

The background of the entire page is a photograph of several pill bottles. The most prominent one is in the foreground, slightly to the left, and is filled with orange, oval-shaped pills. It has a white, ribbed cap. Other bottles are visible in the background, some out of focus, including one with a white cap and another with a red cap. The lighting is soft, creating a clinical or medical atmosphere.

## Summary of Tax Provisions in Health Care Reform

March 2010

TAX

# SUMMARY OF TAX PROVISIONS IN HEALTH CARE REFORM

This document describes tax provisions of the health care reform legislation, in the final form in which it will be enacted when the president signs the *Health Care and Education Affordability Reconciliation Act of 2010* (HCERA), which is anticipated during the week of March 29.

The final legislation is the product of two bills. The Senate and House first passed, and President Obama signed into law on March 23, the *Patient Protection and Affordable Care Act* (PPACA), Pub. L. No. 111-148. The PPACA is the Senate version of health care reform legislation.

The HCERA, H.R. 4872, modifies the revenue provisions of the PPACA in accordance with the agreement between the House and Senate. The House passed the HCERA on March 23, and the Senate, today, March 25, passed a slightly modified version. The House is expected to pass the modified version shortly and send it to the president.

The PPACA as amended by the HCERA will, when the House passes and the president signs the HCERA, constitute the health care reform legislation.

The legislation makes extensive changes to the current system of health care insurance and benefits intended to broaden coverage and reduce costs. Among other things, it mandates health insurance coverage for U.S. residents through a combination of penalties and subsidies, establishes insurance exchanges through which certain individuals and families could receive federal subsidies to reduce the cost of coverage; and significant expands eligibility for Medicaid while reducing payment rates for most services. It also repeals the exclusion for the Medicare prescription drug subsidy.

It also makes various changes to the Internal Revenue Code to offset part of the cost. Among the latter are fees and excise taxes imposed on the pharmaceutical, medical device, and health insurance industries, an excise tax on so-called "Cadillac" health insurance plans, and new limits on flexible spending accounts. It includes, as well, two previously proposed amendments to the Code: codification of the economic substance doctrine and modification of the credit for cellulosic biofuel as it applies to "black liquor." And it includes a 3.8% health insurance tax on passive investment income, as well as a 0.9% increase in the health insurance tax on wage income, for individuals earning more than \$200,000 and couples earning more than \$250,000.

## PROVISIONS AFFECTING INDIVIDUALS

### ***Unearned Income Medicare Contribution***

The FICA hospital insurance (Medicare) tax is currently imposed only on earned income (employee compensation or self employment income). Unlike the 6.2% old age, survivors, and disability (OASDI) portion of FICA, the Medicare portion does not have a cap and thus applies to all compensation income.

The Act adds a tax on “unearned” investment income of highly paid individuals or couples—including capital gains, interest income, dividends, annuity income and possibly rental income—but does not apply to tax-exempt bond income or gain on the sale of a principal residence that is otherwise excluded from income. Investment income does not include a distribution from a qualified retirement plan, and does not include any amount subject to self employment income subject to SECA.

“Net investment income” is the income after deductions for expenses allocable to the income. The tax applies only to married couples filing a joint tax return with modified adjusted gross income in excess of a “threshold” of \$250,000, \$200,000 for single filers, and \$125,000 for married filing separately.

The tax is 3.8% of the lesser of

- Net investment income or
- The taxpayer’s modified adjusted gross income (AGI) that exceeds the taxpayer’s threshold

For example, if net investment income for a married couple (filing a joint return) is \$20,000 and their modified AGI is \$260,000, the 3.8% tax applies to \$10,000 of income.

The tax does not apply to most trades or businesses conducted by a sole proprietor, partnership or S corporation, but applies to a trade or business that is a passive activity for the taxpayer or a trade or business of trading financial instruments or commodities.

The tax paid is not deductible and is not withheld by an employer. The tax must be counted in determining whether taxpayers are required to make estimated tax payments.

Effective: Tax years beginning after 2012.

### ***Additional Hospital Insurance Tax on High Income Taxpayers***

The Act increases the employee portion of the Medicare hospital insurance (HI) tax (currently 1.45% of wages) by an additional 0.9% on wages exceeding a threshold amount.

The threshold amount is \$250,000 for married couples filing a joint return; \$125,000 for married individuals filing separately; and \$200,000 for single filers.

The employer must withhold the additional HI tax on the portion of an employee’s wages received from the employer that exceeds \$200,000, without regard to the amount of wages received by the employee’s spouse.

Unlike the employee portion of the general HI tax of 1.45%, the employee is directly liable for this additional 0.9% HI tax if it is not withheld by the employer; if not withheld, the tax must be taken into account in determining individual estimated tax liability.

