000. In the case of persons treated as a single employer under the provision, the 30-employee reduction in full-time employees for purposes of calculating the maximum penalty is made from the total number of full-time employees employed by such persons (i.e., only one 30-person reduction is permitted per controlled group of employers) and is allocated among such persons in relation to the number of full-time employees employed by each such person.

For example, in 2014, Employer A offers health coverage and has 100 full-time employees, 20 of whom receive a tax credit for the year for enrolling in a State exchange offered plan. For each employee receiving a tax credit, the employer owes \$3,000, for a total penalty of \$60,000. The maximum penalty for this employer is capped at the amount of the penalty that it would have been assessed for a failure to provide coverage, or \$140,000 (\$2,000 multiplied by 70 ((100-30))). Since the calculated penalty of \$60,000 is less than the maximum amount, Employer A pays the \$60,000 calculated penalty. This penalty is assessed on a monthly basis.

For calendar years after 2014, the \$3,000 and \$2,000 dollar amounts are increased by the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary of HHS no later than October 1 of the preceding calendar year) exceeds the average per capita premium for 2013 (as determined by the Secretary of HHS), rounded down to the nearest \$10.

## **Time for payment, deductibility of excise taxes, restrictions on assessment**

The excise taxes imposed under this provision are payable on an annual, monthly or other periodic basis as the Secretary of Treasury may prescribe. The excise taxes imposed under this provision for employees receiving premium tax credits are not deductible under section 162 as a business expense. The restrictions on assessment under section 6213 are not applicable to the excise taxes imposed under the provision.

## **Employer offer of health insurance coverage**

Under the provision, as under current law, an employer is not required to offer health insurance coverage. If an employee is offered health insurance coverage by his or her employer and chooses to enroll in the coverage, the employer-provided portion of the coverage is excluded from gross income. The tax treatment is the same whether the employer offers coverage outside of a State exchange or the employer offers a coverage option through a State exchange.

### Definition of coverage

As a general matter, if an employee is offered affordable minimum essential coverage under an employer-sponsored plan, the individual is ineligible for a premium tax credit and cost sharing reductions for health insurance purchased through a State exchange.

### Unaffordable coverage

If an employee is offered minimum essential coverage by their employer that is either unaffordable or that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60 percent, however, the employee is eligible for a premium tax credit and cost sharing reductions, but only if the employee declines to enroll in the coverage and purchases coverage through the exchange instead. Unaffordable is defined as coverage with a premium required to be paid by the employee that is more than 9.5 percent of the employee's household income (as defined for purposes of the premium tax credits provided under the Senate amendment). This percentage of the employee's income is indexed to the per capita growth in premiums for the insured market as determined by the Secretary of HHS. The employee must seek an affordability waiver from the State exchange and provide information as to family income and the lowest cost employer option offered to them. The State exchange then provides the waiver to the employee. The employer penalty applies for any employee(s) receiving an affordability waiver.

For purposes of determining if coverage is unaffordable, required salary reduction contributions are treated as payments required to be made by the employee. However, if an employee is reimbursed by the employer for any portion of the premium for health insurance coverage purchased through the exchange, including any reimbursement through salary reduction contributions under a cafeteria plan, the coverage is employer-provided and the employee is not eligible for premium tax credits or cost-sharing reductions. Thus, an individual is not permitted to purchase coverage through the exchange, apply for the premium tax credit, and pay for the individual's portion of the premium using salary reduction contributions under the cafeteria plan of the individual's employer.

An employer must be notified if one of its employees is determined to be eligible for a premium assistance credit or a cost-sharing reduction because the employer does not provide minimal essential coverage through an employer-sponsored plan, or the employer does offer such coverage but it is not affordable or the plan's share of the total allowed cost of benefits is less than 60 percent. The notice must include information about the employer's potential liability for payments under section 4980H. The employer must also receive notification of the appeals process established for employers notified of potential liability for payments under section 4980H. An employer is generally not entitled to information about its employees who qualify for the premium assistance credit or cost-sharing reductions; however, the appeals process must provide an employer the opportunity to access the data used to make the determination of an employee's eligibility for a premium assistance credit or cost-sharing reduction, to the extent allowable by law.

The Secretary is required to prescribe rules, regulations or guidance for the repayment of any assessable payment (including interest) if the payment is based on the allowance or payment of a premium tax credit or cost-sharing reduction with respect to an employee that is subsequently disallowed and with respect to which the assessable payment would not have been required to have been made in the absence of the allowance or payment.

#### Effect of medicaid enrollment

A Medicaid-eligible individual can always choose to leave the employer's coverage and enroll in Medicaid, and an employer is not required to pay a penalty for any employees enrolled in Medicaid.

#### **Study and reporting on employer responsibility requirements**

The Secretary of Labor is required to study whether employee wages are reduced by reason of the application of the employer responsibility requirements, using the National Compensation Survey published by the Bureau of Labor Statistics. The Secretary of Labor is to report the results of this study to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

#### **Effective Date**

The provision is effective for months beginning after December 31, 2013.

**K. Reporting of Employer Health Insurance Coverage  
(sec. 1514 of the Senate amendment and new sec. 6056  
of the Code and sec. 6724(d) of the Code)**

**Present Law**

**Employer reporting of health insurance coverage**

No provision.

**Penalties for failure to comply with information reporting requirements**

Present law imposes a variety of information reporting requirements on participants in certain transactions.<sup>91</sup> These requirements are intended to assist taxpayers in preparing their income tax returns and help the IRS determine whether such returns are correct and complete. Failure to comply with the information reporting requirements may result in penalties, including: a penalty for failure to file the information return,<sup>92</sup> a penalty for failure to furnish payee statements,<sup>93</sup> and a penalty for failure to comply with various other reporting requirements.<sup>94</sup>

The penalty for failure to file an information return generally is \$50 for each return for which such failure occurs. The total penalty imposed on a person for all failures during a calendar year cannot exceed \$250,000. Additionally, special rules apply to reduce the per-failure and maximum penalty where the failure is corrected within a specified period.

The penalty for failure to provide a correct payee statement is \$50 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed \$100,000. Special rules apply that increase the per-statement and total penalties where there is intentional disregard of the requirement to furnish a payee statement.

**Explanation of Provision**

Under the provision, each applicable large employer subject to the employer responsibility provisions of new section 4980H and each “offering employer” must report certain health insurance coverage information to both its full-time employees and to the IRS. An offering employer is any employer who offers minimum essential coverage<sup>95</sup> to its employees under an eligible employer-sponsored plan and who pays any portion of the costs of such plan,

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<sup>91</sup> Secs. 6031 through 6060.

<sup>92</sup> Sec. 6721.

<sup>93</sup> Sec. 6722.

<sup>94</sup> Sec. 6723. The penalty for failure to comply timely with a specified information reporting requirement is \$50 per failure, not to exceed \$100,000 for a calendar year.

<sup>95</sup> As defined in section 5000A of the Senate amendment, as amended by section 10106, as further amended by section 1002 of the Reconciliation bill.

but only if the required employer contribution of any employee exceeds eight percent of the wages paid by the employer to the employee. In the case of years after 2014, the eight percent is indexed to reflect the rate of premium growth over income growth between 2013 and the preceding calendar year. In the case of coverage provided by a governmental unit, or any agency or instrumentality thereof, the reporting requirement applies to the person or employee appropriately designated for purposes of making the returns and statements required by the provision.

The information required to be reported includes: (1) the name, address and employer identification number of the employer; (2) a certification as to whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan; (3) the number of full-time employees of the employer for each month during the calendar year; (4) the name, address and taxpayer identification number of each full-time employee employed by the employer during the calendar year and the number of months, if any, during which the employee (and any dependents) was covered under a plan sponsored by the employer during the calendar year; and (5) such other information as the Secretary may require.

Employers who offer the opportunity to enroll in minimum essential coverage must also report: (1) in the case of an applicable large employer, the length of any waiting period with respect to such coverage; (2) the months during the calendar year during which the coverage was available; (3) the monthly premium for the lowest cost option in each of the enrollment categories under the plan; (4) the employer's share of the total allowed costs of benefits under the plan; and (5), in the case of an offering employer, the option for which the employer pays the largest position of the cost of the plan and the portion of the cost paid by the employer in each of the enrollment categories under each option.

The employer is required to report to each full-time employee the above information required to be reported with respect to that employee, along with the name, address and contact information of the reporting employer, on or before January 31 of the year following the calendar year for which the information is required to be reported to the IRS.

The provision amends the information reporting provisions of the Code to provide that an employer who fails to comply with these new reporting requirements is subject to the penalties for failure to file an information return and failure to furnish payee statements, respectively.

To the maximum extent feasible, the Secretary may provide that any information return or payee statement required to be provided under the provision may be provided as part of any return or statement required under new sections 6051<sup>96</sup> or 6055<sup>97</sup> and, in the case of an applicable large employer or offering employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include the

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<sup>96</sup> For additional information on new section 6051, see the explanation of section 9002 of the Senate amendment, "Inclusion of Employer-Sponsored Health Coverage on W-2."

<sup>97</sup> For additional information on new section 6055, see the explanation of section 1502 of the Senate amendment, "Reporting of Health Insurance Coverage."



information required by the provision with the information return and payee statement required under new section 6055.

The Secretary has the authority, in coordination with the Secretary of Labor, to review the accuracy of the information reported by the employer, including the employer's share of the total allowed costs of benefits under the plan.

**Effective Date**

The provision is effective for periods beginning after December 31, 2013.

**L. Offering of Qualified Health Plans Through Cafeteria Plans  
(sec. 1515 of the Senate amendment and sec. 125 of the Code)**

**Present Law**

Currently, there is no Federal requirement that employers offer health insurance coverage to employees or their families. However, as with other compensation, the cost of employer-provided health coverage is a deductible business expense under section 162 of the Code.<sup>98</sup> In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.<sup>99</sup>

**Definition of a cafeteria plan**

If an employee receives a qualified benefit (as defined below) based on the employee's election between the qualified benefit and a taxable benefit under a cafeteria plan, the qualified benefit generally is not includable in gross income.<sup>100</sup> However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the requirements for being a cafeteria plan, the election between taxable and nontaxable benefits results in gross income to the employee, regardless of what benefit is elected and when the election is made.<sup>101</sup> A cafeteria plan is a separate written plan under which all participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit. Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in sections 125(d)(2)(B), (C), or (D).

**Qualified benefits**

Qualified benefits under a cafeteria plan are generally employer-provided benefits that are not includable in gross income under an express provision of the Code. Examples of qualified benefits include employer-provided health insurance coverage, group term life insurance coverage not in excess of \$50,000, and benefits under a dependent care assistance program. In order to be excludable, any qualified benefit elected under a cafeteria plan must independently satisfy any requirements under the Code section that provides the exclusion. However, some employer-provided benefits that are not includable in gross income under an express provision of the Code are explicitly not allowed in a cafeteria plan. These benefits are generally referred to as nonqualified benefits. Examples of nonqualified benefits include scholarships<sup>102</sup>; employer-

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<sup>98</sup> Sec. 162. However see special rules in sections 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

<sup>99</sup> Sec. 106.

<sup>100</sup> Sec. 125(a).

<sup>101</sup> Proposed Treas. Reg. sec. 1.125-1(b).

<sup>102</sup> Sec. 117.

provided meals and lodging;<sup>103</sup> educational assistance;<sup>104</sup> and fringe benefits.<sup>105</sup> A plan offering any nonqualified benefit is not a cafeteria plan.<sup>106</sup>

### **Payment of health insurance premiums through a cafeteria plan**

Employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.<sup>107</sup> Such salary reduction contributions are treated as employer contributions for purposes of the Code, and are thus excluded from gross income.

One way that employers can offer employer-provided health insurance coverage for purposes of the tax exclusion is to offer to reimburse employees for the premiums for health insurance purchased by employees in the individual health insurance market. The payment or reimbursement of employees' substantiated individual health insurance premiums is excludible from employees' gross income.<sup>108</sup> This reimbursement for individual health insurance premiums can also be paid for through salary reduction under a cafeteria plan.<sup>109</sup> This offer to reimburse individual health insurance premiums constitutes a group health plan.

### **Explanation of Provision**

Under the provision, reimbursement (or direct payment) for the premiums for coverage under any qualified health plan (as defined in section 1301(a) of the the Senate amendment) offered through an Exchange established under section 1311 of the Senate amendment is a qualified benefit under a cafeteria plan if the employer is a qualified employer. Under section 1312(f)(2) of the Senate amendment, a qualified employer is generally a small employer that elects to make all its full-time employees eligible for one or more qualified plans offered in the small group market through an Exchange.<sup>110</sup> Otherwise, reimbursement (or direct payment) for the premiums for coverage under any qualified health plan offered through an Exchange is not a

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<sup>103</sup> Sec. 119.

<sup>104</sup> Sec.127.

<sup>105</sup> Sec. 132.

<sup>106</sup> Proposed Treas. Reg. sec. 1.125-1(q). Long-term care services, contributions to Archer Medical Savings Accounts, group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits.

<sup>107</sup> Sec. 125.

<sup>108</sup> Rev. Rul. 61-146 (1961-2 CB 25).

<sup>109</sup> Proposed Treas. Reg. sec.1.125-1(m).

<sup>110</sup> Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in a state to offer qualified plans in the large group market. In that event, a qualified employer includes a small employer that elects to make all its full-time employees eligible for one or more qualified plans offered in the large group market through an Exchange.

qualified benefit under a cafeteria plan. Thus, an employer that is not a qualified employer cannot offer to reimburse an employee for the premium for a qualified plan that the employee purchases through the individual market in an Exchange as a health insurance coverage option under its cafeteria plan.

**Effective Date**

This provision applies to taxable years beginning after December 31, 2013.

**M. Conforming Amendments**  
**(sec. 1562 of the Senate amendment and new sec. 9815 of the Code)**

**Present Law**

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)<sup>111</sup> imposes a number of requirements with respect to group health coverage that are designed to provide protections to health plan participants. These protections include limitations on exclusions from coverage based on pre-existing conditions; the prohibition of discrimination on the basis of health status; guaranteed renewability in multiemployer plans and certain employer welfare arrangements; standards relating to benefits for mother and newborns; parity in the application of certain limits to mental health benefits; and coverage of dependent students on medically necessary leave of absence. The requirements are enforced through the Code, ERISA,<sup>112</sup> and PHSa.<sup>113</sup> The HIPAA requirements in the Code are in chapter 100 of Subtitle K, Group Health Plan Requirements.

A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.<sup>114</sup>

The Code imposes an excise tax on group health plans which fail to meet the HIPAA requirements.<sup>115</sup> The excise tax is equal to \$100 per day during the period of noncompliance and is generally imposed on the employer sponsoring the plan if the plan fails to meet the requirements. The maximum tax that can be imposed during a taxable year cannot exceed the lesser of: (1) 10 percent of the employer’s group health plan expenses for the prior year; or (2) \$500,000. No tax is imposed if the Secretary of the Treasury determines that the employer did not know, and in exercising reasonable diligence would not have known, that the failure existed.

**Explanation of Provision**

The provision adds new Code section 9815 which provides that the provisions of part A of title XXVII of the PHSa (as amended by the Senate amendment) apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in the HIPAA provisions of the Code. To the extent that any HIPAA provision of the Code conflicts with a provision of part A of title XXVII of the PHSa with

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<sup>111</sup> Pub. L. No. 104-191.

<sup>112</sup> Pub. L. No. 93-406.

<sup>113</sup> 42 U.S.C. 6A.

<sup>114</sup> The requirements do not apply to any governmental plan or any group health plan that has fewer than two participants who are current employees.

<sup>115</sup> Sec. 4980D.

respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A generally apply.

The provisions of part A of title XXVII of the PHSA added by section 1001 of the Senate amendment that are incorporated by reference in new section 9815 include the following: section 2711 (No lifetime or annual limits); section 2712 (Prohibition on rescissions); section 2713 (Coverage of preventive health services); section 2714 (Extension of dependent coverage); section 2715 (Development and utilization of uniform explanation of coverage documents and standardized definitions); section 2716 (Prohibition of discrimination based on salary); section 2717 (Ensuring the quality of care); section 2718 (Bringing down the cost of health care coverage); and section 2719 (Appeals process). These new sections of the PHSA, which relate to individual and group market reforms, are effective six months after the date of enactment.

The provisions of part A of title XXVII of the PHSA added by section 1201 of the Senate amendment that are incorporated by reference in new section 9815 include the following: section 2704 (Prohibition of preexisting condition exclusions or other discrimination based on health status); section 2701 (Fair health insurance premiums); section 2702 (Guaranteed availability of coverage) section 2703 (Guaranteed renewability of coverage); section 2705 (Prohibiting discrimination against individual participants and beneficiaries based on health status); section 2706 (Non-discrimination in health care); section 2707 (Comprehensive health insurance coverage); and section 2708 (Prohibition on excessive waiting periods). These new sections of the PHSA, which relate to general health insurance reforms, are effective for plan years beginning on or after January 1, 2014.

New section 9815 specifies that section 2716 (Prohibition of discrimination based on salary) and 2718 (Bringing down the cost of health coverage) of title XXVII of the PHSA (as amended by the Senate amendment) do not apply under the Code provisions of HIPAA with respect to self-insured group health plans.

As a result of incorporating these HIPAA provision by reference, the excise tax that applies in the event of a violation of present law HIPAA requirements also applies in the event of a violation of these new requirements.

#### **Effective Date**

This provision is effective on the date of enactment.

## **TITLE III – IMPROVING THE QUALITY AND EFFICIENCY OF HEALTHCARE**

### **A. Disclosures to Carry Out the Reduction of Medicare Part D Subsidies for High Income Beneficiaries (sec. 3308(b)(2) of the Senate amendment and sec. 6103 of the Code)**

#### **Present Law**

Section 6103 provides that returns and return information are confidential and may not be disclosed by the IRS, other Federal employees, State employees, and certain others having access to such information except as provided in the Code. Section 6103 contains a number of exceptions to the general rule of nondisclosure that authorize disclosure in specifically identified circumstances. For example, section 6103 provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B premium subsidy adjustment.

Specifically, upon written request from the Commissioner of Social Security, the IRS may disclose the following limited return information of a taxpayer whose premium, according to the records of the Secretary, may be subject to adjustment under section 1839(i) of the Social Security Act (relating to Medicare Part B):

- Taxpayer identity information with respect to such taxpayer;
- The filing status of the taxpayer;
- The adjusted gross income of such taxpayer;
- The amounts excluded from such taxpayer's gross income under sections 135 and 911 to the extent such information is available;
- The interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available;
- The amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available;
- Such other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate that the amount of the premium of the taxpayer may be subject to an adjustment and the amount of such adjustment; and
- The taxable year with respect to which the preceding information relates.

This return information may be used by officers, employees, and contractors of the Social Security Administration only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any Medicare Part B premium subsidy adjustment.

Section 6103(p)(4) requires, as a condition of receiving returns and return information, that Federal and State agencies (and certain other recipients) provide safeguards as prescribed by the Secretary by regulation to be necessary or appropriate to protect the confidentiality of returns or return information. Unauthorized disclosure of a return or return information is a felony punishable by a fine not exceeding \$5,000 or imprisonment of not more than five years, or both,

together with the costs of prosecution.<sup>116</sup> The unauthorized inspection of a return or return information is punishable by a fine not exceeding \$1,000 or imprisonment of not more than one year, or both, together with the costs of prosecution.<sup>117</sup> An action for civil damages also may be brought for unauthorized disclosure or inspection.<sup>118</sup>

### **Explanation of Provision**

Upon written request from the Commissioner of Social Security, the IRS may disclose the following limited return information of a taxpayer whose Medicare Part D premium subsidy, according to the records of the Secretary, may be subject to adjustment:

- Taxpayer identity information with respect to such taxpayer;
- The filing status of the taxpayer;
- The adjusted gross income of such taxpayer;
- The amounts excluded from such taxpayer's gross income under sections 135 and 911 to the extent such information is available;
- The interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available;
- The amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available;
- Such other information relating to the liability of the taxpayer as is prescribed by the Secretary by regulation as might indicate that the amount of the Part D premium of the taxpayer may be subject to an adjustment and the amount of such adjustment; and
- The taxable year with respect to which the preceding information relates.

This return information may be used by officers, employees, and contractors of the Social Security Administration only for the purposes of, and to the extent necessary in, establishing the appropriate amount of any Medicare Part D premium subsidy adjustment.

For purposes of both the Medicare Part B premium subsidy adjustment and the Medicare Part D premium subsidy adjustment, the provision provides that the Social Security Administration may redisclose only taxpayer identity and the amount of premium subsidy adjustment to officers and employees and contractors of the Centers for Medicare and Medicaid Services, and officers and employees of the Office of Personnel Management and the Railroad Retirement Board. This redisclosure is permitted only to the extent necessary for the collection of the premium subsidy amount from the taxpayers under the jurisdiction of the respective agencies.

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<sup>116</sup> Sec. 7213.

<sup>117</sup> Sec. 7213A.

<sup>118</sup> Sec. 7431.



Further, the Social Security Administration may redisclose the return information received under this provision to officers and employees of the Department of HHS to the extent necessary to resolve administrative appeals of the Part B and Part D subsidy adjustments and to officers and employees of the Department of Justice to the extent necessary for use in judicial proceedings related to establishing and collecting the appropriate amount of any Medicare Part B or Medicare Part D premium subsidy adjustments.

**Effective Date**

The provision is effective on date of enactment.

## TITLE VI – TRANSPARENCY AND PROGRAM INTEGRITY

### A. Patient-Centered Outcomes Research Trust Fund; Financing for Trust Fund

(sec. 6301 of the Senate amendment and new secs. 4375, 4376, 4377, and 9511 of the Code)

#### Present Law

No provision.

#### Explanation of Provision

##### Patient-Centered Outcomes Research Trust Fund

Under new section 9511, there is established in the Treasury of the United States a trust fund, the Patient Centered Outcomes Research Trust Fund (“PCORTF”), to carry out the provisions in the Senate amendment relating to comparative effectiveness research. The PCORTF is funded in part from fees imposed on health plans under new sections 4375 through 4377.

##### Fee on insured and self-insured health plans

###### Insured plans

Under new section 4375, a fee is imposed on each specified health insurance policy. The fee is equal to two dollars (one dollar in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy. For any policy year beginning after September 30, 2014, the dollar amount is equal to the sum of: (1) the dollar amount for policy years ending in the preceding fiscal year, plus (2) an amount equal to the product of (A) the dollar amount for policy years ending in the preceding fiscal year, multiplied by (B) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year. The issuer of the policy is liable for payment of the fee. A specified health insurance policy includes any accident or health insurance policy<sup>119</sup> issued with respect to individuals residing in the United States.<sup>120</sup> An arrangement under which fixed payments of premiums are received as consideration for a person’s agreement to provide, or arrange for the provision of, accident or

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<sup>119</sup> A specified health insurance policy does not include insurance if substantially all of the coverage provided under such policy consists of excepted benefits described in section 9832(c). Examples of excepted benefits described in section 9832(c) are coverage for only accident, or disability insurance, or any combination thereof; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; coverage for on-site medical clinics; limited scope dental or vision benefits; benefits for long term care, nursing home care, community based care, or any combination thereof; coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; and Medicare supplemental coverage.

<sup>120</sup> Under the provision, the United States includes any possession of the United States.

health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, is treated as a specified health insurance policy. The person agreeing to provide or arrange for the provision of coverage is treated as the issuer.

### Self-insured plans

In the case of an applicable self-insured health plan, new Code section 4376 imposes a fee equal to two dollars (one dollar in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan. For any policy year beginning after September 30, 2014, the dollar amount is equal to the sum of: (1) the dollar amount for policy years ending in the preceding fiscal year, plus (2) an amount equal to the product of (A) the dollar amount for policy years ending in the preceding fiscal year, multiplied by (B) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year. The plan sponsor is liable for payment of the fee. For purposes of the provision, the plan sponsor is: the employer in the case of a plan established or maintained by a single employer or the employee organization in the case of a plan established or maintained by an employee organization. In the case of: (1) a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, (2) a multiple employer welfare arrangement, or (3) a voluntary employees' beneficiary association described in Code section 501(c)(9) ("VEBA"), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. In the case of a rural electric cooperative or a rural telephone cooperative, the plan sponsor is the cooperative or association.

Under the provision, an applicable self-insured health plan is any plan providing accident or health coverage if any portion of such coverage is provided other than through an insurance policy and such plan is established or maintained: (1) by one or more employers for the benefit of their employees or former employees, (2) by one or more employee organizations for the benefit of their members or former members, (3) jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees, (4) by a VEBA, (5) by any organization described in section 501(c)(6) of the Code, or (6) in the case of a plan not previously described, by a multiple employer welfare arrangement (as defined in section 3(40) of ERISA, a rural electric cooperative (as defined in section 3(40)(B)(iv) of ERISA), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA).

### Other special rules

Governmental entities are generally not exempt from the fees imposed under the provision. There is an exception for exempt governmental programs including, Medicare, Medicaid, SCHIP, and any program established by Federal law for providing medical care (other than through insurance policies) to members of the Armed Forces, veterans, or members of Indian tribes.

No amount collected from the fee on health insurance and self-insured plans is covered over to any possession of the United States. For purposes of the Code's procedure and administration rules, the fee imposed under the provision is treated as a tax. The fees imposed under new sections 4375 and 4376 do not apply to plan years ending after September 31, 2019.

### **Effective Date**

The fee on health insurance and self-insured plans is effective with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2012.

## TITLE IX – REVENUE PROVISIONS

### A. Excise Tax on High Cost Employer-Sponsored Health Coverage (sec. 9001<sup>121</sup> of the Senate amendment and new sec. 4980I of the Code)

#### Present Law

##### Taxation of insurance companies

Current law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies generally are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.<sup>122</sup>

Some insurance providers may be exempt from Federal income tax under section 501(a) if specific requirements are satisfied. Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary associations that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than \$600,000 (\$150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals. Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance. A health maintenance organization that is tax-exempt under section 501(c)(3) or (4) is not treated as providing prohibited<sup>123</sup> commercial-type insurance, in the case of incidental health insurance provided by the health maintenance organization that is of a kind customarily provided by such organizations.

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<sup>121</sup> Section 9001 of the Senate amendment, as amended by section 10901, is further amended by section 1401 of the Reconciliation bill.

<sup>122</sup> Sec. 816(a).

<sup>123</sup> Sec. 501(m).

## **Treatment of employer-sponsored health coverage**

As with other compensation, the cost of employer-provided health coverage is a deductible business expense under section 162.<sup>124</sup> Employer-provided health insurance coverage is generally not included in an employee's gross income.

In addition, employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.<sup>125</sup> Such salary reduction contributions are treated as employer contributions for Federal income purposes, and are thus excluded from gross income.

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage.

A flexible spending arrangement for medical expenses under a cafeteria plan ("Health FSA") is an unfunded arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses.<sup>126</sup> Health FSAs that are funded on a salary reduction basis are subject to the requirements for cafeteria plans, including a requirement that amounts remaining under a Health FSA at the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it rule").<sup>127</sup>

Alternatively, the employer may specify a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called Health Reimbursement Arrangements ("HRAs"). Some of the rules applicable to HRAs and Health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at

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<sup>124</sup> Sec. 162. However see special rules in section 419 and 419A for the deductibility of contributions to welfare benefit plans with respect to medical benefits for employees and their dependents.

<sup>125</sup> Sec. 125.

<sup>126</sup> Sec. 125. Prop. Treas. Reg. sec. 1.125-5 provides rules for Health FSAs. There is a similar type of flexible spending arrangement for dependent care expenses.

<sup>127</sup> Sec. 125(d)(2). A cafeteria plan is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used. Notice 2005-42, 2005-1 C.B. 1204.

the end of the year may be carried forward to be used to reimburse medical expenses in following years.<sup>128</sup>

Current law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (“HSA”). An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). Subject to certain limitations,<sup>129</sup> contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Like an HSA, an Archer MSA is a tax-exempt trust or custodial account to which tax-deductible contributions may be made by individuals with a high deductible health plan; however, only self-employed individuals and employees of small employers are eligible to have an Archer MSA. Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans.<sup>130</sup>

ERISA<sup>131</sup> preempts State law relating to certain employee benefit plans, including employer-sponsored health plans. While ERISA specifically provides that its preemption rule does not exempt or relieve any person from any State law which regulates insurance, ERISA also provides that an employee benefit plan is not deemed to be engaged in the business of insurance for purposes of any State law regulating insurance companies or insurance contracts. As a result of this ERISA preemption, self-insured employer-sponsored health plans need not provide benefits that are mandated under State insurance law.

While ERISA does not require an employer to offer health benefits, it does require compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, reporting and disclosure requirements, and procedures for appealing denied benefit claims. ERISA was amended (as well as the PHSAs and the Code) by COBRA<sup>132</sup> and

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<sup>128</sup> Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

<sup>129</sup> For 2010, the maximum aggregate annual contribution that can be made to an HSA is \$3,050 in the case of self-only coverage and \$6,150 in the case of family coverage. The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by \$1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

<sup>130</sup> In addition to being limited to self-employed individuals and employees of small employers, the definition of a high deductible health plan for an Archer MSA differs from that for an HSA. After 2007, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had made Archer MSA contributions and employees who are employed by a participating employer.

<sup>131</sup> Pub. L. No. 93-406.

<sup>132</sup> Pub. L. No. 99-272.

HIPAA,<sup>133</sup> which added other Federal requirements for health plans, including rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

COBRA requires that a group health plan offer continuation coverage to qualified beneficiaries in the case of a qualifying event (such as a loss of employment).<sup>134</sup> A plan may require payment of a premium for any period of continuation coverage. The amount of such premium generally may not exceed 102 percent of the “applicable premium” for such period and the premium must be payable, at the election of the payor, in monthly installments. The applicable premium for any period of continuation coverage means the cost to the plan for such period of coverage for similarly situated non-COBRA beneficiaries with respect to whom a qualifying event has not occurred, and is determined without regard to whether the cost is paid by the employer or employee. There are special rules for determining the applicable premium in the case of self-insured plans. Under the special rules for self-insured plans, the applicable premium generally is equal to a reasonable estimate of the cost of providing coverage for similarly situated beneficiaries which is determined on an actuarial basis and takes into account such other factors as the Secretary of Treasury may prescribe in regulations.

Current law imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements.<sup>135</sup> The excise tax generally is equal to \$100 per day per failure during the period of noncompliance and is imposed on the employer sponsoring the plan.

### **Deduction for health insurance costs of self-employed individuals**

Under current law, self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents.<sup>136</sup> The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual’s earned income from self-employment. The deduction applies only to the cost of insurance (i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance). The deduction does not apply for self-employment tax purposes. For purposes of the deduction, a more-than-two-percent-shareholder-employee of an S corporation is treated the same as a self-employed individual. Thus, the exclusion for employer provided health care coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self-employed.

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<sup>133</sup> Pub. L. No. 104-191.

<sup>134</sup> A group health plan is defined as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. The COBRA requirements are enforced through the Code, ERISA, and the PHSA.

<sup>135</sup> Secs. 4980B and 4980D.

<sup>136</sup> Sec. 162(l).



## **Deductibility of excise taxes**

In general, excise taxes may be deductible under section 162 of the Code if such taxes are paid or incurred in carrying on a trade or business, and are not within the scope of the disallowance of deductions for certain taxes enumerated in section 275 of the Code.

### **Explanation of Provision**

The provision imposes an excise tax on insurers if the aggregate value of employer-sponsored health insurance coverage for an employee (including, for purposes of the provision, any former employee, surviving spouse and any other primary insured individual) exceeds a threshold amount. The tax is equal to 40 percent of the aggregate value that exceeds the threshold amount. For 2018, the threshold amount is \$10,200 for individual coverage and \$27,500 for family coverage, multiplied by the health cost adjustment percentage (as defined below) and increased by the age and gender adjusted excess premium amount (as defined below).

The health cost adjustment percentage is designed to increase the thresholds in the event that the actual growth in the cost of U.S. health care between 2010 and 2018 exceeds the projected growth for that period. The health cost adjustment percentage is equal to 100 percent plus the excess, if any, of (1) the percentage by which the per employee cost of coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan (“standard FEHBP coverage”) <sup>137</sup> for plan year 2018 (as determined using the benefit package for standard FEHBP coverage for plan year 2010) exceeds the per employee cost of standard FEHBP coverage for plan year 2010; over (2) 55 percent. In 2019, the threshold amounts, after application of the health cost adjustment percentage in 2018, if any, are indexed to the CPI-U, as determined by the Department of Labor, plus one percentage point, rounded to the nearest \$50. In 2020 and thereafter, the threshold amounts are indexed to the CPI-U as determined by the Department of Labor, rounded to the nearest \$50.

For each employee (other than for certain retirees and employees in high risk professions, whose thresholds are adjusted under rules described below), the age and gender adjusted excess premium amount is equal to the excess, if any, of (1) the premium cost of standard FEHBP coverage for the type of coverage provided to the individual if priced for the age and gender characteristics of all employees of the individual’s employer over (2) the premium cost, determined under procedures proscribed by the Secretary, for that coverage if priced for the age and gender characteristics of the national workforce.

For example, if the growth in the cost of health care during the period between 2010 and 2018, calculated by reference to the growth in the per employee cost of standard FEHBP

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<sup>137</sup> For purposes of determining the health cost adjustment percentage in 2018 and the age and gender adjusted excess premium amount in any year, in the event the standard Blue Cross/Blue Shield option is not available under the Federal Employees Health Benefit Plan for such year, the Secretary will determine the health cost adjustment percentage by reference to a substantially similar option available under the Federal Employees Health Benefit Plan for that year.

coverage during that period (holding benefits under the standard FEBHP plan constant during the period) is 57 percent, the threshold amounts for 2013 will be \$10,200 for individual coverage and \$27,500 for family coverage, multiplied by 102 percent (100 percent plus the excess of 57 percent over 55 percent), or \$10,404 for individual coverage and \$28,050 for family coverage. In 2019, the new threshold amounts of \$10,404 for individual coverage and \$28,050 for family coverage are indexed for CPI-U, plus one percentage point, rounded to the nearest \$50. Beginning in 2020, the threshold amounts are indexed to the CPI-U, rounded to the nearest \$50.

The new threshold amounts (as indexed) are then increased for any employee by the age and gender adjusted excess premium amount, if any. For an employee with individual coverage in 2019, if standard FEHBP coverage priced for the age and gender characteristics of the workforce of the employee's employer is \$11,400 and the Secretary estimates that the premium cost for individual standard FEHBP coverage priced for the age and gender characteristics of the national workforce is \$10,500, the threshold for that employee is increased by \$900 (\$11,400 less \$10,500) to \$11,304 (\$10,404 plus \$900).

The excise tax is imposed pro rata on the issuers of the insurance. In the case of a self-insured group health plan, a Health FSA or an HRA, the excise tax is paid by the entity that administers benefits under the plan or arrangement ("plan administrator"). Where the employer acts as plan administrator to a self-insured group health plan, a Health FSA or an HRA, the excise tax is paid by the employer. Where an employer contributes to an HSA or an Archer MSA, the employer is responsible for payment of the excise tax, as the insurer.

Employer-sponsored health insurance coverage is health coverage under any group health plan offered by an employer to an employee without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee's gross income) or the employee pays for the coverage with after-tax dollars. Employer-sponsored health insurance coverage includes coverage under any group health plan established and maintained primarily for the civilian employees of the Federal government or any of its agencies or instrumentalities and, except as provided below, of any State government or political subdivision thereof or by any of agencies or instrumentalities of such government or subdivision.

Employer-sponsored health insurance coverage includes both fully-insured and self-insured health coverage excludable from the employee's gross income, including, in the self-insured context, on-site medical clinics that offer more than a de minimis amount of medical care to employees and executive physical programs. In the case of a self-employed individual, employer-sponsored health insurance coverage is coverage for any portion of which a deduction is allowable to the self-employed individual under section 162(l).

In determining the amount by which the value of employer-sponsored health insurance coverage exceeds the threshold amount, the aggregate value of all employer-sponsored health insurance coverage is taken into account, including coverage in the form of reimbursements under a Health FSA or an HRA, contributions to an HSA or Archer MSA, and, except as provided below, other supplementary health insurance coverage. The value of employer-sponsored coverage for long term care and the following benefits described in section 9832(c)(1) that are excepted from the portability, access and renewability requirements of HIPAA are not taken into account in the determination of whether the value of health coverage exceeds the

threshold amount: (1) coverage only for accident or disability income insurance, or any combination of these coverages; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers' compensation or similar insurance; (5) automobile medical payment insurance; (5) credit-only insurance; and (6) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

The value of employer-sponsored health insurance coverage does not include the value of independent, noncoordinated coverage described in section 9832(c)(3) as excepted from the portability, access and renewability requirements of HIPAA if that coverage is purchased exclusively by the employee with after-tax dollars (or, in the case of a self-employed individual, for which a deduction under section 162(l) is not allowable). The value of employer-sponsored health insurance coverage does include the value of such coverage if any portion of the coverage is employer-provided (or, in the case of a self-employed individual, if a deduction is allowable for any portion of the payment for the coverage). Coverage described in section 9832(c)(3) is coverage only for a specified disease or illness or for hospital or other fixed indemnity health coverage. Fixed indemnity health coverage pays fixed dollar amounts based on the occurrence of qualifying events, including but not limited to the diagnosis of a specific disease, an accidental injury or a hospitalization, provided that the coverage is not coordinated with other health coverage.

Finally, the value of employer-sponsored health insurance coverage does not include any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye.

### **Calculation and proration of excise tax and reporting requirements**

#### Applicable threshold

In general, the individual threshold applies to any employee covered by employer-sponsored health insurance coverage. The family threshold applies to an employee only if such individual and at least one other beneficiary are enrolled in coverage other than self-only coverage under an employer-sponsored health insurance plan that provides minimum essential coverage (as determined for purposes of the individual responsibility requirements) and under which the benefits provided do not vary based on whether the covered individual is the employee or other beneficiary.

For all employees covered by a multiemployer plan, the family threshold applies regardless of whether the individual maintains individual or family coverage under the plan. For purposes of the provision, a multiemployer plan is an employee health benefit plan to which more than one employer is required to contribute, which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

### Amount of applicable premium

Under the provision, the aggregate value of all employer-sponsored health insurance coverage, including any supplementary health insurance coverage not excluded from the value of employer-sponsored health insurance, is generally calculated in the same manner as the applicable premiums for the taxable year for the employee determined under the rules for COBRA continuation coverage, but without regard to the excise tax. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan is required to calculate separate individual and family premiums for this purpose. In determining the coverage value for retirees, employers may elect to treat pre-65 retirees together with post-65 retirees.

### Value of coverage in the form of Health FSA reimbursements

In the case of a Health FSA from which reimbursements are limited to the amount of the salary reduction, the value of employer-sponsored health insurance coverage is equal to the dollar amount of the aggregate salary reduction contributions for the year. To the extent that the Health FSA provides for employer contributions in excess of the amount of the employee's salary reduction, the value of the coverage generally is determined in the same manner as the applicable premium for COBRA continuation coverage. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan is required to calculate separate individual and family premiums for this purpose.

### Amount subject to the excise tax and reporting requirement

The amount subject to the excise tax on high cost employer-sponsored health insurance coverage for each employee is the sum of the aggregate premiums for health insurance coverage, the amount of any salary reduction contributions to a Health FSA for the taxable year, and the dollar amount of employer contributions to an HSA or an Archer MSA, minus the dollar amount of the threshold. The aggregate premiums for health insurance coverage include all employer-sponsored health insurance coverage including coverage for any supplementary health insurance coverage. The applicable premium for health coverage provided through an HRA is also included in this aggregate amount.

Under a separate rule,<sup>138</sup> an employer is required to disclose the aggregate premiums for health insurance coverage for each employee on his or her annual Form W-2.

Under the provision, the excise tax is allocated pro rata among the insurers, with each insurer responsible for payment of the excise tax on an amount equal to the amount subject to the total excise tax multiplied by a fraction, the numerator of which is the amount of employer-sponsored health insurance coverage provided by that insurer to the employee and the denominator of which is the aggregate value of all employer-sponsored health insurance coverage provided to the employee. In the case of a self-insured group health plan, a Health

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<sup>138</sup> See the explanation of section 9002 of the Senate amendment, "Inclusion of Cost of Employer Sponsored Health Coverage on W-2."

FSA or an HRA, the excise tax is allocated to the plan administrator. If an employer contributes to an HSA or an Archer MSA, the employer is responsible for payment of the excise tax, as the insurer. The employer is responsible for calculating the amount subject to the excise tax allocable to each insurer and plan administrator and for reporting these amounts to each insurer, plan administrator and the Secretary, in such form and at such time as the Secretary may prescribe. Each insurer and plan administrator is then responsible for calculating, reporting and paying the excise tax to the IRS on such forms and at such time as the Secretary may prescribe.

For example, if in 2018 an employee elects family coverage under a fully-insured health care policy covering major medical and dental with a value of \$31,000, the health cost adjustment percentage for that year is 100 percent, and the age and gender adjusted excess premium amount for the employee is \$600, the amount subject to the excise tax is \$2,900 (\$31,000 less the threshold of \$28,100 (\$27,500 multiplied by 100 percent and increased by \$600)). The employer reports \$2,900 as taxable to the insurer, which calculates and remits the excise tax to the IRS.

Alternatively, if in 2018 an employee elects family coverage under a fully-insured major medical policy with a value of \$28,500 and contributes \$2,500 to a Health FSA, the employee has an aggregate health insurance coverage value of \$31,000. If the health cost adjustment percentage for that year is 100 percent and the age and gender adjusted excess premium amount for the employee is \$600, the amount subject to the excise tax is \$2,900 (\$31,000 less the threshold of \$28,100 (\$27,500 multiplied by 100 percent and increased by \$600)). The employer reports \$2,666 ( $\$2,900 \times \$28,500 / \$31,000$ ) as taxable to the major medical insurer which then calculates and remits the excise tax to the IRS. If the employer uses a third-party administrator for the Health FSA, the employer reports \$234 ( $\$2,900 \times \$2,500 / \$31,000$ ) to the administrator and the administrator calculates and remits the excise tax to the IRS. If the employer is acting as the plan administrator of the Health FSA, the employer is responsible for calculating and remitting the excise tax on the \$234 to the IRS.

### **Penalty for underreporting liability for tax to insurers**

If the employer reports to insurers, plan administrators and the IRS a lower amount of insurance cost subject to the excise tax than required, the employer is subject to a penalty equal to the sum of any additional excise tax that each such insurer and administrator would have owed if the employer had reported correctly and interest attributable to that additional excise tax as determined under Code section 6621 from the date that the tax was otherwise due to the date paid by the employer. This may occur, for example, if the employer undervalues the aggregate premium and thereby lowers the amount subject to the excise tax for all insurers and plan administrators (including the employer, when acting as plan administrator of a self-insured plan).

The penalty will not apply if it is established to the satisfaction of the Secretary that the employer neither knew, nor exercising reasonable diligence would have known, that the failure existed. In addition, no penalty will be imposed on any failure corrected within the 30-day period beginning on the first date that the employer knew, or exercising reasonable diligence, would have known, that the failure existed, so long as the failure is due to reasonable cause and not to willful neglect. All or part of the penalty may be waived by the Secretary in the case of

any failure due to reasonable cause and not to willful neglect, to the extent that the payment of the penalty would be excessive or otherwise inequitable relative to the failure involved.

The penalty is in addition to the amount of excise tax owed, which may not be waived.

### **Increased thresholds for certain retirees and individuals in high-risk professions**

The threshold amounts are increased for an individual who has attained age of 55 who is non-Medicare eligible and receiving employer-sponsored retiree health coverage or who is covered by a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high risk profession or employed to repair or install electrical and telecommunications lines. For these individuals, the threshold amount in 2018 is increased by (1) \$1,650 for individual coverage or \$3,450 for family coverage and (2) the age and gender adjusted excess premium amount (as defined above). In 2019, the additional \$1,650 and \$3,450 amounts are indexed to the CPI-U, plus one percentage point, rounded to the nearest \$50. In 2020 and thereafter, the additional threshold amounts are indexed to the CPI-U, rounded to the nearest \$50.

For purposes of this rule, employees considered to be engaged in a high risk profession are law enforcement officers, employees who engage in fire protection activities, individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. A retiree with at least 20 years of employment in a high risk profession is also eligible for the increased threshold.

Under this provision, an individual's threshold cannot be increased by more than \$1,650 for individual coverage or \$3,450 for family coverage (indexed as described above) and the age and gender adjusted excess premium amount, even if the individual would qualify for an increased threshold both on account of his or her status as a retiree over age 55 and as a participant in a plan that covers employees in a high risk profession.

### **Deductibility of excise tax**

Under the provision, the amount of the excise tax imposed is not deductible for Federal income tax purposes.

### **Regulatory authority**

The Secretary is directed to prescribe such regulations as may be necessary to carry out the provision.

### **Effective Date**

The provision is effective for taxable years beginning after December 31, 2017.

**B. Inclusion of Cost of Employer-Sponsored Health Coverage on W-2  
(sec. 9002 of the Senate amendment and sec. 6051 of the Code)**

**Present Law**

In many cases, an employer pays for all or a portion of its employees' health insurance coverage as an employee benefit. This benefit often includes premiums for major medical, dental, and other supplementary health insurance coverage. Under present law, the value of employer-provided health coverage is not required to be reported to the IRS or any other Federal agency. The value of the employer contribution to health coverage is excludible from an employee's income.<sup>139</sup>

Under current law, every employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. The statement, made on the Form W-2, must be provided to each employee by January 31 of the succeeding year. There is no requirement that the employer report the total value of employer-sponsored health insurance coverage on the Form W-2,<sup>140</sup> although some employers voluntarily report the amount of salary reduction under a cafeteria plan resulting in tax-free employee benefits in box 14.

**Explanation of Provision**

Under the provision, an employer is required to disclose on each employee's annual Form W-2 the value of the employee's health insurance coverage sponsored by the employer. If an employee enrolls in employer-sponsored health insurance coverage under multiple plans, the employer must disclose the aggregate value of all such health coverage (excluding the value of a health flexible spending arrangement). For example, if an employee enrolls in employer-sponsored health insurance coverage under a major medical plan, a dental plan, and a vision plan, the employer is required to report the total value of the combination of all of these health related insurance policies. For this purpose, employers generally use the same value for all similarly situated employees receiving the same category of coverage (such as single or family health insurance coverage).

To determine the value of employer-sponsored health insurance coverage, the employer calculates the applicable premiums for the taxable year for the employee under the rules for COBRA continuation coverage under section 4980B(f)(4) (and accompanying Treasury regulations), including the special rule for self-insured plans. The value that the employer is required to report is the portion of the aggregate premium. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, the plan would be required to calculate separate individual and family premiums for this purpose.

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<sup>139</sup> Sec. 106.

<sup>140</sup> Any portion of employer sponsored coverage that is paid for by the employee with after-tax contributions is included as wages on the W-2 Form.

**Effective Date**

The provision is effective for taxable years beginning after December 31, 2010.



**C. Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin  
(sec. 9003 of the Senate amendment and secs. 105, 106, 220, and 223 of the Code)**

**Present Law**

**Individual deduction for medical expenses**

Expenses for medical care, not compensated for by insurance or otherwise, are deductible by an individual under the rules relating to itemized deductions to the extent the expenses exceed 7.5 percent of adjusted gross income (“AGI”).<sup>141</sup> Medical care generally is defined broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body.<sup>142</sup> However, any amount paid during a taxable year for medicine or drugs is explicitly deductible as a medical expense only if the medicine or drug is a prescribed drug or is insulin.<sup>143</sup> Thus, any amount paid for medicine available without a prescription (“over-the-counter medicine”) is not deductible as a medical expense, including any medicine recommended by a physician.<sup>144</sup>

**Exclusion for employer-provided health care**

The Code generally provides that employees are not taxed on (that is, may exclude from gross income) the value of employer-provided health coverage under an accident or health plan.<sup>145</sup> In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.<sup>146</sup> An employer may agree to reimburse expenses for medical care of its employees (and their spouses and dependents), not covered by a health insurance plan, through a flexible spending arrangement (“FSA”) which allows reimbursement not in excess of a specified dollar amount. Such dollar amount is either elected by an employee under a cafeteria plan (“Health FSA”) or otherwise specified by the employer under an HRA. Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage. The general definition of medical care without the explicit limitation on medicine applies for purposes of the exclusion for employer-provided health coverage and medical care.<sup>147</sup> Thus, under an HRA or under a Health FSA, amounts paid for prescription and over-the-counter

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<sup>141</sup> Sec. 213(a).

<sup>142</sup> Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.

<sup>143</sup> Sec. 213(b).

<sup>144</sup> Rev. Rul. 2003-58, 2003-1 CB 959.

<sup>145</sup> Sec 106.

<sup>146</sup> Sec. 105(b).

<sup>147</sup> Sec. 105(b) provides that reimbursements for medical care within the meaning of section 213(d) pursuant to employer-provided health coverage are excludible from gross income. The definition of medical care in section 213(d) does not include the prescription drug limitation in section 213(b).

medicine are treated as medical expenses, and reimbursements for such amounts are excludible from gross income.

### **Medical savings arrangements**

Present law provides that individuals with a high deductible health plan (and generally no other health plan) purchased either through the individual market or through an employer may establish and make tax-deductible contributions to a health savings account (“HSA”).<sup>148</sup> Subject to certain limitations,<sup>149</sup> contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. Distributions from an HSA that are used for qualified medical expenses are excludible from gross income.<sup>150</sup> The general definition of medical care without the explicit limitation on medicine also applies for purposes of this exclusion.<sup>151</sup> Similar rules apply for another type of medical savings arrangement called an Archer MSA.<sup>152</sup> Thus, a distribution from a HSA or an Archer MSA used to purchase over-the-counter medicine also is excludible as an amount used for qualified medical expenses.

### **Explanation of Provision**

Under the provision, with respect to medicines, the definition of medical expense for purposes of employer-provided health coverage (including HRAs and Health FSAs), HSAs, and Archer MSAs, is conformed to the definition for purposes of the itemized deduction for medical expenses, except that prescribed drug is determined without regard to whether the drug is available without a prescription. Thus, under the provision, the cost of over-the-counter medicines may not be reimbursed with excludible income through a Health FSA, HRA, HSA, or Archer MSA, unless the medicine is prescribed by a physician.

### **Effective Date**

The provision is effective for expenses incurred after December 31, 2010.

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<sup>148</sup> Sec. 223.

<sup>149</sup> For 2009, the maximum aggregate annual contribution that can be made to an HSA is \$3,000 in the case of self-only coverage and \$5,950 in the case of family coverage (\$3,050 and \$6,150 for 2010). The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by \$1,000 in 2009 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

<sup>150</sup> Sec. 223(f).

<sup>151</sup> Sec. 223(d)(2).

<sup>152</sup> Sec. 220.

**D. Increase in Additional Tax on Distributions from HSAs  
Not Used for Medical Expenses  
(sec. 9004 of the bill and sec. 220 and 223 of the Code)**

**Present Law**

**Health savings account**

Present law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (“HSA”).<sup>153</sup> An HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual. An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). The decision to create and fund an HSA is made on an individual-by-individual basis and does not require any action on the part of the employer.

Subject to certain limitations, contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize their deductions on their tax return (rather than claiming the standard deduction). Income from investments made in HSAs is not taxable and the overall income is not taxable upon disbursement for medical expenses.

For 2010, the maximum aggregate annual contribution that can be made to an HSA is \$3,050 in the case of self-only coverage and \$6,150 in the case of family coverage. The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by \$1,000 in 2010 and thereafter. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

A high deductible health plan is a health plan that has an annual deductible that is at least \$1,200 for self-only coverage or \$2,400 for family coverage for 2010 and that limits the sum of the annual deductible and other payments that the individual must make with respect to covered benefits to no more than \$5,950 in the case of self-only coverage and \$11,900 in the case of family coverage for 2010.

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<sup>153</sup> An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is “permitted insurance” or “permitted coverage.” Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker’s compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health FSA is disregarded in determining eligibility for an HSA.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income. An additional 10 percent tax is added for all HSA disbursements not made for qualified medical expenses. The additional 10-percent tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently, age 65). Unlike reimbursements from a flexible spending arrangement or health reimbursement arrangement, distributions from an HSA are not required to be substantiated by the employer or a third party for the distributions to be excludible from income.

As in the case of individual retirement arrangements,<sup>154</sup> the individual is the beneficial owner of his or her HSA, and thus the individual is required to maintain books and records with respect to the expense and claim the exclusion for a distribution from the HSA on their tax return. The determination of whether the distribution is for a qualified medical expense is subject to individual self-reporting and IRS enforcement.

### **Archer medical savings account**

An Archer MSA is also a tax-exempt trust or custodial account to which tax-deductible contributions may be made by individuals with a high deductible health plan.<sup>155</sup> Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. The main differences include: (1) only self-employed individuals and employees of small employers are eligible to have an Archer MSA; (2) for Archer MSA purposes, a high deductible health plan is a health plan with (a) an annual deductible for 2010 of at least \$2,000 and no more than \$3,000 in the case of self-only coverage and at least \$4,050 and no more than \$6,050 in the case of family coverage and (b) maximum out-of-pocket expenses for 2010 of no more than \$4,050 in the case of self-only coverage and no more than \$7,400 in the case of family coverage; and (3) the additional tax on distributions not used for medical expenses is 15 percent rather than 10 percent. After 2007, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had made Archer MSA contributions and employees who are employed by a participating employer.

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<sup>154</sup> Sec. 408.

<sup>155</sup> Sec. 220.

### **Explanation of Provision**

The additional tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses is increased to 20 percent of the disbursed amount.

### **Effective Date**

The change is effective for disbursements made during tax years starting after December 31, 2010.

**E. Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans  
(sec. 9005<sup>156</sup> of the Senate amendment and sec. 125 of the Code)**

**Present law**

**Exclusion from income for employer-provided health coverage**

The Code generally provides that the value of employer-provided health coverage under an accident or health plan is excludible from gross income.<sup>157</sup> In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.<sup>158</sup> The exclusion applies both to health coverage in the case in which an employer absorbs the cost of employees' medical expenses not covered by insurance (i.e., a self-insured plan) as well as in the case in which the employer purchases health insurance coverage for its employees. There is no limit on the amount of employer-provided health coverage that is excludable. A similar rule excludes employer-provided health insurance coverage from the employees' wages for payroll tax purposes.<sup>159</sup>

Employers may also provide health coverage in the form of an agreement to reimburse medical expenses of their employees (and their spouses and dependents), not reimbursed by a health insurance plan, through flexible spending arrangements which allow reimbursement for medical care not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Health coverage provided in the form of one of these arrangements is also excludible from gross income as employer-provided health coverage under an accident or health plan.<sup>160</sup>

**Qualified benefits**

Qualified benefits under a cafeteria plan are generally employer-provided benefits that are not includable in gross income under an express provision of the Code. Examples of qualified benefits include employer-provided health coverage, group term life insurance coverage not in excess of \$50,000, and benefits under a dependent care assistance program. In order to be

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<sup>156</sup> Section 9005 of the Senate amendment, as amended by section 10902, is further amended by section 1403 of the Reconciliation bill.

<sup>157</sup> Sec. 106. Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludable under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

<sup>158</sup> Sec. 105(b).

<sup>159</sup> Secs. 3121(a)(2), and 3306(a)(2). See also section 3231(e)(1) for a similar rule with respect to compensation for purposes of Railroad Retirement Tax.