The additional 0.9% HI tax also applies to the HI portion of SECA tax on self-employment income in excess of the threshold amount.

Effective: For remuneration received and tax years beginning after 2012.

#### ***Excise Tax on Individuals Without Essential Health Benefits Coverage***

Beginning in 2014, most U.S. citizens and legal residents are required to maintain minimum essential health care 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 Health and Human Services (HHS) in coordination with the Secretary of the Treasury. Individuals are exempt from the requirement if they are incarcerated, not legally present in the United States, or are religious objectors.

Subject to additional exceptions and dollar caps, individuals who fail to maintain minimum essential coverage are subject to the following penalties:

- In 2014, the greater of \$95 or 1% of household income over the tax return filing threshold
- In 2015, the greater of \$325 or 2% of household income over the filing threshold
- In 2016 and later, the greater of \$695 or 2.5% of household income over the filing threshold

[Generally, in 2010, the threshold amount of income required for tax return filing is \$9,350 for a single taxpayer, and \$18,700 for a married couple filing a joint return.]

The fee for an uninsured dependent under the age of 18 is one half the adult fee.

Effective: Tax years beginning after 2013.

#### ***Refundable Tax Credit Providing Premium Assistance for Coverage Under a Qualified Health Plan***

The Act creates a refundable tax credit (the “premium assistance credit”) for eligible individuals and families who purchase health insurance through an exchange. 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.

The premium assistance credit is available for individuals (single or married filing joint returns) with household incomes up to 400% of the federal poverty level (FPL) for the family size involved, who do not receive health insurance through an employer or a spouse’s employer. The premium assistance credit increases, on a sliding scale, depending on household income as a percentage of the FPL. The 2010 FPL for a family of four is \$22,050, and for a single individual is \$10,830.

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

Effective: Tax years ending after 2013.

***Reduced Cost-Sharing for Individuals Enrolling in Qualified Health Plans***

The Act provides a cost-sharing subsidy to reduce annual out-of-pocket cost sharing for individuals and households with income up to 400% of the FPL (for the family size involved). The reductions are made in reference to the dollar cap on annual deductibles for high-deductible health plans. The amount of the subsidy is reduced as household income increases.

Effective: Date of enactment.

***Premium Assistance Credit and Cost-Sharing Reduction Payments Disregarded for Federal and Federally Assisted Programs***

Any premium assistance credits and cost-sharing subsidies are disregarded for purposes of determining an individual's eligibility for benefits or assistance—or the extent of the benefits and assistance—under any federal program or under a State or local program financed with federal funds.

Effective: Date of enactment.

***Modified Itemized Deduction for Medical Expenses***

The Act increases the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of AGI to 10% for regular income tax purposes. For the years 2013 through 2016, if either the taxpayer or the taxpayer's spouse turns 65 before the end of the year, the increased threshold does not apply and the threshold remains at 7.5% of AGI. The provision does not change the alternative minimum tax (AMT) treatment of the itemized deduction for medical expenses (for purposes of computing AMT income, medical expenses are deductible only to the extent they exceed 10% of AGI).

Effective: Tax years beginning after 2012.

## INDUSTRY AND EMPLOYER FEES

### ***Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers***

The Act 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. These fees are credited to the Medicare Part B trust fund.

An aggregate annual fee for all covered entities (\$2.5 billion for calendar year 2011, increasing annually to \$2.8 billion for calendar years 2012 and 2013; \$3 billion for calendar years 2014 through 2016; \$4 billion for 2017; \$4.1 billion for 2018; and \$2.8 billion for 2019 and later) is to be apportioned among the covered entities each year based on each entity's relative share of branded prescription drug sales taken into account during the previous calendar year. Generally, sales taken into account for each covered entity are a certain percentage of sales for the previous calendar.

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. Generally, sales taken into account for each covered entity are a certain percentage of sales for the previous calendar year. The sales taken into account during any calendar year are as follows:

Covered Entity Branded Prescription Drug Sales Per Year	Percentage of Sales Used to Determine Relative Market Share
Up to \$5 million	0%
Over \$5 million and up to \$125 million	10%
Over \$125 million and up to \$225 million	40%
Over \$225 million and up to \$400 million	75%
Over \$400 million	100%

It is anticipated the Secretary will publish guidance related to the determination of the fee.

Effective: Calendar years beginning after 2010.

### ***Excise Tax on Medical Device Manufacturers***

Under the Act, a tax equal to 2.3% of the sale price is imposed on the sale of certain taxable medical devices by the manufacturer, producer, or importer of the device. For this purpose, a taxable medical device is any device defined in section 201(h) of the *Federal Food, Drug, and Cosmetic Act* intended for humans.