<sup>160</sup> Sec. 106.

excludable, any qualified benefit elected under a cafeteria plan must independently satisfy any requirements under the Code section that provides the exclusion. However, some employer-provided benefits that are not includable in gross income under an express provision of the Code are explicitly not allowed in a cafeteria plan. These benefits are generally referred to as nonqualified benefits. Examples of nonqualified benefits include scholarships;<sup>161</sup> employer-provided meals and lodging;<sup>162</sup> educational assistance;<sup>163</sup> and fringe benefits.<sup>164</sup> A plan offering any nonqualified benefit is not a cafeteria plan.<sup>165</sup>

### **Flexible spending arrangement under a cafeteria plan**

A flexible spending arrangement for medical expenses under a cafeteria plan (“Health FSA”) is health coverage in the form of an unfunded arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount of the salary reduction contributions made available for use in reimbursing the employee for his or her medical expenses.<sup>166</sup> Health FSAs are subject to the general requirements for cafeteria plans, including a requirement that amounts remaining under a Health FSA at the end of a plan year must be forfeited by the employee (referred to as the “use-it-or-lose-it rule”).<sup>167</sup> A Health FSA is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used.<sup>168</sup> A Health FSA can also include employer flex-credits which are non-elective employer contributions that the employer makes for every employee eligible to participate in the employer’s cafeteria plan, to be used only for one or more tax excludable qualified benefits (but not as cash or a taxable benefit).<sup>169</sup>

A flexible spending arrangement including a Health FSA (under a cafeteria plan) is generally distinguishable from other employer-provided health coverage by the relationship between the value of the coverage for a year and the maximum amount of reimbursement reasonably available during the same period. A flexible spending arrangement for health coverage generally is defined as a benefit program which provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to

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<sup>161</sup> Sec. 117.

<sup>162</sup> Sec. 119.

<sup>163</sup> Sec. 127.

<sup>164</sup> Sec. 132.

<sup>165</sup> Proposed Treas. Reg. sec. 1.125-1(q). Long-term care services, contributions to Archer Medical Savings Accounts, group term life insurance for an employee’s spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits.

<sup>166</sup> Sec. 125 and proposed Treas. Reg. sec. 1.125-5.

<sup>167</sup> Sec. 125(d)(2) and proposed Treas. Reg. sec. 1.125-5(c).

<sup>168</sup> Notice 2005-42, 2005-1 C.B. 1204 and proposed Treas. Reg. sec. 1.125-1(e).

<sup>169</sup> Proposed Treas. Reg. sec. 1-125-5(b).

reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.<sup>170</sup>

### **Health reimbursement arrangement**

Rather than offering a Health FSA through a cafeteria plan, an employer may specify a dollar amount that is available for medical expense reimbursement. These arrangements are commonly called HRAs. Some of the rules applicable to HRAs and Health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.<sup>171</sup>

### **Explanation of Provision**

Under the provision, in order for a Health FSA to be a qualified benefit under a cafeteria plan, the maximum amount available for reimbursement of incurred medical expenses of an employee, the employee's dependents, and any other eligible beneficiaries with respect to the employee, under the Health FSA for a plan year (or other 12-month coverage period) must not exceed \$2500.<sup>172</sup> The \$2,500 limitation is indexed to CPI-U, with any increase that is not a multiple of \$50 rounded to the next lowest multiple of \$50 for years beginning after December 31, 2013.

A cafeteria plan that does not include this limitation on the maximum amount available for reimbursement under any FSA is not a cafeteria plan within the meaning of section 125. Thus, when an employee is given the option under a cafeteria plan maintained by an employer to reduce his or her current cash compensation and instead have the amount of the salary reduction be made available for use in reimbursing the employee for his or her medical expenses under a Health FSA, the amount of the reduction in cash compensation pursuant to a salary reduction election must be limited to \$2,500 for a plan year.

It is intended that regulations would require all cafeteria plans of an employer to be aggregated for purposes of applying this limit. The employer for this purpose is determined after applying the employer aggregation rules in section 414(b), (c), (m), and (o).<sup>173</sup> In the event of a

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<sup>170</sup> Sec. 106(c)(2) and proposed Treas. Reg. sec. 1.125-5(a).

<sup>171</sup> Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002-45, 2002-2 C.B. 93.

<sup>172</sup> The provision does not change the present law treatment as described in proposed Treas. Reg. sec. 1.125-5 for dependent care flexible spending arrangements or adoption assistance flexible spending arrangements.

<sup>173</sup> Section 414(b) provides that, for specified employee benefit purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. There is a similar rule in section 414(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer, and, in section 414(m),



plan year or coverage period that is less than 12 months, it is intended that the limit be required to be prorated.

The provision does not limit the amount permitted to be available for reimbursement under employer-provided health coverage offered through an HRA, including a flexible spending arrangement within the meaning of section 106(c)(2), that is not part of a cafeteria plan.

**Effective Date**

The provision is effective for taxable year beginning after December 31, 2012.

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under which employees of an affiliated service group (as defined in that section) are treated as employed by a single employer. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements under section 414(m). Section 125(g)(4) applies this rule to cafeteria plans.

**F. Additional Requirements for Charitable Hospitals  
(sec. 9007<sup>174</sup> of the Senate amendment and secs. 501(c) and 6033  
and new sec. 4959 of the Code)**

**Present Law**

**Tax exemption**

Charitable organizations, i.e., organizations described in section 501(c)(3), generally are exempt from Federal income tax, are eligible to receive tax deductible contributions,<sup>175</sup> have access to tax-exempt financing through State and local governments (described in more detail below),<sup>176</sup> and generally are exempt from State and local taxes. A charitable organization must operate primarily in pursuit of one or more tax-exempt purposes constituting the basis of its tax exemption.<sup>177</sup> The Code specifies such purposes as religious, charitable, scientific, educational, literary, testing for public safety, to foster international amateur sports competition, or for the prevention of cruelty to children or animals. In general, an organization is organized and operated for charitable purposes if it provides relief for the poor and distressed or the underprivileged.<sup>178</sup>

The Code does not provide a per se exemption for hospitals. Rather, a hospital qualifies for exemption if it is organized and operated for a charitable purpose and otherwise meets the requirements of section 501(c)(3).<sup>179</sup> The promotion of health has been recognized by the IRS as a charitable purpose that is beneficial to the community as a whole.<sup>180</sup> It includes not only the establishment or maintenance of charitable hospitals, but clinics, homes for the aged, and other providers of health care.

Since 1969, the IRS has applied a “community benefit” standard for determining whether a hospital is charitable.<sup>181</sup> According to Revenue Ruling 69-545, community benefit can include,

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<sup>174</sup> Section 9007 of the Senate amendment is amended by section 10903 of the Senate amendment.

<sup>175</sup> Sec. 170.

<sup>176</sup> Sec. 145.

<sup>177</sup> Treas. Reg. sec. 1.501(c)(3)-1(c)(1).

<sup>178</sup> Treas. Reg. sec. 1.501(c)(3)-1(d)(2).

<sup>179</sup> Although nonprofit hospitals generally are recognized as tax-exempt by virtue of being “charitable” organizations, some might qualify for exemption as educational or scientific organizations because they are organized and operated primarily for medical education and research purposes.

<sup>180</sup> Rev. Rul. 69-545, 1969-2 C.B. 117; see also Restatement (Second) of Trusts secs. 368, 372 (1959); see Bruce R. Hopkins, *The Law of Tax-Exempt Organizations*, sec. 6.3 (8th ed. 2003) (discussing various forms of health-care providers that may qualify for exemption under section 501(c)(3)).

<sup>181</sup> Rev. Rul. 69-545, 1969-2 C.B. 117. From 1956 until 1969, the IRS applied a “financial ability” standard, requiring that a charitable hospital be “operated to the extent of its financial ability for those not able to

for example: maintaining an emergency room open to all persons regardless of ability to pay; having an independent board of trustees composed of representatives of the community; operating with an open medical staff policy, with privileges available to all qualifying physicians; providing charity care; and utilizing surplus funds to improve the quality of patient care, expand facilities, and advance medical training, education and research. Beginning in 2009, hospitals generally are required to submit information on community benefit on their annual information returns filed with the IRS.<sup>182</sup> Present law does not include sanctions short of revocation of tax-exempt status for hospitals that fail to satisfy the community benefit standard.

Although section 501(c)(3) hospitals generally are exempt from Federal tax on their net income, such organizations are subject to the unrelated business income tax on income derived from a trade or business regularly carried on by the organization that is not substantially related to the performance of the organization's tax-exempt functions.<sup>183</sup> In general, interest, rents, royalties, and annuities are excluded from the unrelated business income of tax-exempt organizations.<sup>184</sup>

### **Charitable contributions**

In general, a deduction is permitted for charitable contributions, including charitable contributions to tax-exempt hospitals, subject to certain limitations that depend on the type of taxpayer, the property contributed, and the donee organization. The amount of deduction generally equals the fair market value of the contributed property on the date of the contribution. Charitable deductions are provided for income, estate, and gift tax purposes.<sup>185</sup>

### **Tax-exempt financing**

In addition to issuing tax-exempt bonds for government operations and services, State and local governments may issue tax-exempt bonds to finance the activities of charitable organizations described in section 501(c)(3). Because interest income on tax-exempt bonds is excluded from gross income, investors generally are willing to accept a lower pre-tax rate of return on such bonds than they might otherwise accept on a taxable investment. This, in turn, lowers the cost of capital for the users of such financing. Both capital expenditures and limited working capital expenditures of charitable organizations described in section 501(c)(3) generally may be financed with tax-exempt bonds. Private, nonprofit hospitals frequently are the beneficiaries of this type of financing.

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pay for the services rendered and not exclusively for those who are able and expected to pay.” Rev. Rul. 56-185, 1956-1 C.B. 202.

<sup>182</sup> IRS Form 990, Schedule H.

<sup>183</sup> Secs. 511-514.

<sup>184</sup> Sec. 512(b).

<sup>185</sup> Secs. 170, 2055, and 2522, respectively.

Bonds issued by State and local governments may be classified as either governmental bonds or private activity bonds. Governmental bonds are bonds the proceeds of which are primarily used to finance governmental functions or which are repaid with governmental funds. Private activity bonds are bonds in which the State or local government serves as a conduit providing financing to nongovernmental persons (e.g., private businesses or individuals). For these purposes, the term “nongovernmental person” generally includes the Federal government and all other individuals and entities other than States or local governments, including section 501(c)(3) organizations. The exclusion from income for interest on State and local bonds does not apply to private activity bonds, unless the bonds are issued for certain permitted purposes (“qualified private activity bonds”) and other Code requirements are met.

### **Reporting and disclosure requirements**

Exempt organizations are required to file an annual information return, stating specifically the items of gross income, receipts, disbursements, and such other information as the Secretary may prescribe.<sup>186</sup> Section 501(c)(3) organizations that are classified as public charities must file Form 990 (Return of Organization Exempt From Income Tax),<sup>187</sup> including Schedule A, which requests information specific to section 501(c)(3) organizations. Additionally, an organization that operates at least one facility that is, or is required to be, licensed, registered, or similarly recognized by a state as a hospital must complete Schedule H (Form 990), which requests information regarding charity care, community benefits, bad debt expense, and certain management company and joint venture arrangements of a hospital.

An organization described in section 501(c) or (d) generally is also required to make available for public inspection for a period of three years a copy of its annual information return (Form 990) and exemption application materials.<sup>188</sup> This requirement is satisfied if the organization has made the annual return and exemption application widely available (e.g., by posting such information on its website).<sup>189</sup>

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<sup>186</sup> Sec. 6033(a). An organization that has not received a determination of its tax-exempt status, but that claims tax-exempt status under section 501(a), is subject to the same annual reporting requirements and exceptions as organizations that have received a tax-exemption determination.

<sup>187</sup> Social welfare organizations, labor organizations, agricultural organizations, horticultural organizations, and business leagues are subject to the generally applicable Form 990, Form 990-EZ, and Form 990-T annual filing requirements.

<sup>188</sup> Sec. 6104(d).

<sup>189</sup> Sec. 6104(d)(4); Treas. Reg. sec. 301.6104(d)-2(b).

## Explanation of Provision

### Additional requirements for section 501(c)(3) hospitals<sup>190</sup>

#### In general

The provision establishes new requirements applicable to section 501(c)(3) hospitals. The new requirements are in addition to, and not in lieu of, the requirements otherwise applicable to an organization described in section 501(c)(3). The requirements generally apply to any section 501(c)(3) organization that operates at least one hospital facility. For purposes of the provision, a hospital facility generally includes: (1) any facility that is, or is required to be, licensed, registered, or similarly recognized by a State as a hospital; and (2) any other facility or organization the Secretary of the Treasury (the “Secretary”), in consultation with the Secretary of HHS and after public comment, determines has the provision of hospital care as its principal purpose. To qualify for tax exemption under section 501(c)(3), an organization subject to the provision is required to comply with the following requirements with respect to each hospital facility operated by such organization.

#### Community health needs assessment

Each hospital facility is required to conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment. The assessment may be based on current information collected by a public health agency or non-profit organizations and may be conducted together with one or more other organizations, including related organizations. The assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues. The hospital must disclose in its annual information report to the IRS (i.e., Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources). Each hospital facility is required to make the assessment widely available. Failure to complete a community health needs assessment in any applicable three-year period results in a penalty on the organization of up to \$50,000. For example, if a facility does not complete a community health needs assessment in taxable years one, two or three, it is subject to the penalty in year three. If it then fails to complete a community health needs assessment in year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four). An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.<sup>191</sup>

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<sup>190</sup> No inference is intended regarding whether an organization satisfies the present law community benefit standard.

<sup>191</sup> Sec. 6652.

### Financial assistance policy

Each hospital facility is required to adopt, implement, and widely publicize a written financial assistance policy. The financial assistance policy must indicate the eligibility criteria for financial assistance and whether such assistance includes free or discounted care. For those eligible for discounted care, the policy must indicate the basis for calculating the amounts that will be billed to such patients. The policy must also indicate how to apply for such assistance. If a hospital does not have a separate billing and collections policy, the financial assistance policy must also indicate what actions the hospital may take in the event of non-response or non-payment, including collections action and reporting to credit rating agencies. Each hospital facility also is required to adopt and implement a policy to provide emergency medical treatment to individuals. The policy must prevent discrimination in the provision of emergency medical treatment, including denial of service, against those eligible for financial assistance under the facility's financial assistance policy or those eligible for government assistance.

### Limitation on charges

Each hospital facility is permitted to bill for emergency or other medically necessary care provided to individuals who qualify for financial assistance under the facility's financial assistance policy no more than the amounts generally billed to individuals who have insurance covering such care. A hospital facility may not use gross charges (i.e., "chargemaster" rates) when billing individuals who qualify for financial assistance. It is intended that amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates.

### Collection processes

Under the provision, a hospital facility (or its affiliates) may not undertake extraordinary collection actions (even if otherwise permitted by law) against an individual without first making reasonable efforts to determine whether the individual is eligible for assistance under the hospital's financial assistance policy. Such extraordinary collection actions include lawsuits, liens on residences, arrests, body attachments, or other similar collection processes. The Secretary is directed to issue guidance concerning what constitutes reasonable efforts to determine eligibility. It is intended that for this purpose, "reasonable efforts" includes notification by the hospital of its financial assistance policy upon admission and in written and oral communications with the patient regarding the patient's bill, including invoices and telephone calls, before collection action or reporting to credit rating agencies is initiated.

### **Reporting and disclosure requirements**

The provision includes new reporting and disclosure requirements. Under the provision, the Secretary or the Secretary's delegate is required to review information about a hospital's community benefit activities (currently reported on Form 990, Schedule H) at least once every three years. The provision also requires each organization to which the provision applies to file with its annual information return (i.e., Form 990) a copy of its audited financial statements (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statements).

The provision requires the Secretary, in consultation with the Secretary of HHS, to submit annually a report to Congress with information regarding the levels of charity care, bad debt expenses, unreimbursed costs of means-tested government programs, and unreimbursed costs of non-means tested government programs incurred by private tax-exempt, taxable, and governmental hospitals, as well as the costs incurred by private tax-exempt hospitals for community benefit activities. In addition, the Secretary, in consultation with the Secretary of HHS, must conduct a study of the trends in these amounts, and submit a report on such study to Congress not later than five years from date of enactment.

### **Effective Date**

Except as provided below, the provision is effective for taxable years beginning after the date of enactment. The community health needs assessment requirement is effective for taxable years beginning after the date which is two years after the date of enactment.<sup>192</sup> The excise tax on failures to satisfy the community health needs assessment requirement is effective for failures occurring after the date of enactment.

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<sup>192</sup> For example, assume the date of enactment is April 1, 2010. A calendar year taxpayer would test whether it meets the community health needs assessment requirement in the taxable year ending December 31, 2013. To avoid the penalty, the taxpayer must have satisfied the community health needs assessment requirements in 2011, 2012, or 2013.

**G. Imposition of Annual Fee on Branded Prescription Pharmaceutical  
Manufacturers and Importers  
(sec. 9008<sup>193</sup> of the Senate amendment)**

**Present Law**

There are two Medicare trust funds under present law, the Hospital Insurance (“HI”) fund and the Supplementary Medical Insurance (“SMI”) fund.<sup>194</sup> The HI trust fund is primarily funded through payroll tax on covered earnings. Employers and employees each pay 1.45 percent of wages, while self-employed workers pay 2.9 percent of a portion of their net earnings from self-employment. Other HI trust fund revenue sources include a portion of the Federal income taxes paid on Social Security benefits, and interest paid on the U.S. Treasury securities held in the HI trust fund. For the SMI trust fund, transfers from the general fund of the Treasury represent the largest source of revenue, but additional revenues include monthly premiums paid by beneficiaries, and interest paid on the U.S. Treasury securities held in the SMI trust fund.

Present law does not impose a fee creditable to the Medicare trust funds on companies that manufacture or import prescription drugs for sale in the United States.

**Explanation of Provision**

The provision imposes a fee on each covered entity engaged in the business of manufacturing or importing branded prescription drugs for sale to any specified government program or pursuant to coverage under any such program for each calendar year beginning after 2010. Fees collected under the provision are credited to the Medicare Part B trust fund.

The aggregate annual fee for all covered entities is the applicable amount. The applicable amount is \$2.5 billion for calendar year 2011, \$2.8 billion for calendar years 2012 and 2013, \$3 billion for calendar years 2014 through 2016, \$4 billion for calendar year 2017, \$4.1 billion for calendar year 2018, and \$2.8 billion for calendar year 2019 and thereafter. The aggregate fee is apportioned among the covered entities each year based on such entity’s relative share of branded prescription drug sales taken into account during the previous calendar year. The Secretary of the Treasury will establish an annual payment date that will be no later than September 30 of each calendar year.

The Secretary of the Treasury will calculate the amount of each covered entity’s fee for each calendar year by determining the relative market share for each covered entity. A covered entity’s relative market share for a calendar year is the covered entity’s branded prescription drug sales taken into account during the preceding calendar year as a percentage of the aggregate branded prescription drug sales of all covered entities taken into account during the preceding calendar year. The branded prescription drug sales taken into account during any calendar year

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<sup>193</sup> Section 9008 of the Senate amendment is amended by section 1404 of the Reconciliation bill.

<sup>194</sup> See 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, available at <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf>.



with respect to any covered entity is: (1) zero percent of sales not more than \$5 million, (2) 10 percent of sales over \$5 million but not more than \$125 million, (3) 40 percent of sales over \$125 million but not more than \$225 million, (4) 75 percent of sales over \$225 million but not more than \$400 million, and (5) 100 percent of sales over \$400 million.

For purposes of the provision, a covered entity is any manufacturer or importer with gross receipts from branded prescription drug sales. All persons treated as a single employer under section 52(a) or (b) or under section 414(m) or 414(o) will be treated as a single covered entity for purposes of the provision. In applying the single employer rules under 52(a) and (b), foreign corporations will not be excluded. If more than one person is liable for payment of the fee imposed by this provision, all such persons are jointly and severally liable for payment of such fee. It is anticipated that the Secretary may require each covered entity to identify each member of the group that is treated as a single covered entity under the provision.

Under the provision, branded prescription drug sales are sales of branded prescription drugs made to any specified government program or pursuant to coverage under any such program. The term branded prescription drugs includes any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act and for which an application was submitted under section 505(b) of such Act, and any biological product for which an application was submitted under section 351(a) of such Act. Branded prescription drug sales, as defined under the provision, does not include sales of any drug or biological product with respect to which an orphan drug tax credit was allowed for any taxable year under section 45C. The exception for orphan drug sales does not apply to any drug or biological product after such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the rare disease or condition with respect to which the section 45C credit was allowed.

Specified government programs under the provision include: (1) the Medicare Part D program under part D of title XVIII of the Social Security Act; (2) the Medicare Part B program under part B of title XVIII of the Social Security Act; (3) the Medicaid program under title XIX of the Social Security Act; (4) any program under which branded prescription drugs are procured by the Department of Veterans Affairs; (5) any program under which branded prescription drugs are procured by the Department of Defense; or (6) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

The Secretary of HHS, the Secretary of Veterans Affairs, and the Secretary of Defense will report to the Secretary of the Treasury, at a time and in such a manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect to each specified government program under such Secretary's jurisdiction. The provision includes specific information to be included in the reports by the respective Secretaries for each specified government program.

The fees imposed under the provision are treated as excise taxes with respect to which only civil actions for refunds under the provisions of subtitle F will apply. Thus, the fees may be assessed and collected using the procedures in subtitle F without regard to the restrictions on assessment in section 6213.

The Secretary of the Treasury has authority to publish guidance as necessary to carry out the purposes of this provision. It is anticipated that the Secretary of the Treasury will publish guidance related to the determination of the fee under this section. For example, the Secretary may publish initial determinations, allow a notice and comment period, and then provide notice and demand for payment of the fee. It is also anticipated that the Secretary of the Treasury will provide guidance as to the determination of the fee in situations involving mergers, acquisitions, business divisions, bankruptcy, or any other situations where guidance is necessary to account for sales taken into account for determining the fee for any calendar year.

The fees imposed under the provision are not deductible for U.S. income tax purposes.

**Effective Date**

The provision is effective for calendar years beginning after December 31, 2010.

**H. Imposition of Annual Fee on Medical Device Manufacturers and Importers  
(sec. 9009<sup>195</sup> of the Senate amendment)**

**Repeal**

The provision imposing an annual fee on manufactures and importers of medical devices is repealed.

**Effective Date**

The repeal is effective as of the date of enactment of the Senate amendment.

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<sup>195</sup> Section 9009 of the Senate amendment is repealed by section 1405(d) of the Reconciliation bill.

## **I. Imposition of Annual Fee on Health Insurance Providers (sec. 9010<sup>196</sup> of the Senate amendment)**

### **Present Law**

Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates.

An insurance company that provides health insurance is subject to Federal income tax as either a life insurance company or as a property insurance company, depending on its mix of lines of business and on the resulting portion of its reserves that are treated as life insurance reserves. For Federal income tax purposes, an insurance company is treated as a life insurance company if the sum of its (1) life insurance reserves and (2) unearned premiums and unpaid losses on noncancellable life, accident or health contracts not included in life insurance reserves, comprise more than 50 percent of its total reserves.<sup>197</sup>

Some insurance providers may be exempt from Federal income tax under section 501(a) if specific requirements are satisfied. Section 501(c)(8), for example, describes certain fraternal beneficiary societies, orders, or associations operating under the lodge system or for the exclusive benefit of their members that provide for the payment of life, sick, accident, or other benefits to the members or their dependents. Section 501(c)(9) describes certain voluntary employees' beneficiary associations that provide for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or designated beneficiaries. Section 501(c)(12)(A) describes certain benevolent life insurance associations of a purely local character. Section 501(c)(15) describes certain small non-life insurance companies with annual gross receipts of no more than \$600,000 (\$150,000 in the case of a mutual insurance company). Section 501(c)(26) describes certain membership organizations established to provide health insurance to certain high-risk individuals. Section 501(c)(27) describes certain organizations established to provide workmen's compensation insurance.

An excise tax applies to premiums paid to foreign insurers and reinsurers covering U.S. risks.<sup>198</sup> The excise tax is imposed on a gross basis at the rate of one percent on reinsurance and life insurance premiums, and at the rate of four percent on property and casualty insurance premiums. The excise tax does not apply to premiums that are effectively connected with the conduct of a U.S. trade or business or that are exempted from the excise tax under an applicable income tax treaty. The excise tax paid by one party cannot be credited if, for example, the risk is reinsured with a second party in a transaction that is also subject to the excise tax.

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<sup>196</sup> Section 9010 of the Senate amendment, as amended by section 10905, is further amended by section 1406 of the Reconciliation bill.

<sup>197</sup> Sec. 816(a).

<sup>198</sup> Secs. 4371-4374.

IRS authority to assess and collect taxes is generally provided in subtitle F of the Code (secs. 6001 -7874), relating to procedure and administration. That subtitle establishes the rules governing both how taxpayers are required to report information to the IRS and to pay their taxes, as well as their rights. It also establishes the duties and authority of the IRS to enforce the Federal tax law, and sets forth rules relating to judicial proceedings involving Federal tax.

### **Explanation of Provision**

Under the provision, an annual fee applies to any covered entity engaged in the business of providing health insurance with respect to United States health risks. The fee applies for calendar years beginning after 2013. The aggregate annual fee for all covered entities is the applicable amount. The applicable amount is \$8 billion for calendar year 2014, \$11.3 billion for calendar years 2015 and 2016, \$13.9 billion for calendar year 2017, and \$14.3 billion for calendar year 2018. For calendar years after 2018, the applicable amount is indexed to the rate of premium growth.

The annual payment date for a calendar year is determined by the Secretary of the Treasury, but in no event may be later than September 30 of that year.

Under the provision, the aggregate annual fee is apportioned among the providers based on a ratio designed to reflect relative market share of U.S. health insurance business. For each covered entity, the fee for a calendar year is an amount that bears the same ratio to the applicable amount as (1) the covered entity's net premiums written during the preceding calendar year with respect to health insurance for any United States health risk, bears to (2) the aggregate net written premiums of all covered entities during such preceding calendar year with respect to such health insurance.

The provision requires the Secretary of the Treasury to calculate the amount of each covered entity's fee for the calendar year, determining the covered entity's net written premiums for the preceding calendar year with respect to health insurance for any United States health risk on the basis of reports submitted by the covered entity and through the use of any other source of information available to the Treasury Department. It is intended that the Treasury Department be able to rely on published aggregate annual statement data to the extent necessary, and may use annual statement data and filed annual statements that are publicly available to verify or supplement the reports submitted by covered entities.

Net written premiums is intended to mean premiums written, including reinsurance premiums written, reduced by reinsurance ceded, and reduced by ceding commissions. Net written premiums do not include amounts arising under arrangements that are not treated as insurance (i.e., in the absence of sufficient risk shifting and risk distribution for the arrangement to constitute insurance).<sup>199</sup>

The amount of net premiums written that are taken into account for purposes of determining a covered entity's market share is subject to dollar thresholds. A covered entity's

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<sup>199</sup> See *Helvering v. Le Gierse*, 312 U.S. 531 (1941).

net premiums written during the calendar year that are not more than \$25 million are not taken into account for this purpose. With respect to a covered entity's net premiums written during the calendar year that are more than \$25 million but not more than \$50 million, 50 percent are taken into account, and 100 percent of net premiums written in excess of \$50 million are taken into account.

After application of the above dollar thresholds, a special rule provides an exclusion, for purposes of determining an otherwise covered entity's market share, of 50 percent of net premiums written that are attributable to the exempt activities<sup>200</sup> of a health insurance organization that is exempt from Federal income tax<sup>201</sup> by reason of being described in section 501(c)(3) (generally, a public charity), section 501(c)(4) (generally, a social welfare organization), section 501(c)(26) (generally, a high-risk health insurance pool), or section 501(c)(29) (a consumer operated and oriented plan ("CO-OP") health insurance issuer).

A covered entity generally is an entity that provides health insurance with respect to United States health risks during the calendar year in which the fee under this section is due. Thus for example, an insurance company subject to tax under part I or II of subchapter L, an organization exempt from tax under section 501(a), a foreign insurer that provides health insurance with respect to United States health risks, or an insurer that provides health insurance with respect to United States health risks under Medicare Advantage, Medicare Part D, or Medicaid, is a covered entity under the provision except as provided in specific exceptions.

Specific exceptions are provided to the definition of a covered entity. A covered entity does not include an employer to the extent that the employer self-insures the health risks of its employees. For example, a manufacturer that enters into a self-insurance arrangement with respect to the health risks of its employees is not treated as a covered entity. As a further example, an insurer that sells health insurance and that also enters into a self-insurance arrangement with respect to the health risks of its own employees is treated as a covered entity with respect to its health insurance business, but is not treated as a covered entity to the extent of the self-insurance of its own employees' health risks.

A covered entity does not include any governmental entity. For this purpose, it is intended that a governmental entity includes a county organized health system entity that is an independent public agency organized as a nonprofit under State law and that contracts with a State to administer State Medicaid benefits through local care providers or HMOs.

A covered entity does not include an entity that (1) qualifies as nonprofit under applicable State law, (2) meets the private inurement and limitation on lobbying provisions described in section 501(c)(3), and (3) receives more than 80 percent of its gross revenue from government

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<sup>200</sup> The exempt activities for this purpose are activities other than activities of an unrelated trade or business defined in section 513 of the Code.

<sup>201</sup> Section 501(m) of the Code provides that an organization described in section 501(c)(3) or (4) is exempt from Federal income tax only if no substantial part of its activities consists of providing commercial-type insurance. Thus, an organization otherwise described in section 501(c)(3) or (4) that is taxable (under the Federal income tax rules) by reason of section 501(m) is not eligible for the 50-percent exclusion under the insurance fee.

programs that target low-income, elderly, or disabled populations (including Medicare, Medicaid, the State Children’s Health Insurance Plan (“SCHIP”), and dual-eligible plans).

A covered entity does not include an organization that qualifies as a VEBA under section 501(c)(9) that is established by an entity other than the employer (i.e., a union) for the purpose of providing health care benefits. This exclusion does not apply to multi-employer welfare arrangements (“MEWAs”).

For purposes of the provision, all persons treated as a single employer under section 52(a) or (b) or section 414(m) or (o) are treated as a single covered entity (or as a single employer, for purposes of the rule relating to employers that self-insure the health risks of employees), and otherwise applicable exclusion of foreign corporations under those rules is disregarded. However, the exceptions to the definition of a covered entity are applied on a separate entity basis, not taking into account this rule. If more than one person is liable for payment of the fee by reason of being treated as a single covered entity, all such persons are jointly and severally liable for payment of the fee.

A United States health risk means the health risk of an individual who is a U.S. citizen, is a U.S. resident within the meaning of section 7701(b)(1)(A) (whether or not located in the United States), or is located in the United States, with respect to the period that the individual is located there. In general, it is intended that risks in the following lines of business reported on the annual statement as prescribed by the National Association of Insurance Commissioners and as filed with the insurance commissioners of the States in which insurers are licensed to do business constitute health risks for this purpose: comprehensive (hospital and medical), vision, dental, Federal Employees Health Benefit plan, title XVIII Medicare, title XIX Medicaid, and other health.

For purposes of the provision, health insurance does not include coverage only for accident, or disability income insurance, or a combination thereof. Health insurance does not include coverage only for a specified disease or illness, nor does health insurance include hospital indemnity or other fixed indemnity insurance. Health insurance does not include any insurance for long-term care or any Medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

For purposes of procedure and administration under the rules of Subtitle F of the Code, the fee under this provision is treated as an excise tax with respect to which only civil actions for refund under Subtitle F apply. The Secretary of the Treasury may redetermine the amount of a covered entity’s fee under the provision for any calendar year for which the statute of limitations remains open.

For purposes of section 275, relating to the nondeductibility of specified taxes, the fee is considered to be a nondeductible tax described in section 275(a)(6).

A reporting rule applies under the provision. A covered entity is required to report to the Secretary of the Treasury the amount of its net premiums written during any calendar year with respect to health insurance for any United States health risk.

A penalty applies for failure to report, unless it is shown that the failure is due to reasonable cause. The amount of the penalty is \$10,000 plus the lesser of (1) \$1,000 per day while the failure continues, or (2) the amount of the fee imposed for which the report was required. The penalty is treated as a penalty for purposes of subtitle F of the Code, must be paid on notice and demand by the Treasury Department and in the same manner as tax, and with respect to which only civil actions for refund under procedures of subtitle F. The reported information is not treated as taxpayer information under section 6103.

An accuracy-related penalty applies in the case of any understatement of a covered entity's net premiums written. For this purpose, an understatement is the difference between the amount of net premiums written as reported on the return filed by the covered entity and the amount of net premiums written that should have been reported on the return. The penalty is equal to the amount of the fee that should have been paid in the absence of an understatement over the amount of the fee determined based on the understatement. The accuracy-related penalty is subject to the provisions of subtitle F of the Code that apply to assessable penalties imposed under Chapter 68.

The provision provides authority for the Secretary of the Treasury to publish guidance necessary to carry out the purposes of the provision and to prescribe regulations necessary or appropriate to prevent avoidance of the purposes of the provision, including inappropriate actions taken to qualify as an exempt entity under the provision.

#### **Effective Date**

The annual fee is required to be paid in each calendar year beginning after December 31, 2013. The fee under the provision is determined with respect to net premiums written after December 31, 2012, with respect to health insurance for any United States health risk.



**J. Study and Report of Effect on Veterans Health Care  
(sec. 9011 of the Senate amendment)**

**Present Law**

No provision.

**Explanation of Provision**

The provision requires the Secretary of Veterans Affairs to conduct a study on the effect (if any) of the fees assessed on manufacturers and importers of branded prescription drugs, manufacturers and importers of medical devices, and health insurance providers on (1) the cost of medical care provided to veterans and (2) veterans' access to branded prescription drugs and medical devices.

The Secretary of Veterans Affairs will report the results of the study to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate no later than December 31, 2012.

**Effective Date**

The provision is effective on the date of enactment.

**K. Repeal Business Deduction for Federal Subsidies for Certain  
Retiree Prescription Drug Plans  
(sec. 9012<sup>202</sup> of the Senate amendment and sec. 139A of the Code)**

**Present Law**

**In general**

Sponsors<sup>203</sup> of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of HHS with respect to a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").<sup>204</sup> A qualified retiree prescription drug plan is employment-based retiree health coverage<sup>205</sup> that has an actuarial value at least as great as the Medicare Part D standard plan for the risk pool and that meets certain other disclosure and recordkeeping requirements.<sup>206</sup> These qualified retiree prescription drug plan subsidies are excludable from the plan sponsor's gross income for the purposes of regular income tax and alternative minimum tax (including the adjustment for adjusted current earnings).<sup>207</sup>

**Subsidy amounts**

For each qualifying covered retiree enrolled for a coverage year in a qualified retiree prescription drug plan, the qualified retiree prescription drug plan subsidy is equal to 28 percent of the portion of the allowable retiree costs paid by the plan sponsor on behalf of the retiree that exceed the cost threshold but do not exceed the cost limit. A "qualifying covered retiree" is an individual who is eligible for Medicare but not enrolled in either a Medicare Part D prescription

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<sup>202</sup> Section 9012 of the Senate amendment is amended by section 1407 of the Reconciliation bill.

<sup>203</sup> The identity of the plan sponsor is determined in accordance with section 16(B) of ERISA, except that for cases where a plan is maintained jointly by one employer and an employee organization, and the employer is the primary source of financing, the employer is the plan sponsor.

<sup>204</sup> Sec. 1860D-22 of the Social Security Act (SSA), 42 USC Sec. 1395w-132.

<sup>205</sup> Employment-based retiree health coverage is health insurance coverage or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for Medicare Part D eligible individuals (their spouses and dependents) under group health plans based on their status as retired participants in such plans. For purposes of the subsidy, group health plans generally include employee welfare benefit plans (as defined in section 607(1) of ERISA) that provide medical care (as defined in section 213(d)), Federal and State governmental plans, collectively bargained plans, and church plans.

<sup>206</sup> In addition to meeting the actuarial value standard, the plan sponsor must also maintain and provide the Secretary of HHS access to records that meet the Secretary of HHS's requirements for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made to eligible individuals under the plan. In addition, the plan sponsor must disclose to the Secretary of HHS whether the plan meets the actuarial equivalence requirement and if it does not, must disclose to retirees the limitations of their ability to enroll in Medicare Part D and that non-creditable coverage enrollment is subject to penalties such as fees for late enrollment. 42 U.S.C. 1395w-132(a)(2).

<sup>207</sup> Sec. 139A.

drug plan or a Medicare Advantage-Prescription Drug plan, but who is covered under a qualified retiree prescription drug plan. In general, allowable retiree costs are, with respect to prescription drug costs under a qualified retiree prescription drug plan, the part of the actual costs paid by the plan sponsor on behalf of a qualifying covered retiree under the plan.<sup>208</sup> Both the threshold and limit are indexed to the percentage increase in Medicare per capita prescription drug costs; the cost threshold was \$250 in 2006 (\$310 in 2010) and the cost limit was \$5,000 in 2006 (\$6,300 in 2010).<sup>209</sup>

### **Expenses relating to tax-exempt income**

In general, no deduction is allowed under any provision of the Code for any expense or amount which would otherwise be allowable as a deduction if such expense or amount is allocable to a class or classes of exempt income.<sup>210</sup> Thus, expenses or amount paid or incurred with respect to the subsidies excluded from income under section 139A would generally not be deductible. However, a provision under section 139A specifies that the exclusion of the qualified retiree prescription drug plan subsidy from income is not taken into account in determining whether any deduction is allowable with respect to covered retiree prescription drug expenses that are taken into account in determining the subsidy payment. Therefore, under present law, a taxpayer may claim a business deduction for covered retiree prescription drug expenses incurred notwithstanding that the taxpayer excludes from income qualified retiree prescription drug plan subsidies allocable to such expenses.

### **Explanation of Provision**

The provision eliminates the rule that the exclusion for subsidy payments is not taken into account for purposes of determining whether a deduction is allowable with respect to retiree prescription drug expenses. Thus, under the provision, the amount otherwise allowable as a deduction for retiree prescription drug expenses is reduced by the amount of the excludable subsidy payments received.

For example, assume a company receives a subsidy of \$28 with respect to eligible drug expenses of \$100. The \$28 is excludable from income under section 139A, and the amount otherwise allowable as a deduction is reduced by the \$28. Thus, if the company otherwise meets the requirements of section 162 with respect to its eligible drug expenses, it would be entitled to an ordinary business expense deduction of \$72.

### **Effective Date**

The provision is effective for taxable years beginning after December 31, 2012.

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<sup>208</sup> For purposes of calculating allowable retiree costs, actual costs paid are net of discounts, chargebacks, and average percentage rebates, and exclude administrative costs.

<sup>209</sup> <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2010.pdf>. Retrieved on March 19, 2010.

<sup>210</sup> Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

**L. Modify the Itemized Deduction for Medical Expenses  
(sec. 9013 of the Senate amendment and sec. 213 of the Code)**

**Present Law**

**Regular income tax.**

For regular income tax purposes, individuals are allowed an itemized deduction for unreimbursed medical expenses, but only to the extent that such expenses exceed 7.5 percent of AGI.<sup>211</sup>

This deduction is available both to insured and uninsured individuals; thus, for example, an individual with employer-provided health insurance (or certain other forms of tax-subsidized health benefits) may also claim the itemized deduction for the individual's medical expenses not covered by that insurance if the 7.5 percent AGI threshold is met. The medical deduction encompasses health insurance premiums to the extent they have not been excluded from taxable income through the employer exclusion or self-insured deduction.

**Alternative minimum tax.**

For purposes of the alternative minimum tax ("AMT"), medical expenses are deductible only to the extent that they exceed 10 percent of AGI.

**Explanation of Provision**

This provision increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5 percent of AGI to 10 percent of AGI for regular income tax purposes. However, for the years 2013, 2014, 2015 and 2016, if either the taxpayer or the taxpayer's spouse turns 65 before the end of the taxable year, the increased threshold does not apply and the threshold remains at 7.5 percent of AGI. The provision does not change the AMT treatment of the itemized deduction for medical expenses.

**Effective Date**

The provision is effective for taxable years beginning after December 31, 2012.

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<sup>211</sup> Sec. 213.

**M. Limitation on Deduction for Remuneration Paid by Health Insurance Providers  
(sec. 9014 of the Senate amendment and sec. 162 of the Code)**

**Present Law**

An employer generally may deduct reasonable compensation for personal services as an ordinary and necessary business expense. Section 162(m) provides explicit limitations on the deductibility of compensation expenses in the case of corporate employers.

**Section 162(m)**

**In general**

The otherwise allowable deduction for compensation paid or accrued with respect to a covered employee of a publicly held corporation<sup>212</sup> is limited to no more than \$1 million per year.<sup>213</sup> The deduction limitation applies when the deduction would otherwise be taken. Thus, for example, in the case of compensation resulting from a transfer of property in connection with the performance of services, such compensation is taken into account in applying the deduction limitation for the year for which the compensation is deductible under section 83 (i.e., generally the year in which the employee's right to the property is no longer subject to a substantial risk of forfeiture).

**Covered employees**

Section 162(m) defines a covered employee as (1) the chief executive officer of the corporation (or an individual acting in such capacity) as of the close of the taxable year and (2) the four most highly compensated officers for the taxable year (other than the chief executive officer). Treasury regulations under section 162(m) provide that whether an employee is the chief executive officer or among the four most highly compensated officers should be determined pursuant to the executive compensation disclosure rules promulgated under the Securities Exchange Act of 1934 ("Exchange Act").

In 2006, the Securities and Exchange Commission amended certain rules relating to executive compensation, including which executive officers' compensation must be disclosed under the Exchange Act. Under the new rules, such officers consist of (1) the principal executive officer (or an individual acting in such capacity), (2) the principal financial officer (or an individual acting in such capacity), and (3) the three most highly compensated executive officers, other than the principal executive officer or financial officer. In response to the Securities and

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<sup>212</sup> A corporation is treated as publicly held if it has a class of common equity securities that is required to be registered under section 12 of the Securities Exchange Act of 1934.

<sup>213</sup> Sec. 162(m). This deduction limitation applies for purposes of the regular income tax and the alternative minimum tax.

Exchange Commission's new disclosure rules, the IRS issued updated guidance on identifying which employees are covered by section 162(m).<sup>214</sup>

### Remuneration subject to the limit

Unless specifically excluded, the deduction limitation applies to all remuneration for services, including cash and the cash value of all remuneration (including benefits) paid in a medium other than cash. If an individual is a covered employee for a taxable year, the deduction limitation applies to all compensation not explicitly excluded from the deduction limitation, regardless of whether the compensation is for services as a covered employee and regardless of when the compensation was earned. The \$1 million cap is reduced by excess parachute payments (as defined in sec. 280G, discussed below) that are not deductible by the corporation.

Certain types of compensation are not subject to the deduction limit and are not taken into account in determining whether other compensation exceeds \$1 million. The following types of compensation are not taken into account: (1) remuneration payable on a commission basis; (2) remuneration payable solely on account of the attainment of one or more performance goals if certain outside director and shareholder approval requirements are met ("performance-based compensation"); (3) payments to a tax-qualified retirement plan (including salary reduction contributions); (4) amounts that are excludable from the executive's gross income (such as employer-provided health benefits and miscellaneous fringe benefits<sup>215</sup>); and (5) any remuneration payable under a written binding contract which was in effect on February 17, 1993.

Remuneration does not include compensation for which a deduction is allowable after a covered employee ceases to be a covered employee. Thus, the deduction limitation often does not apply to deferred compensation that is otherwise subject to the deduction limitation (e.g., is not performance-based compensation) because the payment of compensation is deferred until after termination of employment.

### **Executive compensation of employers participating in the Troubled Assets Relief Program**

#### In general

Under section 162(m)(5), the deduction limit is reduced to \$500,000 in the case of otherwise deductible compensation of a covered executive for any applicable taxable year of an applicable employer.

An applicable employer means any employer from which one or more troubled assets are acquired under the "troubled assets relief program" ("TARP") established by the Emergency Stabilization Act of 2008<sup>216</sup> ("EESA") if the aggregate amount of the assets so acquired for all

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<sup>214</sup> Notice 2007-49, 2007-25 I.R.B. 1429.

<sup>215</sup> Sec. 132.

<sup>216</sup> Pub. L. No. 110-343.

taxable years (including assets acquired through a direct purchase by the Treasury Department, within the meaning of section 113(c) of Title I of EESA) exceeds \$300,000,000. However, such term does not include any employer from which troubled assets are acquired by the Treasury Department solely through direct purchases (within the meaning of section 113(c) of Title I of EESA). For example, if a firm sells \$250,000,000 in assets through an auction system managed by the Treasury Department, and \$100,000,000 to the Treasury Department in direct purchases, then the firm is an applicable employer. Conversely, if all \$350,000,000 in sales take the form of direct purchases, then the firm would not be an applicable employer.

Unlike section 162(m), an applicable employer under this provision is not limited to publicly held corporations (or even limited to corporations). For example, an applicable employer could be a partnership if the partnership is an employer from which a troubled asset is acquired. The aggregation rules of section 414(b) and (c) apply in determining whether an employer is an applicable employer. However, these rules are applied disregarding the rules for brother-sister controlled groups and combined groups in sections 1563(a)(2) and (3). Thus, this aggregation rule only applies to parent-subsidiary controlled groups. A similar controlled group rule applies for trades and businesses under common control.

The result of this aggregation rule is that all corporations in the same controlled group are treated as a single employer for purposes of identifying the covered executives of that employer and all compensation from all members of the controlled group are taken into account for purposes of applying the \$500,000 deduction limit. Further, all sales of assets under the TARP from all members of the controlled group are considered in determining whether such sales exceed \$300,000,000.

An applicable taxable year with respect to an applicable employer means the first taxable year which includes any portion of the period during which the authorities for the TARP established under EESA are in effect (the “authorities period”) if the aggregate amount of troubled assets acquired from the employer under that authority during the taxable year (when added to the aggregate amount so acquired for all preceding taxable years) exceeds \$300,000,000, and includes any subsequent taxable year which includes any portion of the authorities period.

A special rule applies in the case of compensation that relates to services that a covered executive performs during an applicable taxable year but that is not deductible until a later year (“deferred deduction executive remuneration”), such as nonqualified deferred compensation. Under the special rule, the unused portion (if any) of the \$500,000 limit for the applicable tax year is carried forward until the year in which the compensation is otherwise deductible, and the remaining unused limit is then applied to the compensation.

For example, assume a covered executive is paid \$400,000 in cash salary by an applicable employer in 2008 (assuming 2008 is an applicable taxable year) and the covered executive earns \$100,000 in nonqualified deferred compensation (along with the right to future earnings credits) payable in 2020. Assume further that the \$100,000 has grown to \$300,000 in 2020. The full \$400,000 in cash salary is deductible under the \$500,000 limit in 2008. In 2020, the applicable employer’s deduction with respect to the \$300,000 will be limited to \$100,000 (the lesser of the \$300,000 in deductible compensation before considering the special limitation,

and \$500,000 less \$400,000, which represents the unused portion of the \$500,000 limit from 2008).

Deferred deduction executive remuneration that is properly deductible in an applicable taxable year (before application of the limitation under the provision) but is attributable to services performed in a prior applicable taxable year is subject to the special rule described above and is not double-counted. For example, assume the same facts as above, except that the nonqualified deferred compensation is deferred until 2009 and that 2009 is an applicable taxable year. The employer's deduction for the nonqualified deferred compensation for 2009 would be limited to \$100,000 (as in the example above). The limit that would apply under the provision for executive remuneration that is in a form other than deferred deduction executive remuneration and that is otherwise deductible for 2009 is \$500,000. For example, if the covered executive is paid \$500,000 in cash compensation for 2009, all \$500,000 of that cash compensation would be deductible in 2009 under the provision.

#### Covered executive

The term covered executive means any individual who is the chief executive officer or the chief financial officer of an applicable employer, or an individual acting in that capacity, at any time during a portion of the taxable year that includes the authorities period. It also includes any employee who is one of the three highest compensated officers of the applicable employer for the applicable taxable year (other than the chief executive officer or the chief financial officer and only taking into account employees employed during any portion of the taxable year that includes the authorities period).<sup>217</sup>

#### Executive remuneration

The provision generally incorporates the present law definition of applicable employee remuneration. However, the present law exceptions for remuneration payable on commission and performance-based compensation do not apply for purposes of the \$500,000 limit. In addition, the \$500,000 limit only applies to executive remuneration which is attributable to services performed by a covered executive during an applicable taxable year. For example, assume the same facts as in the example above, except that the covered executive also receives in 2008 a payment of \$300,000 in nonqualified deferred compensation that was attributable to services performed in 2006. Such payment is not treated as executive remuneration for purposes of the \$500,000 limit.

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<sup>217</sup> The determination of the three highest compensated officers is made on the basis of the shareholder disclosure rules for compensation under the Exchange Act, except to the extent that the shareholder disclosure rules are inconsistent with the provision. Such shareholder disclosure rules are applied without regard to whether those rules actually apply to the employer under the Exchange Act. If an employee is a covered executive with respect to an applicable employer for any applicable taxable year, the employee will be treated as a covered executive for all subsequent applicable taxable years (and will be treated as a covered executive for purposes of any subsequent taxable year for purposes of the special rule for deferred deduction executive remuneration).



## **Taxation of insurance companies**

Present law provides special rules for determining the taxable income of insurance companies (subchapter L of the Code). Separate sets of rules apply to life insurance companies and to property and casualty insurance companies. Insurance companies are subject to Federal income tax at regular corporate income tax rates. An insurance company generally may deduct compensation paid in the course of its trade or business.

### **Explanation of Provision**

Under the provision, no deduction is allowed for remuneration which is attributable to services performed by an applicable individual for a covered health insurance provider during an applicable taxable year to the extent that such remuneration exceeds \$500,000. As under section 162(m)(5) for remuneration from TARP participants, the exceptions for performance based remuneration, commissions, or remuneration under existing binding contracts do not apply. This \$500,000 deduction limitation applies without regard to whether such remuneration is paid during the taxable year or a subsequent taxable year. In applying this rule, rules similar to those in section 162(m)(5)(A)(ii) apply. Thus in the case of remuneration that relates to services that an applicable individual performs during a taxable year but that is not deductible until a later year, such as nonqualified deferred compensation, the unused portion (if any) of the \$500,000 limit for the year is carried forward until the year in which the compensation is otherwise deductible, and the remaining unused limit is then applied to the compensation.

In determining whether the remuneration of an applicable individual for a year exceeds \$500,000, all remuneration from all members of any controlled group of corporations (within the meaning of section 414(b)), other businesses under common control (within the meaning of section 414(c)), or affiliated service group (within the meaning of sections 414(m) and (o)) are aggregated.

### **Covered health insurance provider and applicable taxable year**

An insurance provider is a covered health insurance provider if at least 25 percent of the insurance provider's gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements in the bill ("covered health insurance provider"). A taxable year is an applicable taxable year for an insurance provider if an insurance provider is a covered insurance provider for any portion of the taxable year. Employers with self-insured plans are excluded from the definition of covered health insurance provider.

### **Applicable individual**

Applicable individuals include all officers, employees, directors, and other workers or service providers (such as consultants) performing services for or on behalf of a covered health insurance provider. Thus, in contrast to the general rules under section 162(m) and the special rules executive compensation of employers participating in the TARP program, the limitation on the deductibility of remuneration from a covered health insurance provided is not limited to a small group of officers and covered executives but generally applies to remuneration of all employees and service providers. If an individual is an applicable individual with respect to a

covered health insurance provider for any taxable year, the individual is treated as an applicable individual for all subsequent taxable years (and is treated as an applicable individual for purposes of any subsequent taxable year for purposes of the special rule for deferred remuneration).

**Effective Date**

The provision is effective for remuneration paid in taxable years beginning after 2012 with respect to services performed after 2009.

**N. Additional Hospital Insurance Tax on High Income Taxpayers  
(sec. 9015<sup>218</sup> of the Senate amendment and new secs. 3101 and 1401 of the Code)**

**Present Law**

**Federal Insurance Contributions Act tax**

The Federal Insurance Contributions Act imposes tax on employers based on the amount of wages paid to an employee during the year. The tax imposed is composed of two parts: (1) the old age, survivors, and disability insurance (“OASDI”) tax equal to 6.2 percent of covered wages up to the taxable wage base (\$106,800 in 2010); and (2) the HI tax amount equal to 1.45 percent of covered wages. Generally, covered wages means all remuneration for employment, including the cash value of all remuneration (including benefits) paid in any medium other than cash. Certain exceptions from covered wages are also provided. In addition to the tax on employers, each employee is subject to FICA taxes equal to the amount of tax imposed on the employer.

The employee portion of the FICA tax generally must be withheld and remitted to the Federal government by the employer.<sup>219</sup> The employer generally is liable for the amount of this tax whether or not the employer withholds the amount from the employee’s wages.<sup>220</sup> In the event that the employer fails to withhold from an employee, the employee generally is not liable to the IRS for the amount of the tax. However, if the employer pays its liability for the amount of the tax not withheld, the employer generally has a right to collect that amount from the employee. Further, if the employer deducts and pays the tax the employer is indemnified against the claims and demands of any person for the amount of any payment of the tax made by the employer.<sup>221</sup>

**Self-Employment Contributions Act tax**

As a parallel to FICA taxes, the Self-Employment Contributions Act (“SECA”) imposes taxes on the net income from self employment of self employed individuals. The rate of the OASDI portion of SECA taxes is equal to the combined employee and employer OASDI FICA tax rates and applies to self employment income up to the FICA taxable wage base. Similarly, the rate of the HI portion is the same as the combined employer and employee HI rates and there is no cap on the amount of self employment income to which the rate applies.<sup>222</sup>

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<sup>218</sup> Section 9015 of the Senate bill is amended by section 10906 of the Senate bill.

<sup>219</sup> Sec. 3102(a).

<sup>220</sup> Sec. 3102(b).

<sup>221</sup> *Ibid.*

<sup>222</sup> For purposes of computing net earnings from self employment, taxpayers are permitted a deduction equal to the product of the taxpayer’s earnings (determined without regard to this deduction) and one-half of the sum of the rates for OASDI (12.4 percent) and HI (2.9 percent), i.e., 7.65 percent of net earnings. This deduction reflects

For purposes of computing net earnings from self employment, taxpayers are permitted a deduction equal to the product of the taxpayer's earnings (determined without regard to this deduction) and one-half of the sum of the rates for OASDI (12.4 percent) and HI (2.9 percent), i.e., 7.65 percent of net earnings. This deduction reflects the fact that the FICA rates apply to an employee's wages, which do not include FICA taxes paid by the employer, whereas the self-employed individual's net earnings are economically equivalent to an employee's wages plus the employer share of FICA taxes.

### **Explanation of Provision**

#### **Additional HI tax on employee portion of HI tax**

##### Calculation of additional tax

The employee portion of the HI tax is increased by an additional tax of 0.9 percent on wages<sup>223</sup> received in excess of the threshold amount. However, unlike the general 1.45 percent HI tax on wages, this additional tax is on the combined wages of the employee and the employee's spouse, in the case of a joint return. The threshold amount is \$250,000 in the case of a joint return or surviving spouse, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case.

##### Liability for the additional HI tax on wages

As under present law, the employer is required to withhold the additional HI tax on wages but is liable for the tax if the employer fails to withhold the amount of the tax from wages, or collect the tax from the employee if the employer fails to withhold. However, in determining the employer's requirement to withhold and liability for the tax, only wages that the employee receives from the employer in excess of \$200,000 for a year are taken into account and the employer must disregard the amount of wages received by the employee's spouse. Thus, the employer is only required to withhold on wages in excess of \$200,000 for the year, even though the tax may apply to a portion of the employee's wages at or below \$200,000, if the employee's spouse also has wages for the year, they are filing a joint return, and their total combined wages for the year exceed \$250,000.

For example, if a taxpayer's spouse has wages in excess of \$250,000 and the taxpayer has wages of \$100,000, the employer of the taxpayer is not required to withhold any portion of the additional tax, even though the combined wages of the taxpayer and the taxpayer's spouse are over the \$250,000 threshold. In this instance, the employer of the taxpayer's spouse is obligated to withhold the additional 0.9-percent HI tax with respect to the \$50,000 above the threshold with respect to the wages of \$250,000 for the taxpayer's spouse.

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the fact that the FICA rates apply to an employee's wages, which do not include FICA taxes paid by the employer, whereas the self-employed individual's net earnings are economically equivalent to an employee's wages plus the employer share of FICA taxes.

<sup>223</sup> Sec. 3121(a).

In contrast to the employee portion of the general HI tax of 1.45 percent of wages for which the employee generally has no direct liability to the IRS to pay the tax, the employee is also liable for this additional 0.9-percent HI tax to the extent the tax is not withheld by the employer. The amount of this tax not withheld by an employer must also be taken into account in determining a taxpayer's liability for estimated tax.

### **Additional HI for self-employed individuals**

This same additional HI tax applies to the HI portion of SECA tax on self-employment income in excess of the threshold amount. Thus, an additional tax of 0.9 percent is imposed on every self-employed individual on self-employment income<sup>224</sup> in excess of the threshold amount.

As in the case of the additional HI tax on wages, the threshold amount for the additional SECA HI tax is \$250,000 in the case of a joint return or surviving spouse, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case. The threshold amount is reduced (but not below zero) by the amount of wages taken into account in determining the FICA tax with respect to the taxpayer. No deduction is allowed under section 164(f) for the additional SECA tax, and the deduction under 1402(a)(12) is determined without regard to the additional SECA tax rate.

### **Effective Date**

The provision applies to remuneration received and taxable years beginning after December 31, 2012.

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<sup>224</sup> Sec. 1402(b).

**O. Modification of Section 833 Treatment of Certain Health Organizations  
(sec. 9010 of the Senate amendment and sec. 833 of the Code)**

**Present Law**

A property and casualty insurance company is subject to tax on its taxable income, generally defined as its gross income less allowable deductions (sec. 832). For this purpose, gross income includes underwriting income and investment income, as well as other items. Underwriting income is the premiums earned on insurance contracts during the year, less losses incurred and expenses incurred. The amount of losses incurred is determined by taking into account the discounted unpaid losses. Premiums earned during the year is determined taking into account a 20-percent reduction in the otherwise allowable deduction, intended to represent the allocable portion of expenses incurred in generating the unearned premiums (sec. 832(b)(4)(B)).

Present law provides that an organization described in sections 501(c)(3) and (4) of the Code is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance (sec. 501(m)). When this rule was enacted in 1986,<sup>225</sup> special rules were provided under section 833 for Blue Cross and Blue Shield organizations providing health insurance that (1) were in existence on August 16, 1986; (2) were determined at any time to be tax-exempt under a determination that had not been revoked; and (3) were tax-exempt for the last taxable year beginning before January 1, 1987 (when the present-law rule became effective), provided that no material change occurred in the structure or operations of the organizations after August 16, 1986, and before the close of 1986 or any subsequent taxable year. Any other organization is eligible for section 833 treatment if it meets six requirements set forth in section 833(c): (1) substantially all of its activities involve providing health insurance; (2) at least 10 percent of its health insurance is provided to individuals and small groups (not taking into account Medicare supplemental coverage); (3) it provides continuous full-year open enrollment for individuals and small groups; (4) for individuals, it provides full coverage of pre-existing conditions of high-risk individuals and coverage without regard to age, income, or employment of individuals under age 65; (5) at least 35 percent of its premiums are community rated; and (6) no part of its net earnings inures to the benefit of any private shareholder or individual.

Section 833 provides a deduction with respect to health business of such organizations. The deduction is equal to 25 percent of the sum of (1) claims incurred, and liabilities incurred under cost-plus contracts, for the taxable year, and (2) expenses incurred in connection with administration, adjustment, or settlement of claims or in connection with administration of cost-plus contracts during the taxable year, to the extent this sum exceeds the adjusted surplus at the beginning of the taxable year. Only health-related items are taken into account.

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<sup>225</sup> See H. Rep. 99-426, Tax Reform Act of 1985, (December 7, 1985) at 664. The Committee stated, “[T]he availability of tax-exempt status under [then-]present law has allowed some large insurance entities to compete directly with commercial insurance companies. For example, the Blue Cross/Blue Shield organizations historically have been treated as tax-exempt organizations described in sections 501(c)(3) or (4). This group of organizations is now among the largest health care insurers in the United States.” See also Joint Committee on Taxation, General Explanation of the Tax Reform Act of 1986, JCS-10-87 (May 4, 1987) at 583-592.

Section 833 provides an exception for such an organization from the application of the 20-percent reduction in the deduction for increases in unearned premiums that applies generally to property and casualty companies.

Section 833 provides that such an organization is taxable as a stock property and casualty insurer under the Federal income tax rules applicable to property and casualty insurers.

#### **Explanation of Provision**

The provision limits eligibility for the rules of section 833 to those organizations meeting a medical loss ratio standard of 85 percent for the taxable year. Thus, under the provision, an organization that does not meet the 85-percent standard is not allowed the 25-percent deduction and the exception from the 20-percent reduction in the unearned premium reserve deduction under section 833.

For this purpose, an organization's medical loss ratio is determined as the percentage of total premium revenue expended on reimbursement for clinical services that are provided to enrollees under the organization's policies during the taxable year, as reported under section 2718 of the PHSA.

It is intended that the medical loss ratio under this provision be determined on an organization-by-organization basis, not on an affiliated or other group basis, and that Treasury Department guidance be promulgated promptly to carry out the purposes of the provision.

#### **Effective Date**

The provision is effective for taxable years beginning after December 31, 2009.

**P. Excise Tax on Indoor Tanning Services**  
**(sec. 9017<sup>226</sup> of the Senate amendment and new sec. 5000B of the Code)**

**Present Law**

There is no tax on indoor tanning services under present law.

**Explanation of Provision**

**In general**

The provision imposes a tax on each individual on whom indoor tanning services are performed. The tax is equal to 10 percent of the amount paid for indoor tanning services.

For purposes of the provision, indoor tanning services are services employing any electronic product designed to induce skin tanning and which incorporate one or more ultraviolet lamps and intended for the irradiation of an individual by ultraviolet radiation, with wavelengths in air between 200 and 400 nanometers. Indoor tanning services do not include any phototherapy service performed by a licensed medical professional.

**Payment of tax**

The tax is paid by the individual on whom the indoor tanning services are performed. The tax is collected by each person receiving a payment for tanning services on which a tax is imposed. If the tax is not paid by the person receiving the indoor tanning services at the time the payment for the service is received, the person performing the procedure pays the tax.

Payment of the tax is remitted quarterly to the Secretary by the person collecting the tax. The Secretary is given discretion over the manner of the payment.

**Effective Date**

The provision applies to services performed on or after July 1, 2010.

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<sup>226</sup> Section 9017 of the Senate amendment, as amended by section 10907.



**Q. Exclusion of Health Benefits Provided by Indian Tribal Governments  
(sec. 9021 of the Senate amendment and new sec. 139D of the Code)**

**Present Law**

Present law generally provides that gross income includes all income from whatever source derived.<sup>227</sup> Exclusions from income are provided, however, for certain health care benefits.

**Exclusion from income for employer-provided health coverage**

Employees generally are not taxed on (that is, may “exclude” from gross income) the value of employer-provided health coverage under an accident or health plan.<sup>228</sup> In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.<sup>229</sup> As with cash or other compensation, the amount paid by employers for employer-provided health coverage is a deductible business expense. Unlike other forms of compensation, however, if an employer contributes to a plan providing health coverage for employees (and the employees’ spouses and dependents), the value of the coverage and all benefits (including reimbursements) in the form of medical care under the plan are excludable from the employees’ income for income tax purposes.<sup>230</sup> The exclusion applies both to health coverage in the case in which an employer absorbs the cost of employees’ medical expenses not covered by insurance (i.e., a self-insured plan) as well as in the case in which the employer purchases health insurance coverage for its employees. There is no limit on the amount of employer-provided health coverage that is excludable.

In addition, employees participating in a cafeteria plan may be able to pay the portion of premiums for health insurance coverage not otherwise paid for by their employers on a pre-tax basis through salary reduction.<sup>231</sup> Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

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<sup>227</sup> Sec. 61.

<sup>228</sup> Sec 106.

<sup>229</sup> Sec. 105(b).

<sup>230</sup> Secs. 104, 105, 106, 125. A similar rule excludes employer provided health insurance coverage and reimbursements for medical expenses from the employees’ wages for payroll tax purposes under sections 3121(a)(2), and 3306(a)(2). Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludable under section 134. That section provides an exclusion for “qualified military benefits,” defined as benefits received by reason of status or service as a member of the uniformed services and which were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

<sup>231</sup> Sec. 125.

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage.

### **The general welfare exclusion**

Under the general welfare exclusion doctrine, certain payments made to individuals are excluded from gross income. The exclusion has been interpreted to cover payments by governmental units under legislatively provided social benefit programs for the promotion of the general welfare.<sup>232</sup>

The general welfare exclusion generally applies if the payments: (1) are made from a governmental fund, (2) are for the promotion of general welfare (on the basis of the need of the recipient), and (3) do not represent compensation for services.<sup>233</sup> A representative of the IRS recently expressed the view that the general welfare exclusion does not apply to persons with significant income or assets, and that any such extension would represent a departure from well-established administrative practice.<sup>234</sup> The representative further expressed the view that

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<sup>232</sup> See, e.g., Rev. Rul. 78-170, 1978-1 C.B. 24 (government payments to assist low-income persons with utility costs are not income); Rev. Rul. 76-395, 1976-2 C.B. 16, 17 (government grants to assist low-income city inhabitants to refurbish homes are not income); Rev. Rul. 76-144, 1976-1 C.B. 17 (government grants to persons eligible for relief under the Disaster Relief Act of 1974 are not income); Rev. Rul. 74-153, 1974-1 C.B. 20 (government payments to assist adoptive parents with support and maintenance of adoptive children are not income); Rev. Rul. 74-205, 1974-1 C.B. 20 (replacement housing payments received by individuals under the Housing and Urban Development Act of 1968 are not includible in gross income); Gen. Couns. Mem. 34506 (May 26, 1971) (federal mortgage assistance payments excluded from income under general welfare exception); Rev. Rul. 57-102, 1957-1 C.B. 26 (government benefits paid to blind persons are not income). The courts have also acknowledged the existence of this doctrine. See, e.g., *Bailey v. Commissioner*, 88 T.C. 1293, 1299-1301 (1987) (new building façade paid for by urban renewal agency on taxpayer's property under facade grant program not considered payments under general welfare doctrine because awarded without regard to any need of the recipients); *Graff v. Commissioner*, 74 TC 743, 753-754 (1980) (court acknowledged that rental subsidies under Housing Act were excludable under general welfare doctrine but found that payments at issue made by HUD on taxpayer landlord's behalf were taxable income to him), *affd. per curiam* 673 F.2d 784 (5th Cir. 1982).

<sup>233</sup> See Rev. Rul. 98-19, 1998-1 C.B. 840 (excluding relocation payments made by local governments to those whose homes were damaged by floods). Recent guidance as to whether the need of the recipient (taken into account under the second requirement of the general welfare exclusion) must be based solely on financial means or whether the need can be based on a variety of other considerations including health, educational background, or employment status, has been mixed. Chief Couns. Adv. 200021036 (May 25, 2000) (excluding state adoption assistant payments made to individuals adopting special needs children without regard to financial means of parents; the children were considered to be the recipients); Priv. Ltr. Rul. 200632005 (April 13, 2006) (excluding payments made by Tribe to members based on multiple factors of need pursuant to housing assistance program); Chief Couns. Adv. 200648027 (Jul 25, 2006) (excluding subsidy payments based on financial need of recipient made by state to certain participants in state health insurance program to reduce cost of health insurance premiums).

<sup>234</sup> Testimony of Sarah H. Ingram, Commissioner, Tax Exempt and Government Entities, Internal Revenue Service, before the Senate Committee on Indian Affairs, *Oversight Hearing to Examine the Federal Tax Treatment of Health Care Benefits Provided by Tribal Governments to Their Citizens*, September 17, 2009.

application of the general welfare exclusion to an Indian tribal government providing coverage or benefits to tribal members is dependent upon the structure and administration of the particular program.<sup>235</sup>

### **Explanation of Provision**

The provision allows an exclusion from gross income for the value of specified Indian tribe health care benefits. The exclusion applies to the value of: (1) health services or benefits provided or purchased by the Indian Health Service (“IHS”), either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the IHS;<sup>236</sup> (2) medical care (in the form of provided or purchased medical care services, accident or health insurance or an arrangement having the same effect, or amounts paid directly or indirectly, to reimburse the member for expenses incurred for medical care) provided by an Indian tribe or tribal organization to a member of an Indian tribe, including the member’s spouse or dependents;<sup>237</sup> (3) accident or health plan coverage (or an arrangement having the same effect) provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, including the member’s spouse or dependents; and (4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for the programs and services provided by the Federal government to Indian tribes or Indians.

This provision does not apply to any amount which is deducted or excluded from gross income under another provision of the Code.

No change made by the provision is intended to create an inference with respect to the exclusion from gross income of benefits provided prior to the date of enactment. Additionally, no inference is intended with respect to the tax treatment of other benefits provided by an Indian tribe or tribal organization not covered by this provision.

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<sup>235</sup> *Ibid.*

<sup>236</sup> The term “Indian tribe” means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined by, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et. seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. The term “tribal organization” has the same meaning as such term in section 4(1) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(1)).

<sup>237</sup> The terms “accident or health insurance” and “accident or health plan” have the same meaning as when used in section 105. The term “medical care” is the same as the definition under section 213. For purposes of the provision, dependents are determined under section 152, but without regard to subsections (b)(1), (b)(2), and (d)(1)(B). Section 152(b)(1) generally provides that if an individual is a dependent of another taxpayer during a taxable year such individual is treated as having no dependents for such taxable year. Section 152(b)(2) provides that a married individual filing a joint return with his or her spouse is not treated as a dependent of a taxpayer. Section 152(d)(1)(B) provides that a “qualifying relative” (i.e., a relative that qualifies as a dependent) does not include a person whose gross income for the calendar year in which the taxable year begins equals or exceeds the exempt amount (as defined under section 151).

**Effective Date**

The provision applies to benefits and coverage provided after the date of enactment.

**R. Require Information Reporting on Payments to Corporations  
(sec. 9006 of the Senate amendment and sec. 6041 of the Code)<sup>238</sup>**

**Present Law**

Present law imposes a variety of information reporting requirements on participants in certain transactions.<sup>239</sup> These requirements are intended to assist taxpayers in preparing their income tax returns and to help the IRS determine whether such returns are correct and complete.

The primary provision governing information reporting by payors requires an information return by every person engaged in a trade or business who makes payments aggregating \$600 or more in any taxable year to a single payee in the course of that payor's trade or business.<sup>240</sup> Payments subject to reporting include fixed or determinable income or compensation, but do not include payments for goods or certain enumerated types of payments that are subject to other specific reporting requirements.<sup>241</sup> The payor is required to provide the recipient of the payment with an annual statement showing the aggregate payments made and contact information for the payor.<sup>242</sup> The regulations generally except from reporting, payments to corporations, exempt organizations, governmental entities, international organizations, or retirement plans.<sup>243</sup> However, the following types of payments to corporations must be reported: Medical and healthcare payments;<sup>244</sup> fish purchases for cash;<sup>245</sup> attorney's fees;<sup>246</sup> gross proceeds paid to an

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<sup>238</sup> This description is based upon the discussion at page 334 in S. Report 111-89, final Committee Report of the Senate Finance Committee on "America's Healthy Future Act of 2009," published October 21, 2009.

<sup>239</sup> Secs. 6031 through 6060.

<sup>240</sup> Sec. 6041(a). The information return is generally submitted electronically as a Form-1099 or Form-1096, although certain payments to beneficiaries or employees may require use of Forms W-3 or W-2, respectively. Treas. Reg. sec. 1.6041-1(a)(2).

<sup>241</sup> Sec. 6041(a) requires reporting as to "other fixed or determinable gains, profits, and income (other than payments to which section 6042(a)(1), 6044(a)(1), 6047(c), 6049(a) or 6050N(a) applies and other than payments with respect to which a statement is required under authority of section 6042(a), 6044(a)(2) or 6045[.])" These excepted payments include most interest, royalties, and dividends.

<sup>242</sup> Sec. 6041(d).

<sup>243</sup> Treas. Reg. sec. 1.6041-3(p). Certain for-profit health provider corporations are not covered by this general exception, including those organizations providing billing services for such companies.

<sup>244</sup> Sec. 6050T.

<sup>245</sup> Sec. 6050R.

<sup>246</sup> Sec. 6045(f)(1) and (2); Treas. Reg. secs. 1.6041-1(d)(2) and 1.6045-5(d)(5).

attorney;<sup>247</sup> substitute payments in lieu of dividends or tax-exempt interest;<sup>248</sup> and payments by a Federal executive agency for services.<sup>249</sup>

Failure to comply with the information reporting requirements results in penalties, which may include a penalty for failure to file the information return,<sup>250</sup> and a penalty for failure to furnish payee statements<sup>251</sup> or failure to comply with other various reporting requirements.<sup>252</sup>

Detailed rules are provided for the reporting of various types of investment income, including interest, dividends, and gross proceeds from brokered transactions (such as a sale of stock).<sup>253</sup> In general, the requirement to file Form 1099 applies with respect to amounts paid to U.S. persons and is linked to the backup withholding rules of section 3406. Thus, a payor of interest, dividends or gross proceeds generally must request that a U.S. payee (other than certain exempt recipients) furnish a Form W-9 providing that person's name and taxpayer identification number.<sup>254</sup> That information is then used to complete the Form 1099.

### **Explanation of Provision**

Under the provision, a business is required to file an information return for all payments aggregating \$600 or more in a calendar year to a single payee (other than a payee that is a tax-exempt corporation), notwithstanding any regulation promulgated under section 6041 prior to the date of enactment. The payments to be reported include gross proceeds paid in consideration for property or services. However, the provision does not override specific provisions elsewhere in the Code that except certain payments from reporting, such as securities or broker transactions as defined under section 6045(a) and the regulations thereunder.

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<sup>247</sup> *Ibid.*

<sup>248</sup> Sec. 6045(d).

<sup>249</sup> Sec. 6041(d)(3).

<sup>250</sup> Sec. 6721. The penalty for the failure to file an information return generally is \$50 for each return for which such failure occurs. The total penalty imposed on a person for all failures during a calendar year cannot exceed \$250,000. Additionally, special rules apply to reduce the per-failure and maximum penalty where the failure is corrected within a specified period.

<sup>251</sup> Sec. 6722. The penalty for failure to provide a correct payee statement is \$50 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed \$100,000. Special rules apply that increase the per-statement and total penalties where there is intentional disregard of the requirement to furnish a payee statement.

<sup>252</sup> Sec. 6723. The penalty for failure to timely comply with a specified information reporting requirement is \$50 per failure, not to exceed \$100,000 for a calendar year.

<sup>253</sup> Secs. 6042 (dividends), 6045 (broker reporting) and 6049 (interest) and the Treasury regulations thereunder.

<sup>254</sup> See Treas. Reg. sec. 31.3406(h)-3.

**Effective Date**

The provision is effective for payments made after December 31, 2011.

**S. Establishment of SIMPLE Cafeteria Plans for Small Businesses  
(sec. 9022 of the Senate amendment and sec. 125 of the Code)**

**Present Law**

**Definition of a cafeteria plan**

If an employee receives a qualified benefit (as defined below) based on the employee's election between the qualified benefit and a taxable benefit under a cafeteria plan, the qualified benefit generally is not includable in gross income.<sup>255</sup> However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the requirements for being a cafeteria plan, the election between taxable and nontaxable benefits results in gross income to the employee, regardless of what benefit is elected and when the election is made.<sup>256</sup> A cafeteria plan is a separate written plan under which all participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit. Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in sections 125(d)(2)(B), (C), or (D).

**Qualified benefits**

Qualified benefits under a cafeteria plan are generally employer-provided benefits that are not includable in gross income under an express provision of the Code. Examples of qualified benefits include employer-provided health insurance coverage, group term life insurance coverage not in excess of \$50,000, and benefits under a dependent care assistance program. In order to be excludable, any qualified benefit elected under a cafeteria plan must independently satisfy any requirements under the Code section that provides the exclusion. However, some employer-provided benefits that are not includable in gross income under an express provision of the Code are explicitly not allowed in a cafeteria plan. These benefits are generally referred to as nonqualified benefits. Examples of nonqualified benefits include scholarships,<sup>257</sup> employer-provided meals and lodging,<sup>258</sup> educational assistance,<sup>259</sup> and fringe benefits.<sup>260</sup> A plan offering any nonqualified benefit is not a cafeteria plan.<sup>261</sup>

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<sup>255</sup> Sec. 125(a).

<sup>256</sup> Proposed Treas. Reg. sec. 1.125-1(b).

<sup>257</sup> Sec. 117.

<sup>258</sup> Sec. 119.

<sup>259</sup> Sec.127.

<sup>260</sup> Sec. 132.

<sup>261</sup> Proposed Treas. Reg. sec. 1.125-1(q). Long-term care services, contributions to Archer Medical Savings Accounts, group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits.



## **Employer contributions through salary reduction**

Employees electing a qualified benefit through salary reduction are electing to forego salary and instead to receive a benefit that is excludible from gross income because it is provided by employer contributions. Section 125 provides that the employee is treated as receiving the qualified benefit from the employer in lieu of the taxable benefit. For example, active employees participating in a cafeteria plan may be able to pay their share of premiums for employer-provided health insurance on a pre-tax basis through salary reduction.<sup>262</sup>

## **Nondiscrimination requirements**

Cafeteria plans and certain qualified benefits (including group term life insurance, self-insured medical reimbursement plans, and dependent care assistance programs) are subject to nondiscrimination requirements to prevent discrimination in favor of highly compensated individuals generally as to eligibility for benefits and as to actual contributions and benefits provided. There are also rules to prevent the provision of disproportionate benefits to key employees (within the meaning of section 416(i)) through a cafeteria plan.<sup>263</sup> Although the basic purpose of each of the nondiscrimination rules is the same, the specific rules for satisfying the relevant nondiscrimination requirements, including the definition of highly compensated individual,<sup>264</sup> vary for cafeteria plans generally and for each qualified benefit. An employer maintaining a cafeteria plan in which any highly compensated individual participates must make sure that both the cafeteria plan and each qualified benefit satisfies the relevant nondiscrimination requirements, as a failure to satisfy the nondiscrimination rules generally results in a loss of the tax exclusion by the highly compensated individuals.

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<sup>262</sup> Sec. 125.

<sup>263</sup> A key employee generally is an employee who, at any time during the year is (1) a five-percent owner of the employer, or (2) a one-percent owner with compensation of more than \$150,000 (not indexed for inflation), or (3) an officer with compensation more than \$160,000 (for 2010). A special rule limits the number of officers treated as key employees. If the employer is a corporation, a five-percent owner is a person who owns more than five percent of the outstanding stock or stock possessing more than five percent of the total combined voting power of all stock. If the employer is not a corporation, a five-percent owner is a person who owns more than five percent of the capital or profits interest. A one-percent owner is determined by substituting one percent for five percent in the preceding definitions. For purposes of determining employee ownership in the employer, certain attribution rules apply.

<sup>264</sup> For cafeteria plan purposes, a “highly compensated individual” is (1) an officer, (2) a five-percent shareholder, (3) an individual who is highly compensated, or (4) the spouse or dependent of any of the preceding categories. A “highly compensated participant” is a participant who falls in any of those categories. “Highly compensated” is not defined for this purpose. Under section 105(h), a self-insured medical expense reimbursement plan must not discriminate in favor of a “highly compensated individual,” defined as (1) one of the five highest paid officers, (2) a 10-percent shareholder, or (3) an individual among the highest paid 25 percent of all employees. Under section 129 for a dependent care assistance program, eligibility for benefits, and the benefits and contributions provided, generally must not discriminate in favor of highly compensated employees within the meaning of section 414(q).

## **Explanation of Provision**

Under the provision, an eligible small employer is provided with a safe harbor from the nondiscrimination requirements for cafeteria plans as well as from the nondiscrimination requirements for specified qualified benefits offered under a cafeteria plan, including group term life insurance, benefits under a self insured medical expense reimbursement plan, and benefits under a dependent care assistance program. Under the safe harbor, a cafeteria plan and the specified qualified benefits are treated as meeting the specified nondiscrimination rules if the cafeteria plan satisfies minimum eligibility and participation requirements and minimum contribution requirements.

### **Eligibility requirement**

The eligibility requirement is met only if all employees (other than excludable employees) are eligible to participate, and each employee eligible to participate is able to elect any benefit available under the plan (subject to the terms and conditions applicable to all participants). However, a cafeteria plan will not fail to satisfy this eligibility requirement merely because the plan excludes employees who (1) have not attained the age of 21 (or a younger age provided in the plan) before the close of a plan year, (2) have fewer than 1,000 hours of service for the preceding plan year, (3) have not completed one year of service with the employer as of any day during the plan year, (4) are covered under an agreement that the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or (5) are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States). An employer may have a shorter age and service requirement but only if such shorter service or younger age applies to all employees.

### **Minimum contribution requirement**

The minimum contribution requirement is met if the employer provides a minimum contribution for each nonhighly compensated employee (employee who is not a highly compensated employee<sup>265</sup> or a key employee (within the meaning of section 416(i))) in addition to any salary reduction contributions made by the employee. The minimum must be available for application toward the cost of any qualified benefit (other than a taxable benefit) offered under the plan. The minimum contribution is permitted to be calculated under either the nonelective contribution method or the matching contribution method, but the same method must be used for calculating the minimum contribution for all nonhighly compensated employees. The minimum contribution under the nonelective contribution method is an amount equal to a uniform percentage (not less than two percent) of each eligible employee's compensation for the plan year, determined without regard to whether the employees makes any salary reduction

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<sup>265</sup> Section 414(q) generally defines a highly compensated employee as an employee (1) who was a five-percent owner during the year or the preceding year, or (2) who had compensation of \$110,000 (for 2010) or more for the preceding year. An employer may elect to limit the employees treated as highly compensated employees based upon their compensation in the preceding year to the highest paid 20 percent of employees in the preceding year. Five-percent owner is defined by cross-reference to the definition of key employee in section 416(i).

contribution under the cafeteria plan. The minimum matching contribution is the lesser of 100 percent of the amount of the salary reduction contribution elected to be made by the employee for the plan year or (2) six percent of the employee's compensation for the plan year. Compensation for purposes of this minimum contribution requirement is compensation with the meaning of section 414(s).

A simple cafeteria plan is permitted to provide for the matching contributions in addition to the minimum required but only if matching contributions with respect to salary reduction contributions for any highly compensated employee or key employee are not made at a greater rate than the matching contributions for any nonhighly compensated employee. Nothing in this provision prohibits an employer from providing qualified benefits under the plan in addition to the required contributions.

### **Eligible employer**

An eligible small employer under the provision is, with respect to any year, an employer who employed an average of 100 or fewer employees on business days during either of the two preceding years. For purposes of the provision, a year may only be taken into account if the employer was in existence throughout the year. If an employer was not in existence throughout the preceding year, the determination is based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year. If an employer was an eligible employer for any year and maintained a simple cafeteria plan for its employees for such year, then, for each subsequent year during which the employer continues, without interruption, to maintain the cafeteria plan, the employer is deemed to be an eligible small employer until the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

The determination of whether an employer is an eligible small employer is determined by applying the controlled group rules of sections 52(a) and (b) under which all members of the controlled group are treated as a single employer. In addition, the definition of employee includes leased employees within the meaning of sections 414(n) and (o).<sup>266</sup>

### **Effective Date**

The provision is effective for taxable years beginning after December 31, 2010.

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<sup>266</sup> Section 52(b) provides that, for specified purposes, all employees of all corporations which are members of a controlled group of corporations are treated as employed by a single employer. However, section 52(b) provides certain modifications to the control group rules including substituting 50 percent ownership for 80 percent ownership as the measure of control. There is a similar rule in section 52(c) under which all employees of trades or businesses (whether or not incorporated) which are under common control are treated under regulations as employed by a single employer. Section 414(n) provides rules for specified purposes when leased employees are treated as employed by the service recipient and section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements of section 414(n).

**T. Investment Credit for Qualifying Therapeutic Discovery Projects  
(sec. 9023 of the Senate amendment and new sec. 48D of the Code)**

**Present Law**

Present law provides for a research credit equal to 20 percent (14 percent in the case of the alternative simplified credit) of the amount by which the taxpayer's qualified research expenses for a taxable year exceed its base amount for that year.<sup>267</sup> Thus, the research credit is generally available with respect to incremental increases in qualified research.

A 20-percent research tax credit is also available with respect to the excess of (1) 100 percent of corporate cash expenses (including grants or contributions) paid for basic research conducted by universities (and certain nonprofit scientific research organizations) over (2) the sum of (a) the greater of two minimum basic research floors plus (b) an amount reflecting any decrease in nonresearch giving to universities by the corporation as compared to such giving during a fixed-base period, as adjusted for inflation. This separate credit computation is commonly referred to as the "university basic research credit."<sup>268</sup>

Finally, a research credit is available for a taxpayer's expenditures on research undertaken by an energy research consortium. This separate credit computation is commonly referred to as the "energy research credit." Unlike the other research credits, the energy research credit applies to all qualified expenditures, not just those in excess of a base amount.

The research credit, including the university basic research credit and the energy research credit, expired for amounts paid or incurred after December 31, 2009.<sup>269</sup>

Qualified research expenses eligible for the research tax credit consist of: (1) in-house expenses of the taxpayer for wages and supplies attributable to qualified research; (2) certain time-sharing costs for computer use in qualified research; and (3) 65 percent of amounts paid or incurred by the taxpayer to certain other persons for qualified research conducted on the taxpayer's behalf (so-called contract research expenses).<sup>270</sup> Notwithstanding the limitation for contract research expenses, qualified research expenses include 100 percent of amounts paid or incurred by the taxpayer to an eligible small business, university, or Federal laboratory for qualified energy research.

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<sup>267</sup> Sec. 41.

<sup>268</sup> Sec. 41(e).

<sup>269</sup> Sec. 41(h).

<sup>270</sup> Under a special rule, 75 percent of amounts paid to a research consortium for qualified research are treated as qualified research expenses eligible for the research credit (rather than 65 percent under the general rule of section 41(b)(3) governing contract research expenses) if (1) such research consortium is a tax-exempt organization that is described in section 501(c)(3) (other than a private foundation) or section 501(c)(6) and is organized and operated primarily to conduct scientific research, and (2) such qualified research is conducted by the consortium on behalf of the taxpayer and one or more persons not related to the taxpayer. Sec. 41(b)(3)(C).

Present law also provides a 50-percent credit<sup>271</sup> for expenses related to human clinical testing of drugs for the treatment of certain rare diseases and conditions, generally those that afflict less than 200,000 persons in the United States. Qualifying expenses are those paid or incurred by the taxpayer after the date on which the drug is designated as a potential treatment for a rare disease or disorder by the Food and Drug Administration (“FDA”) in accordance with section 526 of the Federal Food, Drug, and Cosmetic Act.

Present law does not provide a credit specifically designed to encourage investment in new therapies relating to diseases.

### **Explanation of Provision**

#### **In general**

The provision establishes a 50 percent nonrefundable investment tax credit for qualified investments in qualifying therapeutic discovery projects. The provision allocates \$1 billion during the two-year period 2009 through 2010 for the program. The Secretary, in consultation with the Secretary of HHS, will award certifications for qualified investments. The credit is available only to companies having 250 or fewer employees.<sup>272</sup>

A “qualifying therapeutic discovery project” is a project which is designed to develop a product, process, or therapy to diagnose, treat, or prevent diseases and afflictions by: (1) conducting pre-clinical activities, clinical trials, clinical studies, and research protocols, or (2) by developing technology or products designed to diagnose diseases and conditions, including molecular and companion drugs and diagnostics, or to further the delivery or administration of therapeutics.

The qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project. The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project does not include any cost for: (1) remuneration for an employee described in section 162(m)(3), (2) interest expense, (3) facility maintenance expenses, (4) a service cost identified under Treas. Reg. Sec. 1.263A-1(e)(4), or (5) any other expenditure as determined by the Secretary as appropriate to carry out the purposes of the provision.

Companies must apply to the Secretary to obtain certification for qualifying investments.<sup>273</sup> The Secretary, in determining qualifying projects, will consider only those

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<sup>271</sup> Sec. 45C.

<sup>272</sup> The number of employees is determined taking into account all businesses of the taxpayer at the time it submits an application, and is determined taking into account the rules for determining a single employer under section 52(a) or (b) or section 414(m) or (o).

<sup>273</sup> The Secretary must take action to approve or deny an application within 30 days of the submission of such application.

projects that show reasonable potential to: (1) result in new therapies to treat areas of unmet medical need or to prevent, detect, or treat chronic or acute disease and conditions, (2) reduce long-term health care costs in the United States, or (3) significantly advance the goal of curing cancer within a 30-year period. Additionally, the Secretary will take into consideration which projects would have the greatest potential to: (1) create and sustain (directly or indirectly) high quality, high paying jobs in the United States, and (2) advance the United States' competitiveness in the fields of life, biological, and medical sciences.

Qualified therapeutic discovery project expenditures do not qualify for the research credit, orphan drug credit, or bonus depreciation.<sup>274</sup> If a credit is allowed for an expenditure related to property subject to depreciation, the basis of the property is reduced by the amount of the credit. Additionally, expenditures taken into account in determining the credit are nondeductible to the extent of the credit claimed that is attributable to such expenditures.

### **Election to receive grant in lieu of tax credit**

Taxpayers may elect to receive credits that have been allocated to them in the form of Treasury grants equal to 50 percent of the qualifying investment. Any such grant is not includible in the taxpayer's gross income.

In making grants under this section, the Secretary of the Treasury is to apply rules similar to the rules of section 50. In applying such rules, if an investment ceases to be a qualified investment, the Secretary of the Treasury shall provide for the recapture of the appropriate percentage of the grant amount in such manner as the Secretary of the Treasury determines appropriate. The Secretary of the Treasury shall not make any grant under this section to: (1) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof), (2) any organization described in section 501(c) and exempt from tax under section 501(a), (3) any entity referred to in paragraph (4) of section 54(j), or (4) any partnership or other pass-thru entity any partner (or other holder of an equity or profits interest) of which is described in paragraph (1), (2) or (3).

### **Effective Date**

The provision applies to expenditures paid or incurred after December 31, 2008, in taxable years beginning after December 31, 2008.

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<sup>274</sup> Any expenses for the taxable year that are qualified research expenses under section 41(b) are taken into account in determining base period research expenses for purposes of computing the research credit under section 41 for subsequent taxable years.

**TITLE X – STRENGTHENING QUALITY, AFFORDABLE  
HEALTH CARE FOR ALL AMERICANS**

**A. Study of Geographic Variation in Application of FPL  
(sec. 10105 of the Senate amendment)**

**Present Law**

No provision.

**Explanation of Provision**

The Secretary of HHS is instructed to conduct a study on the feasibility and implication of adjusting the application of the FPL under the provisions enacted in the bill for different geographical areas so as to reflect disparities in the cost of living among different areas in the United States, including the territories. If the Secretary deems such an adjustment feasible, then the study should include a methodology for implementing the adjustment. The Secretary is required to report the results of the study to Congress no later than January 1, 2013. The provision requires that special attention be paid to the impact of disparities between the poverty levels and the cost of living in the territories and the impact of this disparity on the expansion of health coverage in the territories. The territories are the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands and any other territory or possession of the United States.

**Effective Date**

The provision is effective on date of enactment.

**B. Free Choice Vouchers**  
**(sec. 10108 of the Senate amendment and sec. 139D of the Code)**

**Present Law**

No provision.

**Explanation of Provision**

**Provision of vouchers**

Employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage must provide qualified employees with a voucher whose value can be applied to purchase of a health plan through the Exchange. Qualified employees are employees whose required contribution for employer sponsored minimum essential coverage exceeds eight percent, but does not exceed 9.5 percent of the employee's household income for the taxable year and the employee's total household income does not exceed 400 percent of the poverty line for the family. In addition, the employee must not participate in the employer's health plan.

The value of the voucher is equal to the dollar value of the employer contribution to the employer offered health plan. If multiple plans are offered by the employer, the value of the voucher is the dollar amount that would be paid if the employee chose the plan for which the employer would pay the largest percentage of the premium cost.<sup>275</sup> The value of the voucher is for self-only coverage unless the individual purchases family coverage in the Exchange. Under the provision, for purposes of calculating the dollar value of the employer contribution, the premium for any health plan is determined under the rules of section 2204 of PHSA, except that the amount is adjusted for age and category of enrollment in accordance with regulations established by the Secretary.

In the case of years after 2014, the eight percent and the 9.5 percent are indexed to the excess of premium growth over income growth for the preceding calendar year.

**Use of vouchers**

Vouchers can be used in the Exchange towards the monthly premium of any qualified health plan in the Exchange. The value of the voucher to the extent it is used for the purchase of a health plan is not includable in gross income. If the value of the voucher exceeds the premium

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<sup>275</sup> For example, if an employer offering the same plans for \$200 and \$300 offers a flat \$180 contribution for all plans, a contribution of 90 percent for the \$200 plan and a contribution of 60 percent for the \$300 plan, and the value of the voucher would equal the value of the contribution to the \$200 since it received a 90 percent contribution, a value of \$180. However, if the firm offers a \$150 contribution to the \$200 plan (75 percent) and a \$200 contribution to the \$300 plan (67 percent), the value of the voucher is based on the plan receiving the greater percentage paid by the employer and would be \$150. If a firm offers health plans with monthly premiums of \$200 and \$300 and provides a payment of 60 percent of any plan purchased, the value of the voucher will be 60 percent the higher premium plan, in this case, 60 percent of \$300 or \$180.



of the health plan chosen by the employee, the employee is paid the excess value of the voucher. The excess amount received by the employee is includible in the employee's gross income.

If an individual receives a voucher the individual is disqualified from receiving any tax credit or cost sharing credit for the purchase of a plan in the Exchange. Similarly, if any employee receives a free choice voucher, the employer is not be assessed a shared responsibility payment on behalf of that employee.<sup>276</sup>

### **Definition of terms**

The terms used for this provision have the same meaning as any term used in the provision for the requirement to maintain minimum essential coverage (section 1501 of the Senate amendment and new section 5000A). Thus for example, the terms "household income," "poverty line," "required contribution," and "eligible employer-sponsored plan" have the same meaning for both provisions. Thus, the required contribution includes the amount of any salary reduction contribution.

### **Effective Date**

The provision is effective after December 31, 2013.

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<sup>276</sup> Section 1513 of the Senate amendment and new section 4980H.

**C. Exclusion for Assistance Provided to Participants in State Student Loan  
Repayment Programs for Certain Health Professionals  
(sec. 10908 of the Senate amendment and sec. 108(f)(4) of the Code)**

**Present Law**

Gross income generally includes the discharge of indebtedness of the taxpayer. Under an exception to this general rule, gross income does not include any amount from the forgiveness (in whole or in part) of certain student loans, provided that the forgiveness is contingent on the student's working for a certain period of time in certain professions for any of a broad class of employers.

Student loans eligible for this special rule must be made to an individual to assist the individual in attending an educational institution that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of students in attendance at the place where its education activities are regularly carried on. Loan proceeds may be used not only for tuition and required fees, but also to cover room and board expenses. The loan must be made by (1) the United States (or an instrumentality or agency thereof), (2) a State (or any political subdivision thereof), (3) certain tax-exempt public benefit corporations that control a State, county, or municipal hospital and whose employees have been deemed to be public employees under State law, or (4) an educational organization that originally received the funds from which the loan was made from the United States, a State, or a tax-exempt public benefit corporation.

In addition, an individual's gross income does not include amounts from the forgiveness of loans made by educational organizations (and certain tax-exempt organizations in the case of refinancing loans) out of private, nongovernmental funds if the proceeds of such loans are used to pay costs of attendance at an educational institution or to refinance any outstanding student loans (not just loans made by educational organizations) and the student is not employed by the lender organization. In the case of such loans made or refinanced by educational organizations (or refinancing loans made by certain tax-exempt organizations), cancellation of the student loan must be contingent upon the student working in an occupation or area with unmet needs and such work must be performed for, or under the direction of, a tax-exempt charitable organization or a governmental entity.

Finally, an individual's gross income does not include any loan repayment amount received under the National Health Service Corps loan repayment program or certain State loan repayment programs.

**Explanation of Provision**

The provision modifies the gross income exclusion for amounts received under the National Health Service Corps loan repayment program or certain State loan repayment programs to include any amount received by an individual 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 (as determined by the State).

### **Effective Date**

The provision is effective for amounts received by an individual in taxable years beginning after December 31, 2008.

**D. Expansion of Adoption Credit and the Exclusion from Gross Income  
for Employer-Provided Adoption Assistance  
(sec. 10909 of the Senate amendment and secs. 23 and 137 of the Code)**

**Present Law**

**Tax credit**

**Non-special needs adoptions**

Generally a nonrefundable tax credit is allowed for qualified adoption expenses paid or incurred by a taxpayer subject to the maximum credit. The maximum credit is \$12,170 per eligible child for taxable years beginning in 2010. An eligible child is an individual who: (1) has not attained age 18; or (2) is physically or mentally incapable of caring for himself or herself. The maximum credit is applied per child rather than per year. Therefore, while qualified adoption expenses may be incurred in one or more taxable years, the tax credit per adoption of an eligible child may not exceed the maximum credit.

**Special needs adoptions**

In the case of a special needs adoption finalized during a taxable year, the taxpayer may claim as an adoption credit the amount of the maximum credit minus the aggregate qualified adoption expenses with respect to that adoption for all prior taxable years. A special needs child is an eligible child who is a citizen or resident of the United States whom a State has determined: (1) cannot or should not be returned to the home of the birth parents; and (2) has a specific factor or condition (such as the child's ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as medical conditions, or physical, mental, or emotional handicaps) because of which the child cannot be placed with adoptive parents without adoption assistance.

**Qualified adoption expenses**

Qualified adoption expenses are reasonable and necessary adoption fees, court costs, attorneys fees, and other expenses that are: (1) directly related to, and the principal purpose of which is for, the legal adoption of an eligible child by the taxpayer; (2) not incurred in violation of State or Federal law, or in carrying out any surrogate parenting arrangement; (3) not for the adoption of the child of the taxpayer's spouse; and (4) not reimbursed (e.g., by an employer).

**Phase-out for higher-income individuals**

The adoption credit is phased out ratably for taxpayers with modified adjusted gross income between \$182,520 and \$222,520 for taxable years beginning in 2010. Under present law, modified adjusted gross income is the sum of the taxpayer's adjusted gross income plus amounts excluded from income under sections 911, 931, and 933 (relating to the exclusion of income of U.S. citizens or residents living abroad; residents of Guam, American Samoa, and the Northern Mariana Islands; and residents of Puerto Rico, respectively).

## EGTRRA sunset<sup>277</sup>

For taxable years after 2010, the adoption credit will be reduced to a maximum credit of \$6,000 for special needs adoptions and no tax credit for non-special needs adoptions. Also, the credit phase-out range will revert to the pre-EGTRRA levels (i.e., a ratable phase-out between modified adjusted gross income between \$75,000 and \$115,000). Finally, the adoption credit will be allowed only to the extent the individual's regular income tax liability exceeds the individual's tentative minimum tax, determined without regard to the minimum foreign tax credit.

### **Exclusion for employer-provided adoption assistance**

An exclusion from the gross income of an employee is allowed for qualified adoption expenses paid or reimbursed by an employer under an adoption assistance program. For 2010, the maximum exclusion is \$12,170. Also for 2010, the exclusion is phased out ratably for taxpayers with modified adjusted gross income between \$182,520 and \$222,520. Modified adjusted gross income is the sum of the taxpayer's adjusted gross income plus amounts excluded from income under Code sections 911, 931, and 933 (relating to the exclusion of income of U.S. citizens or residents living abroad; residents of Guam, American Samoa, and the Northern Mariana Islands; and residents of Puerto Rico, respectively). For purposes of this exclusion, modified adjusted gross income also includes all employer payments and reimbursements for adoption expenses whether or not they are taxable to the employee.

Adoption expenses paid or reimbursed by the employer under an adoption assistance program are not eligible for the adoption credit. A taxpayer may be eligible for the adoption credit (with respect to qualified adoption expenses he or she incurs) and also for the exclusion (with respect to different qualified adoption expenses paid or reimbursed by his or her employer).

Because of the EGTRRA sunset, the exclusion for employer-provided adoption assistance does not apply to amounts paid or incurred after December 31, 2010.

### **Explanation of Provision**

#### **Tax credit**

For 2010, the maximum credit is increased to \$13,170 per eligible child (a \$1,000 increase). This increase applies to both non-special needs adoptions and special needs adoptions. Also, the adoption credit is made refundable.

The new dollar limit and phase-out of the adoption credit are adjusted for inflation in taxable years beginning after December 31, 2010.

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<sup>277</sup> "EGTRRA" refers to the Economic Growth and Tax Relief Reconciliation Act of 2001.

The EGTRRA sunset is delayed for one year (i.e., the sunset becomes effective for taxable years beginning after December 31, 2011).

**Adoption assistance program**

The maximum exclusion is increased to \$13,170 per eligible child (a \$1,000 increase).

The new dollar limit and income limitations of the employer-provided adoption assistance exclusion are adjusted for inflation in taxable years beginning after December 31, 2010.

The EGTRRA sunset is delayed for one year (i.e., the sunset becomes effective for taxable years beginning after December 31, 2011).

**Effective Date**

The provisions generally are effective for taxable years beginning after December 31, 2009.

## HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010

### A. Adult Dependents

(sec. 1004 of the Reconciliation bill and secs. 105, 162, 401, and 501 of the Code)

#### Present Law

##### Definition of dependent for exclusion for employer-provided health coverage

The Code generally provides that employees are not taxed on (that is, may “exclude” from gross income) the value of employer-provided health coverage under an accident or health plan.<sup>278</sup> This exclusion applies to coverage for personal injuries or sickness for employees (including retirees), their spouses and their dependents.<sup>279</sup> In addition, any reimbursements under an accident or health plan for medical care expenses for employees (including retirees), their spouses, and their dependents (as defined in section 152) generally are excluded from gross income.<sup>280</sup> Section 152 defines a dependent as a qualifying child or qualifying relative.

Under section 152(c), a child generally is a qualifying child of a taxpayer if the child satisfies each of five tests for the taxable year: (1) the child has the same principal place of abode as the taxpayer for more than one-half of the taxable year; (2) the child has a specified relationship to the taxpayer; (3) the child has not yet attained a specified age; (4) the child has not provided over one-half of their own support for the calendar year in which the taxable year of the taxpayer begins; and (5) the qualifying child has not filed a joint return (other than for a claim of refund) with their spouse for the taxable year beginning in the calendar year in which the taxable year of the taxpayer begins. A tie-breaking rule applies if more than one taxpayer claims a child as a qualifying child. The specified relationship is that the child is the taxpayer’s son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, or a descendant of any such individual. With respect to the specified age, a child must be under age 19 (or under age 24 in the case of a full-time student). However, no age limit applies with respect to individuals who are totally and permanently disabled within the meaning of section 22(e)(3) at any time during the calendar year. Other rules may apply.

Under section 152(d), a qualifying relative means an individual that satisfies four tests for the taxable year: (1) the individual bears a specified relationship to the taxpayer; (2) the individual’s gross income for the calendar year in which such taxable year begins is less than the exemption amount under section 151(d); (3) the taxpayer provides more than one-half the individual’s support for the calendar year in which the taxable year begins; and (4) the individual is not a qualifying child of the taxpayer or any other taxpayer for any taxable year beginning in the calendar year in which such taxable year begins. The specified relationship test for qualifying relative is satisfied if that individual is the taxpayer’s: (1) child or descendant of a child; (2) brother, sister, stepbrother or stepsister; (3) father, mother or ancestor of either; (4)

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<sup>278</sup> Sec 106.

<sup>279</sup> Treas. Reg. sec. 1.106-1.

<sup>280</sup> Sec. 105(b).

stepfather or stepmother; (5) niece or nephew; (6) aunt or uncle; (7) in-law; or (8) certain other individuals, who for the taxable year of the taxpayer, have the same principal place of abode as the taxpayer and are members of the taxpayer's household.<sup>281</sup>

Employers may agree to reimburse medical expenses of their employees (and their spouses and dependents), not covered by a health insurance plan, through flexible spending arrangements which allow reimbursement not in excess of a specified dollar amount (either elected by an employee under a cafeteria plan or otherwise specified by the employer). Reimbursements under these arrangements are also excludible from gross income as employer-provided health coverage. The same definition of dependents applies for purposes of flexible spending arrangements.

### **Deduction for health insurance premiums of self-employed individuals**

Under present law, self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents. The deduction is not available for any month in which the self-employed individual is eligible to participate in an employer-subsidized health plan. Moreover, the deduction may not exceed the individual's self-employment income. The deduction applies only to the cost of insurance (i.e., it does not apply to out-of-pocket expenses that are not reimbursed by insurance). The deduction does not apply for self-employment tax purposes. For purposes of the deduction, a more than two percent shareholder-employee of an S corporation is treated the same as a self-employed individual. Thus, the exclusion for employer-provided health care coverage does not apply to such individuals, but they are entitled to the deduction for health insurance costs as if they were self-employed.

### **Voluntary Employees' Beneficiary Associations**

A VEBA is a tax-exempt entity that is a part of a plan for providing life, sick or accident benefits to its members or their dependents or designated beneficiaries.<sup>282</sup> No part of the net earnings of the association inures (other than through the payment of life, sick, accident or other benefits) to the benefit of any private shareholder or individual. A VEBA may be funded with employer contributions or employee contributions or a combination of employer contributions and employee contributions. The same definition of dependent applies for purposes of receipt of medical benefits through a VEBA.

### **Qualified plans providing retiree health benefits**

A qualified pension or annuity plan can establish and maintain a separate account to provide for the payment of sickness, accident, hospitalization, and medical expenses for retired employees, their spouses and their dependents ("401(h) account"). An employer's contributions to a 401(h) account must be reasonable and ascertainable, and retiree health benefits must be

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<sup>281</sup> Generally, same-sex partners do not qualify as dependents under section 152. In addition, same-sex partners are not recognized as spouses for purposes of the Code. Defense of Marriage Act, Pub. L. No. 104-199.

<sup>282</sup> Secs. 419(e) and 501(c)(9).



subordinate to the retirement benefits provided by the plan. In addition, it must be impossible, at any time prior to the satisfaction of all retiree health liabilities under the plan, for any part of the corpus or income of the 401(h) account to be (within the taxable year or thereafter) used for, or diverted to, any purpose other than providing retiree health benefits and, upon satisfaction of all retiree health liabilities, the plan must provide that any amount remaining in the 401(h) account be returned to the employer.

### **Explanation of Provision**

The provision amends sections 105(b) to extend the general exclusion for reimbursements for medical care expenses under an employer-provided accident or health plan to any child of an employee who has not attained age 27 as of the end of the taxable year. This change is also intended to apply to the exclusion for employer-provided coverage under an accident or health plan for injuries or sickness for such a child. A parallel change is made for VEBA's and 401(h) accounts.

The provision similarly amends section 162(l) to permit self-employed individuals to take a deduction for any child of the taxpayer who has not attained age 27 as of the end of the taxable year.

For purposes of the provision, "child" means an individual who is a son, daughter, stepson, stepdaughter or eligible foster child of the taxpayer.<sup>283</sup> An eligible foster child means an individual who is placed with the taxpayer by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

### **Effective Date**

The provision is effective as of the date of enactment.

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<sup>283</sup> Sec. 152(f)(1). Under section 152(f)(1), a legally adopted child of the taxpayer or an individual who is lawfully placed with the taxpayer for legal adoption by the taxpayer is treated as a child of the taxpayer by blood.

**B. Unearned Income Medicare Contribution**  
**(sec. 1402 of the Reconciliation bill and new sec. 1411 of the Code)**

**Present Law**

Social security benefits and certain Medicare benefits are financed primarily by payroll taxes on covered wages. FICA imposes tax on employers based on the amount of wages paid to an employee during the year. The tax imposed is composed of two parts: (1) the OASDI tax equal to 6.2 percent of covered wages up to the taxable wage base (\$106,800 in 2010); and (2) the Medicare hospital insurance (“HI”) tax amount equal to 1.45 percent of covered wages. In addition to the tax on employers, each employee is subject to FICA taxes equal to the amount of tax imposed on the employer. The employee level tax generally must be withheld and remitted to the Federal government by the employer.

As a parallel to FICA taxes, SECA imposes taxes on the net income from self employment of self employed individuals. The rate of the OASDI portion of SECA taxes is equal to the combined employee and employer OASDI FICA tax rates and applies to self employment income up to the FICA taxable wage base. Similarly, the rate of the HI portion is the same as the combined employer and employee HI rates and there is no cap on the amount of self employment income to which the rate applies.<sup>284</sup>

**Explanation of Provision**

**In general**

In the case of an individual, estate, or trust an unearned income Medicare contribution tax is imposed.

In the case of an individual, the tax is the 3.8 percent of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount.

The threshold amount is \$250,000 in the case of a joint return or surviving spouse, \$125,000 in the case of a married individual filing a separate return, and \$200,000 in any other case.

Modified adjusted gross income is adjusted gross income increased by the amount excluded from income as foreign earned income under section 911(a)(1) (net of the deductions and exclusions disallowed with respect to the foreign earned income).

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<sup>284</sup> For purposes of computing net earnings from self employment, taxpayers are permitted a deduction equal to the product of the taxpayer’s earnings (determined without regard to this deduction) and one-half of the sum of the rates for OASDI (12.4 percent) and HI (2.9 percent), i.e., 7.65 percent of net earnings. This deduction reflects the fact that the FICA rates apply to an employee’s wages, which do not include FICA taxes paid by the employer, whereas the self-employed individual’s net earnings are economically equivalent to an employee’s wages plus the employer share of FICA taxes.

In the case of an estate or trust, the tax is 3.8 percent of the lesser of undistributed net investment income or the excess of adjusted gross income (as defined in section 67(e)) over the dollar amount at which the highest income tax bracket applicable to an estate or trust begins.

The tax does not apply to a non-resident alien or to a trust all the unexpired interests in which are devoted to charitable purposes. The tax also does not apply to a trust that is exempt from tax under section 501 or a charitable remainder trust exempt from tax under section 664.

The tax is subject to the individual estimated tax provisions. The tax is not deductible in computing any tax imposed by subtitle A of the Internal Revenue Code (relating to income taxes).

### **Net investment income**

Net investment income is investment income reduced by the deductions properly allocable to such income.

Investment income is the sum of (i) gross income from interest, dividends, annuities, royalties, and rents (other than income derived from any trade or business to which the tax does not apply), (ii) other gross income derived from any business to which the tax applies, and (iii) net gain (to the extent taken into account in computing taxable income) attributable to the disposition of property other than property held in a trade or business to which the tax does not apply.<sup>285</sup>

In the case of a trade or business, the tax applies if the trade or business is a passive activity with respect to the taxpayer or the trade or business consists of trading financial instruments or commodities (as defined in section 475(e)(2)). The tax does not apply to other trades or businesses conducted by a sole proprietor, partnership, or S corporation.

In the case of the disposition of a partnership interest or stock in an S corporation, gain or loss is taken into account only to the extent gain or loss would be taken into account by the partner or shareholder if the entity had sold all its properties for fair market value immediately before the disposition. Thus, only net gain or loss attributable to property held by the entity which is not property attributable to an active trade or business is taken into account.<sup>286</sup>

Income, gain, or loss on working capital is not treated as derived from a trade or business. Investment income does not include distributions from a qualified retirement plan or amounts subject to SECA tax.

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<sup>285</sup> Gross income does not include items, such as interest on tax-exempt bonds, veterans' benefits, and excluded gain from the sale of a principal residence, which are excluded from gross income under the income tax.

<sup>286</sup> For this purpose, a business of trading financial instruments or commodities is not treated as an active trade or business.

**Effective Date**

The provision applies to taxable years beginning after December 31, 2012.

**C. Excise Tax on Medical Device Manufacturers<sup>287</sup>**  
**(sec. 1405 of the Reconciliation bill and new sec. 4191 of the Code)**

**Present Law**

Chapter 32 imposes excise taxes on sales by manufacturers of certain products. Terms and procedures related to the imposition, payment, and reporting of these excise taxes are included in various provisions within the Code.

Certain sales are exempt from the excise tax imposed on manufacturers. Exempt sales include sales (1) for use by the purchaser for further manufacture, or for resale to a second purchaser in further manufacture, (2) for export or for resale to a second purchaser for export, (3) for use by the purchaser as supplies for vessels or aircraft, (4) to a State or local government for the exclusive use of a State or local government, (5) to a nonprofit educational organization for its exclusive use, or (6) to a qualified blood collector organization for such organization's exclusive use in the collection, storage, or transportation of blood.<sup>288</sup> If an article is sold free of tax for resale to a second purchaser for further manufacture or for export, the exemption will not apply unless, within the six-month period beginning on the date of sale by the manufacturer, the manufacturer receives proof that the article has been exported or resold for the use in further manufacturing.<sup>289</sup> In general, the exemptions will not apply unless the manufacturer, the first purchaser, and the second purchaser are registered with the Secretary of the Treasury.

The lease of an article is generally considered to be a sale of such article.<sup>290</sup> Special rules apply for the imposition of tax to each lease payment. Rules are also imposed that treat the use of articles subject to tax by manufacturers, producers, or importers of such articles, as sales for the purpose of imposition of certain excise taxes.<sup>291</sup>

There are also rules for determining the price of an article on which excise tax is imposed.<sup>292</sup> These rules provide for: (1) the inclusion of containers, packaging, and certain transportation charges in the price, (2) determining a constructive sales price if an article is sold for less than the fair market price, and (3) determining the tax due in the case of partial payments or installment sales.

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<sup>287</sup> The excise tax on medical devices as imposed by this provision replaces the annual fee on medical device manufacturers and importers under section 9009 of the Senate amendment.

<sup>288</sup> Sec. 4221(a).

<sup>289</sup> Sec. 4221(b).

<sup>290</sup> Sec. 4217(a).

<sup>291</sup> Sec. 4218.

<sup>292</sup> Sec. 4216.

A credit or refund is generally allowed for overpayments of manufacturers excise taxes.<sup>293</sup> Overpayments may occur when tax-paid articles are sold for export and for certain specified uses and resales, when there are price adjustments, and where tax paid articles are subject to further manufacture. Generally, no credit or refund of any overpayment of tax is allowed or made unless the person who paid the tax establishes one of four prerequisites: (1) the tax was not included in the price of the article or otherwise collected from the person who purchased the article; (2) the tax was repaid to the ultimate purchaser of the article; (3) for overpayments due to specified uses and resales, the tax has been repaid to the ultimate vendor or the person has obtained the written consent of such ultimate vendor; or (4) the person has filed with the Secretary of the Treasury the written consent of the ultimate purchaser of the article to the allowance of the credit or making of the refund.<sup>294</sup>

### **Explanation of Provision**

Under the provision, a tax equal to 2.3 percent of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of such device. A taxable medical device is any device, defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act,<sup>295</sup> intended for humans. The excise tax does not apply to eyeglasses, contact lenses, hearing aids, and any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use. The Secretary may determine that a specific medical device is exempt under the provision if the device is generally sold at retail establishments (including over the internet) to individuals for their personal use. The exemption for such items is not limited by device class as defined in section 513 of the Federal Food, Drug, and Cosmetic Act. For example, items purchased by the general public at retail for individual use could include Class I items such as certain bandages and tipped applicators, Class II items such as certain pregnancy test kits and diabetes testing supplies, and Class III items such as certain denture adhesives and snake bite kits. Such items would only be exempt if they are generally designed and sold for individual use. It is anticipated that the Secretary will publish a list of medical device classifications<sup>296</sup> that are of a type generally purchased by the general public at retail for individual use.

The present law manufacturers excise tax exemptions for further manufacture and for export apply to tax imposed under this provision; however exemptions for use as supplies for

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<sup>293</sup> Sec. 6416.

<sup>294</sup> Sec. 6416(a).

<sup>295</sup> 21 U.S.C. 321. Section 201(h) defines device as an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.

<sup>296</sup> Medical device classifications are found in Title 21 of the Code of Federal Regulations, Parts 862-892.

vessels or aircraft, and for sales to State or local governments, nonprofit educational organizations, and qualified blood collector organizations are not applicable.

The provision repeals section 9009 of the Senate amendment (relating to an annual fee on medical device manufacturers and importers).

**Effective Date**

The provision applies to sales after December 31, 2012.

The repeal of section 9009 of the Senate amendment is effective on the date of enactment of the Senate amendment.

**D. Elimination of Unintended Application of Cellulosic Biofuel Producer Credit  
(sec. 1408 of the Reconciliation bill and sec. 40 of the Code)**

**Present Law**

The “cellulosic biofuel producer credit” is a nonrefundable income tax credit for each gallon of qualified cellulosic fuel production of the producer for the taxable year. The amount of the credit is generally \$1.01 per gallon.<sup>297</sup>

“Qualified cellulosic biofuel production” is any cellulosic biofuel which is produced by the taxpayer and which is: (1) sold by the taxpayer to another person (a) for use by such other person in the production of a qualified cellulosic biofuel mixture in such person’s trade or business (other than casual off-farm production), (b) for use by such other person as a fuel in a trade or business, or (c) who sells such cellulosic biofuel at retail to another person and places such cellulosic biofuel in the fuel tank of such other person; or (2) used by the producer for any purpose described in (1)(a), (b), or (c).

“Cellulosic biofuel” means any liquid fuel that (1) is produced in the United States and used as fuel in the United States, (2) is derived from any lignocellulosic or hemicellulosic matter that is available on a renewable or recurring basis, and (3) meets the registration requirements for fuels and fuel additives established by the Environmental Protection Agency (“EPA”) under section 211 of the Clean Air Act. The cellulosic biofuel producer credit cannot be claimed unless the taxpayer is registered by the IRS as a producer of cellulosic biofuel.

Cellulosic biofuel eligible for the section 40 credit is precluded from qualifying as biodiesel, renewable diesel, or alternative fuel for purposes of the applicable income tax credit, excise tax credit, or payment provisions relating to those fuels.<sup>298</sup>

Because it is a credit under section 40(a), the cellulosic biofuel producer credit is part of the general business credits in section 38. However, the credit can only be carried forward three taxable years after the termination of the credit. The credit is also allowable against the alternative minimum tax. Under section 87, the credit is included in gross income. The cellulosic biofuel producer credit terminates on December 31, 2012.

The kraft process for making paper produces a byproduct called black liquor, which has been used for decades by paper manufacturers as a fuel in the papermaking process. Black liquor is composed of water, lignin and the spent chemicals used to break down the wood. The amount of the biomass in black liquor varies. The portion of the black liquor that is not consumed as a fuel source for the paper mills is recycled back into the papermaking process.

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<sup>297</sup> In the case of cellulosic biofuel that is alcohol, the \$1.01 credit amount is reduced by the credit amount of the alcohol mixture credit, and for ethanol, the credit amount for small ethanol producers, as in effect at the time the cellulosic biofuel fuel is produced.

<sup>298</sup> See secs. 40A(d)(1), 40A(f)(3), and 6426(h).



Black liquor has ash content (mineral and other inorganic matter) significantly above that of other fuels.

In an informal Chief Counsel Advice (“CCA”), the IRS has concluded that black liquor is a liquid fuel from biomass and may qualify for the cellulosic biofuel producer credit, as well as the refundable alternative fuel mixture credit.<sup>299</sup> A taxpayer cannot claim both the alternative fuel mixture credit and the cellulosic biofuel producer credit. The alternative fuel credits and payment provisions expired December 31, 2009.

### **Explanation of Provision**

The provision modifies the cellulosic biofuel producer credit to exclude fuels with significant water, sediment, or ash content, such as black liquor. Consequently, credits will cease to be available for these fuels. Specifically, the provision excludes from the definition of cellulosic biofuel any fuels that (1) are more than four percent (determined by weight) water and sediment in any combination, or (2) have an ash content of more than one percent (determined by weight). Water content (including both free water and water in solution with dissolved solids) is determined by distillation, using for example ASTM method D95 or a similar method suitable to the specific fuel being tested. Sediment consists of solid particles that are dispersed in the liquid fuel and is determined by centrifuge or extraction using, for example, ASTM method D1796 or D473 or similar method that reports sediment content in weight percent. Ash is the residue remaining after combustion of the sample using a specified method, such as ASTM D3174 or a similar method suitable for the fuel being tested.

### **Effective Date**

The provision is effective for fuels sold or used on or after January 1, 2010.

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<sup>299</sup> IRS C.C.A. 200941011, 2009 W.L. 3239569 (June 30, 2009). The Code provides for a tax credit of 50 cents for each gallon of alternative fuel used to produce an alternative fuel mixture that is used or sold for use as a fuel. (sec. 6426(e)). Under Notice 2006-92, an alternative fuel mixture is a mixture of alternative fuel and a taxable fuel (such as diesel) that contains at least 0.1 percent taxable fuel. Liquid fuel derived from biomass is an alternative fuel (sec. 6426(d)(2)(G)). Diesel fuel has been added to black liquor to qualify for the alternative mixture credit and the mixture is burned in a recovery boiler as fuel. Persons that have an alternative fuel mixture credit amount in excess of their taxable fuel excise tax liability may make a claim for payment from the Treasury in the amount of the excess.

**E. Codification of Economic Substance Doctrine and Imposition of Penalties  
(sec. 1409 of the Reconciliation bill and secs. 7701, 6662, 6662A, 6664 and 6676 of the Code)**

**Present Law**

**In general**

The Code provides detailed rules specifying the computation of taxable income, including the amount, timing, source, and character of items of income, gain, loss, and deduction. These rules permit both taxpayers and the government to compute taxable income with reasonable accuracy and predictability. Taxpayers generally may plan their transactions in reliance on these rules to determine the Federal income tax consequences arising from the transactions.

In addition to the statutory provisions, courts have developed several doctrines that can be applied to deny the tax benefits of a tax-motivated transaction, notwithstanding that the transaction may satisfy the literal requirements of a specific tax provision. These common-law doctrines are not entirely distinguishable, and their application to a given set of facts is often blurred by the courts, the IRS, and litigants. Although these doctrines serve an important role in the administration of the tax system, they can be seen as at odds with an objective, “rule-based” system of taxation.

One common-law doctrine applied over the years is the “economic substance” doctrine. In general, this doctrine denies tax benefits arising from transactions that do not result in a meaningful change to the taxpayer’s economic position other than a purported reduction in Federal income tax.<sup>300</sup>

**Economic substance doctrine**

Courts generally deny claimed tax benefits if the transaction that gives rise to those benefits lacks economic substance independent of U.S. Federal income tax considerations –

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<sup>300</sup> See, e.g., *ACM Partnership v. Commissioner*, 157 F.3d 231 (3d Cir. 1998), *aff’d* 73 T.C.M. (CCH) 2189 (1997), *cert. denied* 526 U.S. 1017 (1999); *Klamath Strategic Investment Fund, LLC v. United States*, 472 F. Supp. 2d 885 (E.D. Texas 2007), *aff’d* 568 F.3d 537 (5th Cir. 2009); *Coltec Industries, Inc. v. United States*, 454 F.3d 1340 (Fed. Cir. 2006), *vacating and remanding* 62 Fed. Cl. 716 (2004) (slip opinion at 123-124, 128); *cert. denied*, 127 S. Ct. 1261 (Mem.) (2007).

Closely related doctrines also applied by the courts (sometimes interchangeable with the economic substance doctrine) include the “sham transaction doctrine” and the “business purpose doctrine.” See, e.g., *Knetsch v. United States*, 364 U.S. 361 (1960) (denying interest deductions on a “sham transaction” that lacked “commercial economic substance”). Certain “substance over form” cases involving tax-indifferent parties, in which courts have found that the substance of the transaction did not comport with the form asserted by the taxpayer, have also involved examination of whether the change in economic position that occurred, if any, was consistent with the form asserted, and whether the claimed business purpose supported the particular tax benefits that were claimed. See, e.g., *TIFD III-E, Inc. v. United States*, 459 F.3d 220 (2d Cir. 2006); *BB&T Corporation v. United States*, 2007-1 USTC P 50,130 (M.D.N.C. 2007), *aff’d* 523 F.3d 461 (4th Cir. 2008). Although the Second Circuit found for the government in *TIFD III-E, Inc.*, on remand to consider issues under section 704(e), the District Court found for the taxpayer. See, *TIFD III-E Inc. v. United States*, No. 3:01-cv-01839, 2009 WL 3208650 (D. Conn. Oct. 23, 2009).

notwithstanding that the purported activity actually occurred. The Tax Court has described the doctrine as follows:

The tax law . . . requires that the intended transactions have economic substance separate and distinct from economic benefit achieved solely by tax reduction. The doctrine of economic substance becomes applicable, and a judicial remedy is warranted, where a taxpayer seeks to claim tax benefits, unintended by Congress, by means of transactions that serve no economic purpose other than tax savings.<sup>301</sup>

#### Business purpose doctrine

A common law doctrine that often is considered together with the economic substance doctrine is the business purpose doctrine. The business purpose doctrine involves an inquiry into the subjective motives of the taxpayer – that is, whether the taxpayer intended the transaction to serve some useful non-tax purpose. In making this determination, some courts have bifurcated a transaction in which activities with non-tax objectives have been combined with unrelated activities having only tax-avoidance objectives, in order to disallow the tax benefits of the overall transaction.<sup>302</sup>

### **Application by the courts**

#### Elements of the doctrine

There is a lack of uniformity regarding the proper application of the economic substance doctrine.<sup>303</sup> Some courts apply a conjunctive test that requires a taxpayer to establish the presence of both economic substance (i.e., the objective component) and business purpose (i.e., the subjective component) in order for the transaction to survive judicial scrutiny.<sup>304</sup> A narrower approach used by some courts is to conclude that either a business purpose or economic substance is sufficient to respect the transaction.<sup>305</sup> A third approach regards economic

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<sup>301</sup> *ACM Partnership v. Commissioner*, 73 T.C.M. at 2215.

<sup>302</sup> See, *ACM Partnership v. Commissioner*, 157 F.3d at 256 n.48.

<sup>303</sup> “The casebooks are glutted with [economic substance] tests. Many such tests proliferate because they give the comforting illusion of consistency and precision. They often obscure rather than clarify.” *Collins v. Commissioner*, 857 F.2d 1383, 1386 (9th Cir. 1988).

<sup>304</sup> See, e.g., *Pasternak v. Commissioner*, 990 F.2d 893, 898 (6th Cir. 1993) (“The threshold question is whether the transaction has economic substance. If the answer is yes, the question becomes whether the taxpayer was motivated by profit to participate in the transaction.”). See also, *Klamath Strategic Investment Fund v. United States*, 568 F.3d 537, (5th Cir. 2009) (even if taxpayers may have had a profit motive, a transaction was disregarded where it did not in fact have any realistic possibility of profit and funding was never at risk).

<sup>305</sup> See, e.g., *Rice’s Toyota World v. Commissioner*, 752 F.2d 89, 91-92 (4th Cir. 1985) (“To treat a transaction as a sham, the court must find that the taxpayer was motivated by no business purposes other than obtaining tax benefits in entering the transaction, and, second, that the transaction has no economic substance because no reasonable possibility of a profit exists.”); *IES Industries v. United States*, 253 F.3d 350, 358 (8th Cir. 2001) (“In determining whether a transaction is a sham for tax purposes [under the Eighth Circuit test], a transaction will be characterized as a sham if it is not motivated by any economic purpose outside of tax considerations (the

substance and business purpose as “simply more precise factors to consider” in determining whether a transaction has any practical economic effects other than the creation of tax benefits.<sup>306</sup>

One decision by the Court of Federal Claims questioned the continuing viability of the doctrine. That court also stated that “the use of the ‘economic substance’ doctrine to trump ‘mere compliance with the Code’ would violate the separation of powers” though that court also found that the particular transaction at issue in the case did not lack economic substance. The Court of Appeals for the Federal Circuit (“Federal Circuit Court”) overruled the Court of Federal Claims decision, reiterating the viability of the economic substance doctrine and concluding that the transaction in question violated that doctrine.<sup>307</sup> The Federal Circuit Court stated that “[w]hile the doctrine may well also apply if the taxpayer’s sole subjective motivation is tax avoidance even if the transaction has economic substance, [footnote omitted], a lack of economic substance is sufficient to disqualify the transaction without proof that the taxpayer’s sole motive is tax avoidance.”<sup>308</sup>

### Nontax economic benefits

There also is a lack of uniformity regarding the type of non-tax economic benefit a taxpayer must establish in order to demonstrate that a transaction has economic substance. Some courts have denied tax benefits on the grounds that a stated business benefit of a particular structure was not in fact obtained by that structure.<sup>309</sup> Several courts have denied tax benefits on

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business purpose test), and if it is without economic substance because no real potential for profit exists (the economic substance test).”). As noted earlier, the economic substance doctrine and the sham transaction doctrine are similar and sometimes are applied interchangeably. For a more detailed discussion of the sham transaction doctrine, see, e.g., Joint Committee on Taxation, *Study of Present-Law Penalty and Interest Provisions as Required by Section 3801 of the Internal Revenue Service Restructuring and Reform Act of 1998 (including Provisions Relating to Corporate Tax Shelters)* (JCS-3-99) at 182.

<sup>306</sup> See, e.g., *ACM Partnership v. Commissioner*, 157 F.3d at 247; *James v. Commissioner*, 899 F.2d 905, 908 (10th Cir. 1995); *Sacks v. Commissioner*, 69 F.3d 982, 985 (9th Cir. 1995) (“Instead, the consideration of business purpose and economic substance are simply more precise factors to consider . . . We have repeatedly and carefully noted that this formulation cannot be used as a ‘rigid two-step analysis.’”)

<sup>307</sup> *Coltec Industries, Inc. v. United States*, 62 Fed. Cl. 716 (2004) (slip opinion at 123-124, 128); *vacated and remanded*, 454 F.3d 1340 (Fed. Cir. 2006), *cert. denied*, 127 S. Ct. 1261 (Mem.) (2007).

<sup>308</sup> The Federal Circuit Court stated that “when the taxpayer claims a deduction, it is the taxpayer who bears the burden of proving that the transaction has economic substance.” The Federal Circuit Court quoted a decision of its predecessor court, stating that “*Gregory v. Helvering* requires that a taxpayer carry an unusually heavy burden when he attempts to demonstrate that Congress intended to give favorable tax treatment to the kind of transaction that would never occur absent the motive of tax avoidance.” The Court also stated that “while the taxpayer’s subjective motivation may be pertinent to the existence of a tax avoidance purpose, all courts have looked to the objective reality of a transaction in assessing its economic substance.” *Coltec Industries, Inc. v. United States*, 454 F.3d at 1355, 1356.

<sup>309</sup> See, e.g., *Coltec Industries v. United States*, 454 F.3d 1340 (Fed. Cir. 2006). The court analyzed the transfer to a subsidiary of a note purporting to provide high stock basis in exchange for a purported assumption of liabilities, and held these transactions unnecessary to accomplish any business purpose of using a subsidiary to

the grounds that the subject transactions lacked profit potential.<sup>310</sup> In addition, some courts have applied the economic substance doctrine to disallow tax benefits in transactions in which a taxpayer was exposed to risk and the transaction had a profit potential, but the court concluded that the economic risks and profit potential were insignificant when compared to the tax benefits.<sup>311</sup> Under this analysis, the taxpayer's profit potential must be more than nominal. Conversely, other courts view the application of the economic substance doctrine as requiring an objective determination of whether a "reasonable possibility of profit" from the transaction existed apart from the tax benefits.<sup>312</sup> In these cases, in assessing whether a reasonable possibility of profit exists, it may be sufficient if there is a nominal amount of pre-tax profit as measured against expected tax benefits.

### Financial accounting benefits

In determining whether a taxpayer had a valid business purpose for entering into a transaction, at least two courts have concluded that financial accounting benefits arising from tax savings do not qualify as a non-tax business purpose.<sup>313</sup> However, based on court decisions that recognize the importance of financial accounting treatment, taxpayers have asserted that financial accounting benefits arising from tax savings can satisfy the business purpose test.<sup>314</sup>

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manage asbestos liabilities. The court also held that the purported business purpose of adding a barrier to veil-piercing claims by third parties was not accomplished by the transaction. 454 F.3d at 1358-1360 (Fed. Cir. 2006).

<sup>310</sup> See, e.g., *Knetsch*, 364 U.S. at 361; *Goldstein v. Commissioner*, 364 F.2d 734 (2d Cir. 1966) (holding that an unprofitable, leveraged acquisition of Treasury bills, and accompanying prepaid interest deduction, lacked economic substance).

<sup>311</sup> See, e.g., *Goldstein v. Commissioner*, 364 F.2d at 739-40 (disallowing deduction even though taxpayer had a possibility of small gain or loss by owning Treasury bills); *Sheldon v. Commissioner*, 94 T.C. 738, 768 (1990) (stating that "potential for gain . . . is infinitesimally nominal and vastly insignificant when considered in comparison with the claimed deductions").

<sup>312</sup> See, e.g., *Rice's Toyota World v. Commissioner*, 752 F. 2d 89, 94 (4th Cir. 1985) (the economic substance inquiry requires an objective determination of whether a reasonable possibility of profit from the transaction existed apart from tax benefits); *Compaq Computer Corp. v. Commissioner*, 277 F.3d 778, 781 (5th Cir. 2001) (applied the same test, citing *Rice's Toyota World*); *IES Industries v. United States*, 253 F.3d 350, 354 (8th Cir. 2001); *Wells Fargo & Company v. United States*, No. 06-628T, 2010 WL 94544, at \*57-58 (Fed. Cl. Jan. 8, 2010).

<sup>313</sup> See *American Electric Power, Inc. v. United States*, 136 F. Supp. 2d 762, 791-92 (S.D. Ohio 2001), *aff'd*, 326 F.3d 737 (6th Cir. 2003) and *Wells Fargo & Company v. United States*, No. 06-628T, 2010 WL 94544, at \*59 (Fed. Cl. Jan. 8, 2010).

<sup>314</sup> See, e.g., Joint Committee on Taxation, *Report of Investigation of Enron Corporation and Related Entities Regarding Federal Tax and Compensation Issues, and Policy Recommendations* (JSC-3-03) February, 2003 ("Enron Report"), Volume III at C-93, 289. Enron Corporation relied on *Frank Lyon Co. v. United States*, 435 U.S. 561, 577-78 (1978), and *Newman v. Commissioner*, 902 F.2d 159, 163 (2d Cir. 1990), to argue that financial accounting benefits arising from tax savings constitute a good business purpose.

## Tax-indifferent parties

A number of cases have involved transactions structured to allocate income for Federal tax purposes to a tax-indifferent party, with a corresponding deduction, or favorable basis result, to a taxable person. The income allocated to the tax-indifferent party for tax purposes was structured to exceed any actual economic income to be received by the tax indifferent party from the transaction. Courts have sometimes concluded that this particular type of transaction did not satisfy the economic substance doctrine.<sup>315</sup> In other cases, courts have indicated that the substance of a transaction did not support the form of income allocations asserted by the taxpayer and have questioned whether asserted business purpose or other standards were met.<sup>316</sup>

## Penalty regime

### General accuracy-related penalty

An accuracy-related penalty under section 6662 applies to the portion of any underpayment that is attributable to (1) negligence, (2) any substantial understatement of income tax, (3) any substantial valuation misstatement, (4) any substantial overstatement of pension liabilities, or (5) any substantial estate or gift tax valuation understatement. If the correct income tax liability exceeds that reported by the taxpayer by the greater of 10 percent of the correct tax or \$5,000 (or, in the case of corporations, by the lesser of (a) 10 percent of the correct tax (or \$10,000 if greater) or (b) \$10 million), then a substantial understatement exists and a penalty may be imposed equal to 20 percent of the underpayment of tax attributable to the understatement.<sup>317</sup> The section 6662 penalty is increased to 40 percent in the case of gross valuation misstatements as defined in section 6662(h). Except in the case of tax shelters,<sup>318</sup> the amount of any understatement is reduced by any portion attributable to an item if (1) the treatment of the item is supported by substantial authority, or (2) facts relevant to the tax treatment of the item were adequately disclosed and there was a reasonable basis for its tax treatment. The Treasury Secretary may prescribe a list of positions which the Secretary believes do not meet the requirements for substantial authority under this provision.

The section 6662 penalty generally is abated (even with respect to tax shelters) in cases in which the taxpayer can demonstrate that there was “reasonable cause” for the underpayment and

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<sup>315</sup> See, e.g., *ACM Partnership v. Commissioner*, 157 F.3d 231 (3d Cir. 1998), *aff’d* 73 T.C.M. (CCH) 2189 (1997), *cert. denied* 526 U.S. 1017 (1999).

<sup>316</sup> See, e.g., *TIFD III-E, Inc. v. United States*, 459 F.3d 220 (2d Cir. 2006). Although the Second Circuit found for the government in *TIFD III-E, Inc.*, on remand to consider issues under section 704(e), the District Court found for the taxpayer. See, *TIFD III-E Inc. v. United States*, No. 3:01-cv-01839, 2009 WL 3208650 (Oct. 23, 2009).

<sup>317</sup> Sec. 6662.

<sup>318</sup> A tax shelter is defined for this purpose as a partnership or other entity, an investment plan or arrangement, or any other plan or arrangement if a significant purpose of such partnership, other entity, plan, or arrangement is the avoidance or evasion of Federal income tax. Sec. 6662(d)(2)(C).

that the taxpayer acted in good faith.<sup>319</sup> The relevant regulations for a tax shelter provide that reasonable cause exists where the taxpayer “reasonably relies in good faith on an opinion based on a professional tax advisor’s analysis of the pertinent facts and authorities [that] . . . unambiguously concludes that there is a greater than 50-percent likelihood that the tax treatment of the item will be upheld if challenged” by the IRS.<sup>320</sup> For transactions other than tax shelters, the relevant regulations provide a facts and circumstances test, the most important factor generally being the extent of the taxpayer’s effort to assess the proper tax liability. If a taxpayer relies on an opinion, reliance is not reasonable if the taxpayer knows or should have known that the advisor lacked knowledge in the relevant aspects of Federal tax law, or if the taxpayer fails to disclose a fact that it knows or should have known is relevant. Certain additional requirements apply with respect to the advice.<sup>321</sup>

### Listed transactions and reportable avoidance transactions

#### In general

A separate accuracy-related penalty under section 6662A applies to any “listed transaction” and to any other “reportable transaction” that is not a listed transaction, if a significant purpose of such transaction is the avoidance or evasion of Federal income tax<sup>322</sup> (hereinafter referred to as a “reportable avoidance transaction”). The penalty rate and defenses available to avoid the penalty vary depending on whether the transaction was adequately disclosed.

Both listed transactions and other reportable transactions are allowed to be described by the Treasury department under section 6011 as transactions that must be reported, and section 6707A(c) imposes a penalty for failure adequately to report such transactions under section 6011. A reportable transaction is defined as one that the Treasury Secretary determines is required to be disclosed because it is determined to have a potential for tax avoidance or evasion.<sup>323</sup> A listed transaction is defined as a reportable transaction which is the same as, or substantially similar to,

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<sup>319</sup> Sec. 6664(c).

<sup>320</sup> Treas. Reg. sec. 1.6662-4(g)(4)(i)(B); Treas. Reg. sec. 1.6664-4(c).

<sup>321</sup> See Treas. Reg. Sec. 1.6664-4(c). In addition to the requirements applicable to taxpayers under the regulations, advisors may be subject to potential penalties under section 6694 (applicable to return preparers), and to monetary penalties and other sanctions under Circular 230 (which provides rules governing persons practicing before the IRS). Under Circular 230, if a transaction is a “covered transaction” (a term that includes listed transactions and certain non-listed reportable transactions) a “more likely than not” confidence level is required for written tax advice that may be relied upon by a taxpayer for the purpose of avoiding penalties, and certain other standards must also be met. Treasury Dept. Circular 230 (Rev. 4-2008) Sec. 10.35. For other tax advice, Circular 230 generally requires a lower “realistic possibility” confidence level or a “non-frivolous” confidence level coupled with advising the client of any opportunity to avoid the accuracy related penalty under section 6662 by adequate disclosure. Treasury Dept. Circular 230 (Rev. 4-2008) Sec. 10.34.

<sup>322</sup> Sec. 6662A(b)(2).

<sup>323</sup> Sec. 6707A(c)(1).

a transaction specifically identified by the Secretary as a tax avoidance transaction for purposes of the reporting disclosure requirements.<sup>324</sup>

### Disclosed transactions

In general, a 20-percent accuracy-related penalty is imposed on any understatement attributable to an adequately disclosed listed transaction or reportable avoidance transaction.<sup>325</sup> The only exception to the penalty is if the taxpayer satisfies a more stringent reasonable cause and good faith exception (hereinafter referred to as the “strengthened reasonable cause exception”), which is described below. The strengthened reasonable cause exception is available only if the relevant facts affecting the tax treatment were adequately disclosed, there is or was substantial authority for the claimed tax treatment, and the taxpayer reasonably believed that the claimed tax treatment was more likely than not the proper treatment. A “reasonable belief” must be based on the facts and law as they exist at the time that the return in question is filed, and not take into account the possibility that a return would not be audited. Moreover, reliance on professional advice may support a “reasonable belief” only in certain circumstances.<sup>326</sup>

### Undisclosed transactions

If the taxpayer does not adequately disclose the transaction, the strengthened reasonable cause exception is not available (i.e., a strict liability penalty generally applies), and the taxpayer is subject to an increased penalty equal to 30 percent of the understatement.<sup>327</sup> However, a taxpayer will be treated as having adequately disclosed a transaction for this purpose if the IRS Commissioner has separately rescinded the separate penalty under section 6707A for failure to disclose a reportable transaction.<sup>328</sup> The IRS Commissioner is authorized to do this only if the failure does not relate to a listed transaction and only if rescinding the penalty would promote compliance and effective tax administration.<sup>329</sup>

A public entity that is required to pay a penalty for an undisclosed listed or reportable transaction must disclose the imposition of the penalty in reports to the SEC for such periods as the Secretary specifies. The disclosure to the SEC applies without regard to whether the taxpayer determines the amount of the penalty to be material to the reports in which the penalty must appear, and any failure to disclose such penalty in the reports is treated as a failure to disclose a listed transaction. A taxpayer must disclose a penalty in reports to the SEC once the

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<sup>324</sup> Sec. 6707A(c)(2).

<sup>325</sup> Sec. 6662A(a).

<sup>326</sup> Section 6664(d)(3)(B) does not allow a reasonable belief to be based on a “disqualified opinion” or on an opinion from a “disqualified tax advisor.”

<sup>327</sup> Sec. 6662A(c).

<sup>328</sup> Sec. 6664(d).

<sup>329</sup> Sec. 6707A(d).



taxpayer has exhausted its administrative and judicial remedies with respect to the penalty (or if earlier, when paid).<sup>330</sup>

#### Determination of the understatement amount

The penalty is applied to the amount of any understatement attributable to the listed or reportable avoidance transaction without regard to other items on the tax return. For purposes of this provision, the amount of the understatement is determined as the sum of: (1) the product of the highest corporate or individual tax rate (as appropriate) and the increase in taxable income resulting from the difference between the taxpayer's treatment of the item and the proper treatment of the item (without regard to other items on the tax return);<sup>331</sup> and (2) the amount of any decrease in the aggregate amount of credits which results from a difference between the taxpayer's treatment of an item and the proper tax treatment of such item.

Except as provided in regulations, a taxpayer's treatment of an item will not take into account any amendment or supplement to a return if the amendment or supplement is filed after the earlier of when the taxpayer is first contacted regarding an examination of the return or such other date as specified by the Secretary.<sup>332</sup>

#### Strengthened reasonable cause exception

A penalty is not imposed under section 6662A with respect to any portion of an understatement if it is shown that there was reasonable cause for such portion and the taxpayer acted in good faith. Such a showing requires: (1) adequate disclosure of the facts affecting the transaction in accordance with the regulations under section 6011;<sup>333</sup> (2) that there is or was substantial authority for such treatment; and (3) that the taxpayer reasonably believed that such treatment was more likely than not the proper treatment. For this purpose, a taxpayer will be treated as having a reasonable belief with respect to the tax treatment of an item only if such belief: (1) is based on the facts and law that exist at the time the tax return (that includes the item) is filed; and (2) relates solely to the taxpayer's chances of success on the merits and does not take into account the possibility that (a) a return will not be audited, (b) the treatment will not be raised on audit, or (c) the treatment will be resolved through settlement if raised.<sup>334</sup>

A taxpayer may (but is not required to) rely on an opinion of a tax advisor in establishing its reasonable belief with respect to the tax treatment of the item. However, a taxpayer may not

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<sup>330</sup> Sec. 6707A(e).

<sup>331</sup> For this purpose, any reduction in the excess of deductions allowed for the taxable year over gross income for such year, and any reduction in the amount of capital losses which would (without regard to section 1211) be allowed for such year, will be treated as an increase in taxable income. Sec. 6662A(b).

<sup>332</sup> Sec. 6662A(e)(3).

<sup>333</sup> See the previous discussion regarding the penalty for failing to disclose a reportable transaction.

<sup>334</sup> Sec. 6664(d).

rely on an opinion of a tax advisor for this purpose if the opinion (1) is provided by a “disqualified tax advisor” or (2) is a “disqualified opinion.”

### Disqualified tax advisor

A disqualified tax advisor is any advisor who: (1) is a material advisor<sup>335</sup> and who participates in the organization, management, promotion, or sale of the transaction or is related (within the meaning of section 267(b) or 707(b)(1)) to any person who so participates; (2) is compensated directly or indirectly<sup>336</sup> by a material advisor with respect to the transaction; (3) has a fee arrangement with respect to the transaction that is contingent on all or part of the intended tax benefits from the transaction being sustained; or (4) as determined under regulations prescribed by the Secretary, has a disqualifying financial interest with respect to the transaction.

A material advisor is considered as participating in the “organization” of a transaction if the advisor performs acts relating to the development of the transaction. This may include, for example, preparing documents: (1) establishing a structure used in connection with the transaction (such as a partnership agreement); (2) describing the transaction (such as an offering memorandum or other statement describing the transaction); or (3) relating to the registration of the transaction with any Federal, state, or local government body.<sup>337</sup> Participation in the “management” of a transaction means involvement in the decision-making process regarding any business activity with respect to the transaction. Participation in the “promotion or sale” of a transaction means involvement in the marketing or solicitation of the transaction to others. Thus, an advisor who provides information about the transaction to a potential participant is involved in the promotion or sale of a transaction, as is any advisor who recommends the transaction to a potential participant.

### Disqualified opinion

An opinion may not be relied upon if the opinion: (1) is based on unreasonable factual or legal assumptions (including assumptions as to future events); (2) unreasonably relies upon representations, statements, findings or agreements of the taxpayer or any other person; (3) does

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<sup>335</sup> The term “material advisor” means any person who provides any material aid, assistance, or advice with respect to organizing, managing, promoting, selling, implementing, or carrying out any reportable transaction, and who derives gross income in excess of \$50,000 in the case of a reportable transaction substantially all of the tax benefits from which are provided to natural persons (\$250,000 in any other case). Sec. 6111(b)(1).

<sup>336</sup> This situation could arise, for example, when an advisor has an arrangement or understanding (oral or written) with an organizer, manager, or promoter of a reportable transaction that such party will recommend or refer potential participants to the advisor for an opinion regarding the tax treatment of the transaction.

<sup>337</sup> An advisor should not be treated as participating in the organization of a transaction if the advisor’s only involvement with respect to the organization of the transaction is the rendering of an opinion regarding the tax consequences of such transaction. However, such an advisor may be a “disqualified tax advisor” with respect to the transaction if the advisor participates in the management, promotion, or sale of the transaction (or if the advisor is compensated by a material advisor, has a fee arrangement that is contingent on the tax benefits of the transaction, or as determined by the Secretary, has a continuing financial interest with respect to the transaction). See Notice 2005-12, 2005-1 C.B. 494 regarding disqualified compensation arrangements.

not identify and consider all relevant facts; or (4) fails to meet any other requirement prescribed by the Secretary.

#### Coordination with other penalties

Any understatement upon which a penalty is imposed under section 6662A is not subject to the accuracy related penalty for underpayments under section 6662.<sup>338</sup> However, that understatement is included for purposes of determining whether any understatement (as defined in sec. 6662(d)(2)) is a substantial understatement under section 6662(d)(1).<sup>339</sup> Thus, in the case of an understatement (as defined in sec. 6662(d)(2)), the amount of the understatement (determined without regard to section 6662A(e)(1)(A)) is increased by the aggregate amount of reportable transaction understatements for purposes of determining whether the understatement is a substantial understatement. The section 6662(a) penalty applies only to the excess of the amount of the substantial understatement (if any) after section 6662A(e)(1)(A) is applied over the aggregate amount of reportable transaction understatements.<sup>340</sup> Accordingly, every understatement is penalized, but only under one penalty provision.

The penalty imposed under section 6662A does not apply to any portion of an understatement to which a fraud penalty applies under section 6663 or to which the 40-percent penalty for gross valuation misstatements under section 6662(h) applies.<sup>341</sup>

#### Erroneous claim for refund or credit

If a claim for refund or credit with respect to income tax (other than a claim relating to the earned income tax credit) is made for an excessive amount, unless it is shown that the claim for such excessive amount has a reasonable basis, the person making such claim is subject to a penalty in an amount equal to 20 percent of the excessive amount.<sup>342</sup>

The term “excessive amount” means the amount by which the amount of the claim for refund for any taxable year exceeds the amount of such claim allowable for the taxable year.

This penalty does not apply to any portion of the excessive amount of a claim for refund or credit which is subject to a penalty imposed under the accuracy related or fraud penalty provisions (including the general accuracy related penalty, or the penalty with respect to listed and reportable transactions, described above).

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<sup>338</sup> Sec. 6662(b) (flush language). In addition, section 6662(b) provides that section 6662 does not apply to any portion of an underpayment on which a fraud penalty is imposed under section 6663.

<sup>339</sup> Sec. 6662A(e)(1).

<sup>340</sup> Sec. 6662(d)(2)(A) (flush language)

<sup>341</sup> Sec. 6662A(e)(2).

<sup>342</sup> Sec. 6676.

## Explanation of Provision

The provision clarifies and enhances the application of the economic substance doctrine. Under the provision, new section 7701(o) provides that in the case of any transaction<sup>343</sup> to which the economic substance doctrine is relevant, such transaction is treated as having economic substance only if (1) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and (2) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction. The provision provides a uniform definition of economic substance, but does not alter the flexibility of the courts in other respects.

The determination of whether the economic substance doctrine is relevant to a transaction is made in the same manner as if the provision had never been enacted. Thus, the provision does not change present law standards in determining when to utilize an economic substance analysis.<sup>344</sup>

The provision is not intended to alter the tax treatment of certain basic business transactions that, under longstanding judicial and administrative practice are respected, merely because the choice between meaningful economic alternatives is largely or entirely based on comparative tax advantages. Among<sup>345</sup> these basic transactions are (1) the choice between capitalizing a business enterprise with debt or equity;<sup>346</sup> (2) a U.S. person's choice between utilizing a foreign corporation or a domestic corporation to make a foreign investment;<sup>347</sup> (3) the choice to enter a transaction or series of transactions that constitute a corporate organization or reorganization under subchapter C;<sup>348</sup> and (4) the choice to utilize a related-party entity in a

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<sup>343</sup> The term "transaction" includes a series of transactions.

<sup>344</sup> If the realization of the tax benefits of a transaction is consistent with the Congressional purpose or plan that the tax benefits were designed by Congress to effectuate, it is not intended that such tax benefits be disallowed. See, e.g., Treas. Reg. sec. 1.269-2, stating that characteristic of circumstances in which an amount otherwise constituting a deduction, credit, or other allowance is not available are those in which the effect of the deduction, credit, or other allowance would be to distort the liability of the particular taxpayer when the essential nature of the transaction or situation is examined in the light of the basic purpose or plan which the deduction, credit, or other allowance was designed by the Congress to effectuate. Thus, for example, it is not intended that a tax credit (e.g., section 42 (low-income housing credit), section 45 (production tax credit), section 45D (new markets tax credit), section 47 (rehabilitation credit), section 48 (energy credit), etc.) be disallowed in a transaction pursuant to which, in form and substance, a taxpayer makes the type of investment or undertakes the type of activity that the credit was intended to encourage.

<sup>345</sup> The examples are illustrative and not exclusive.

<sup>346</sup> See, e.g., *John Kelley Co. v. Commissioner*, 326 U.S. 521 (1946) (respecting debt characterization in one case and not in the other, based on all the facts and circumstances).

<sup>347</sup> See, e.g., *Sam Siegel v. Commissioner*, 45 T.C. 566 (1966), *acq.* 1966-2 C.B. 3. But see *Commissioner v. Bollinger*, 485 U.S. 340 (1988) (agency principles applied to title-holding corporation under the facts and circumstances).

<sup>348</sup> See, e.g., *Rev. Proc. 2010-3 2010-1 I.R.B. 110, Secs. 3.01(38), (39), (40), and (42)* (IRS will not rule on certain matters relating to incorporations or reorganizations unless there is a "significant issue"); compare *Gregory v. Helvering*, 293 U.S. 465 (1935).

transaction, provided that the arm's length standard of section 482 and other applicable concepts are satisfied.<sup>349</sup> Leasing transactions, like all other types of transactions, will continue to be analyzed in light of all the facts and circumstances.<sup>350</sup> As under present law, whether a particular transaction meets the requirements for specific treatment under any of these provisions is a question of facts and circumstances. Also, the fact that a transaction meets the requirements for specific treatment under any provision of the Code is not determinative of whether a transaction or series of transactions of which it is a part has economic substance.<sup>351</sup>

The provision does not alter the court's ability to aggregate, disaggregate, or otherwise recharacterize a transaction when applying the doctrine. For example, the provision reiterates the present-law ability of the courts to bifurcate a transaction in which independent activities with non-tax objectives are combined with an unrelated item having only tax-avoidance objectives in order to disallow those tax-motivated benefits.<sup>352</sup>

### **Conjunctive analysis**

The provision clarifies that the economic substance doctrine involves a conjunctive analysis – there must be an inquiry regarding the objective effects of the transaction on the taxpayer's economic position as well as an inquiry regarding the taxpayer's subjective motives for engaging in the transaction. Under the provision, a transaction must satisfy both tests, i.e.,

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<sup>349</sup> See, e.g., *National Carbide v. Commissioner*, 336 U.S. 422 (1949), *Moline Properties v. Commissioner*, 319 U.S. 435 (1943); compare, e.g. *Aiken Industries, Inc. v. Commissioner*, 56 T.C. 925 (1971), *acq.*, 1972-2 C.B. 1; *Commissioner v. Bollinger*, 485 U.S. 340 (1988); see also sec. 7701(l).

<sup>350</sup> See, e.g., *Frank Lyon Co. v. Commissioner*, 435 U.S. 561 (1978); *Hilton v. Commissioner*, 74 T.C. 305, *aff'd*, 671 F. 2d 316 (9<sup>th</sup> Cir. 1982), *cert. denied*, 459 U.S. 907 (1982); *Coltec Industries v. United States*, 454 F.3d 1340 (Fed. Cir. 2006), *cert. denied*, 127 S. Ct. 1261 (Mem) (2007); *BB&T Corporation v. United States*, 2007-1 USTC P 50,130 (M.D.N.C. 2007), *aff'd*, 523 F.3d 461 (4th Cir. 2008); *Wells Fargo & Company v. United States*, No. 06-628T, 2010 WL 94544, at \*60 (Fed. Cl. Jan. 8, 2010) (distinguishing leasing case *Consolidated Edison Company of New York*, No. 06-305T, 2009 WL 3418533 (Fed. Cl. Oct. 21, 2009) by observing that “considerations of economic substance are factually specific to the transaction involved”).

<sup>351</sup> As examples of cases in which courts have found that a transaction does not meet the requirements for the treatment claimed by the taxpayer under the Code, or does not have economic substance, see e.g., *BB&T Corporation v. United States*, 2007-1 USTC P 50,130 (M.D.N.C. 2007) *aff'd*, 523 F.3d 461 (4th Cir. 2008); *Tribune Company and Subsidiaries v. Commissioner*, 125 T.C. 110 (2005); *H.J. Heinz Company and Subsidiaries v. United States*, 76 Fed. Cl. 570 (2007); *Coltec Industries, Inc. v. United States*, 454 F.3d 1340 (Fed. Cir. 2006), *cert. denied* 127 S. Ct. 1261 (Mem.) (2007); *Long Term Capital Holdings LP v. United States*, 330 F. Supp. 2d 122 (D. Conn. 2004), *aff'd*, 150 Fed. Appx. 40 (2d Cir. 2005); *Klamath Strategic Investment Fund, LLC v. United States*, 472 F. Supp. 2d 885 (E.D. Texas 2007); *aff'd*, 568 F. 3d 537 (5th Cir. 2009); *Santa Monica Pictures LLC v. Commissioner*, 89 T.C.M. 1157 (2005).

<sup>352</sup> See, e.g., *Coltec Industries, Inc. v. United States*, 454 F.3d 1340 (Fed. Cir. 2006), *cert. denied* 127 S. Ct. 1261 (Mem.) (2007) (“the first asserted business purpose focuses on the wrong transaction--the creation of Garrison as a separate subsidiary to manage asbestos liabilities. . . . [W]e must focus on the transaction that gave the taxpayer a high basis in the stock and thus gave rise to the alleged benefit upon sale. . . .”) 454 F.3d 1340, 1358 (Fed. Cir. 2006). See also *ACM Partnership v. Commissioner*, 157 F.3d at 256 n.48; *Minnesota Tea Co. v. Helvering*, 302 U.S. 609, 613 (1938) (“A given result at the end of a straight path is not made a different result because reached by following a devious path.”).

the transaction must change in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position and the taxpayer must have a substantial non-Federal-income-tax purpose for entering into such transaction, in order for a transaction to be treated as having economic substance. This clarification eliminates the disparity that exists among the Federal circuit courts regarding the application of the doctrine, and modifies its application in those circuits in which either a change in economic position or a non-tax business purpose (without having both) is sufficient to satisfy the economic substance doctrine.<sup>353</sup>

### **Non-Federal-income-tax business purpose**

Under the provision, a taxpayer's non-Federal-income-tax purpose<sup>354</sup> for entering into a transaction (the second prong in the analysis) must be "substantial." For purposes of this analysis, any State or local income tax effect which is related to a Federal income tax effect is treated in the same manner as a Federal income tax effect. Also, a purpose of achieving a favorable accounting treatment for financial reporting purposes is not taken into account as a non-Federal-income-tax purpose if the origin of the financial accounting benefit is a reduction of Federal income tax.<sup>355</sup>

### **Profit potential**

Under the provision, a taxpayer may rely on factors other than profit potential to demonstrate that a transaction results in a meaningful change in the taxpayer's economic position or that the taxpayer has a substantial non-Federal-income-tax purpose for entering into such

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<sup>353</sup> The provision defines "economic substance doctrine" as the common law doctrine under which tax benefits under subtitle A with respect to a transaction are not allowable if the transaction does not have economic substance or lacks a business purpose. Thus, the definition includes any doctrine that denies tax benefits for lack of economic substance, for lack of business purpose, or for lack of both.

<sup>354</sup> See, e.g., Treas. Reg. sec. 1.269-2(b) (stating that a distortion of tax liability indicating the principal purpose of tax evasion or avoidance might be evidenced by the fact that "the transaction was not undertaken for reasons germane to the conduct of the business of the taxpayer"). Similarly, in *ACM Partnership v. Commissioner*, 73 T.C.M. (CCH) 2189 (1997), the court stated:

Key to [the determination of whether a transaction has economic substance] is that the transaction must be rationally related to a useful nontax purpose that is plausible in light of the taxpayer's conduct and useful in light of the taxpayer's economic situation and intentions. Both the utility of the stated purpose and the rationality of the means chosen to effectuate it must be evaluated in accordance with commercial practices in the relevant industry. A rational relationship between purpose and means ordinarily will not be found unless there was a reasonable expectation that the nontax benefits would be at least commensurate with the transaction costs. [citations omitted]

<sup>355</sup> Claiming that a financial accounting benefit constitutes a substantial non-tax purpose fails to consider the origin of the accounting benefit (i.e., reduction of taxes) and significantly diminishes the purpose for having a substantial non-tax purpose requirement. See, e.g., *American Electric Power, Inc. v. United States*, 136 F. Supp. 2d 762, 791-92 (S.D. Ohio 2001) ("AEP's intended use of the cash flows generated by the [corporate-owned life insurance] plan is irrelevant to the subjective prong of the economic substance analysis. If a legitimate business purpose for the use of the tax savings 'were sufficient to breathe substance into a transaction whose only purpose was to reduce taxes, [then] every sham tax-shelter device might succeed,'" (citing *Winn-Dixie v. Commissioner*, 113 T.C. 254, 287 (1999)); *aff'd*, 326 F.3d 737 (6<sup>th</sup> Cir. 2003).

transaction. The provision does not require or establish a minimum return that will satisfy the profit potential test. However, if a taxpayer relies on a profit potential, the present value of the reasonably expected pre-tax profit must be substantial in relation to the present value of the expected net tax benefits that would be allowed if the transaction were respected.<sup>356</sup> Fees and other transaction expenses are taken into account as expenses in determining pre-tax profit. In addition, the Secretary is to issue regulations requiring foreign taxes to be treated as expenses in determining pre-tax profit in appropriate cases.<sup>357</sup>

### **Personal transactions of individuals**

In the case of an individual, the provision applies only to transactions entered into in connection with a trade or business or an activity engaged in for the production of income.

### **Other rules**

No inference is intended as to the proper application of the economic substance doctrine under present law. The provision is not intended to alter or supplant any other rule of law, including any common-law doctrine or provision of the Code or regulations or other guidance thereunder; and it is intended the provision be construed as being additive to any such other rule of law.

As with other provisions in the Code, the Secretary has general authority to prescribe rules and regulations necessary for the enforcement of the provision.<sup>358</sup>

### **Penalty for underpayments and understatements attributable to transactions lacking economic substance**

The provision imposes a new strict liability penalty under section 6662 for an underpayment attributable to any disallowance of claimed tax benefits by reason of a transaction lacking economic substance, as defined in new section 7701(o), or failing to meet the requirements of any similar rule of law.<sup>359</sup> The penalty rate is 20 percent (increased to 40 percent if the taxpayer does not adequately disclose the relevant facts affecting the tax treatment in the return or a statement attached to the return). An amended return or supplement to a return

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<sup>356</sup> See, e.g., *Rice's Toyota World v. Commissioner*, 752 F.2d at 94 (the economic substance inquiry requires an objective determination of whether a reasonable possibility of profit from the transaction existed apart from tax benefits); *Compaq Computer Corp. v. Commissioner*, 277 F.3d at 781 (applied the same test, *citing Rice's Toyota World*); *IES Industries v. United States*, 253 F.3d at 354 (the application of the objective economic substance test involves determining whether there was a "reasonable possibility of profit . . . apart from tax benefits.").

<sup>357</sup> There is no intention to restrict the ability of the courts to consider the appropriate treatment of foreign taxes in particular cases, as under present law.

<sup>358</sup> Sec. 7805(a).

<sup>359</sup> It is intended that the penalty would apply to a transaction the tax benefits of which are disallowed as a result of the application of the similar factors and analysis that is required under the provision for an economic substance analysis, even if a different term is used to describe the doctrine.

is not taken into account if filed after the taxpayer has been contacted for audit or such other date as is specified by the Secretary. No exceptions (including the reasonable cause rules) to the penalty are available. Thus, under the provision, outside opinions or in-house analysis would not protect a taxpayer from imposition of a penalty if it is determined that the transaction lacks economic substance or fails to meet the requirements of any similar rule of law. Similarly, a claim for refund or credit that is excessive under section 6676 due to a claim that is lacking in economic substance or failing to meet the requirements of any similar rule of law is subject to the 20 percent penalty under that section, and the reasonable basis exception is not available.

The penalty does not apply to any portion of an underpayment on which a fraud penalty is imposed.<sup>360</sup> The new 40-percent penalty for nondisclosed transactions is added to the penalties to which section 6662A will not also apply.<sup>361</sup>

As described above, under the provision, the reasonable cause and good faith exception of present law section 6664(c)(1) does not apply to any portion of an underpayment which is attributable to a transaction lacking economic substance, as defined in section 7701(o), or failing to meet the requirements of any similar rule of law. Likewise, the reasonable cause and good faith exception of present law section 6664(d)(1) does not apply to any portion of a reportable transaction understatement which is attributable to a transaction lacking economic substance, as defined in section 7701(o), or failing to meet the requirements of any similar rule of law.

#### **Effective Date**

The provision applies to transactions entered into after the date of enactment and to underpayments, understatements, and refunds and credits attributable to transactions entered into after the date of enactment.

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<sup>360</sup> As under present law, the penalties under section 6662 (including the new penalty) do not apply to any portion of an underpayment on which a fraud penalty is imposed.

<sup>361</sup> As revised by the provision, new section 6662A(e)(2)(b) provides that section 6662A will not apply to any portion of an understatement due to gross valuation misstatement under section 6662(h) or nondisclosed noneconomic substance transactions under new section 6662(i).



**F. Time for Payment of Corporate Estimated Taxes  
(sec. 1410 of the Reconciliation bill and sec. 6655 of the Code)**

**Present Law**

In general, corporations are required to make quarterly estimated tax payments of their income tax liability.<sup>362</sup> For a corporation whose taxable year is a calendar year, these estimated tax payments must be made by April 15, June 15, September 15, and December 15. In the case of a corporation with assets of at least \$1 billion (determined as of the end of the preceding taxable year), payments due in July, August, or September, 2014, are increased to 157.75 percent of the payment otherwise due and the next required payment is reduced accordingly.<sup>363</sup>

**Explanation of Provision**

The provision increases the required payment of estimated tax otherwise due in July, August, or September, 2014, by 15.75 percentage points.

**Effective Date**

The provision is effective on the date of enactment of the bill.

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<sup>362</sup> Sec. 6655.

<sup>363</sup> The Hiring Incentives to Restore Employment (“HIRE”) Act, Sec.561; Pub. L. No. 111-124, Sec. 4; Pub. L. No. 111-92, Sec. 18; Pub. L. No. 111-42, Sec. 202(b)(1).