The excise tax does not apply to eyeglasses, contact lenses, hearing aids, and any other medical device determined by the Secretary of the Treasury to be of a type that is generally purchased by the general public at retail for individual use.

Manufacturers excise tax exemptions for further manufacture and for export apply to the tax imposed under this provision. Exemptions for use as supplies for vessels or aircraft, and for sales to State or local governments, nonprofit educational organizations, and qualified blood collector organizations are not applicable.

Effective: For sales after 2012.

### ***Annual Fee on Health Insurance Providers***

The Act imposes an annual fee on any covered entity engaged in the business of providing health insurance with respect to U.S. health risks (generally, the health risk of a U.S. citizen or resident).

The aggregate annual fee for all covered entities is \$8 billion for calendar year 2014, increases annually to \$14.3 billion for calendar year 2018, and is indexed thereafter based on the rate of premium growth. The fee is apportioned among the covered entities each year based on a ratio designed to reflect relative market share of U.S. health insurance business.

Generally, for each covered entity, the annual fee is a pro rata share of the aggregate annual fee, based on the percentage of that covered entity's net premiums written during the preceding calendar year with respect to health insurance for any U.S. health risk, in relation to the aggregate amount of such net written premiums of all covered entities during the preceding calendar year.

Certain formulas and exclusions apply for purposes of determining the amount of net premiums for a covered entity, including—as part of the calculation—that only 50% of net premiums attributable to the exempt activities of tax-exempt insurance providers are taken into account. The definition of covered entity does not apply to employers who self-insure the health risks of employees, governmental entities, VEBA's, and nonprofit providers which receive more than 80% of gross revenues from government programs that target low income, elderly, or disabled populations.

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 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 U.S. health risk. Penalties apply for failure to report as required and for an understatement of the net premiums written.

Effective: The annual fee applies for each calendar year beginning after 2013, determined with respect to net premiums written after 2012, with respect to any U.S. health risk.

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

The Act imposes a fee on issuers of each accident or health insurance policy covering individuals residing in the United States (a "specified health insurance policy"), in order to fund the Patient Centered Outcomes Research Trust Fund to support comparative effective research.

The issuer, (or the person agreeing to provide or arrange for the provision of coverage in exchange for fixed payments of premiums) is liable for the payment of the fee. The fee is generally \$2 (\$1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

The Act also imposes a similar a fee on the plan sponsor of an applicable self-insured health plan. The plan sponsor is liable for the fee. For purposes of this provision, the plan sponsor is the employer in case of a plan established or maintained by a single employer. In the case of a

plan established by two or more employers or employee organizations, a multiple employer welfare arrangement, or a VEBA, the plan sponsor is the associate, committee, joint board of trustees, or other similar group that establishes or maintains the plan.

Effective: For policies and plan years (or portions thereof) beginning on or after October 1, 2012.



## PROVISIONS AFFECTING EMPLOYERS

### ***Credits and Penalties (and Plan Provisions to Reduce Penalties)***

#### *Small Business Tax Credit*

A “qualified small employer” that pays for at least 50% of qualified health insurance from an insurance company for its employees can receive a credit of up to 35% of the payments during the first phase of the credit, for tax years beginning in 2010 through 2013. For tax years beginning after 2013, the credit is only available for the first two years for which a qualified small employer provides coverage and is only provided if the employer purchases the health care coverage from a State exchange. The tax credit percentage for tax years after 2013 is up to 50% of the payments. The amount of the credit depends on the size of the company and on a benchmark premium.

The credit offsets any deduction the employer could otherwise take for the employer contributions to pay for health care.

A qualified small employer has no more than 25 full-time equivalent employees whose average compensation is no more than \$50,000 (but the full credit is only available to employers with 10 or fewer employees).

Effective: Tax years beginning after 2009.

#### *Small Business Tax Credit Applicable to Tax Exempt Employers*

Tax-exempt organizations (described in section 501(c)) that otherwise qualify for the small business tax credit are eligible to receive the credit. For tax-exempt organizations, the applicable percentage for the credit for tax years beginning in 2010, 2011, 2012, or 2013 is limited to 25%, and the applicable percentage for the credit for tax years beginning after 2013 is limited to 35%. Tax-exempt organizations may apply the tax credit against certain payroll taxes to the extent of the income tax and hospital insurance tax withheld from the employees and the hospital tax imposed on the organization.

#### *Shared Responsibility for Employers*

A “large employer” that does not offer “minimum essential coverage” at an “affordable” rate, or pays less than 60% of the cost of health care benefits for full-time employees, must pay a penalty if any of the full-time employees are allowed or paid a tax credit or cost-sharing reduction for buying insurance from a State exchange plan. The penalty is assessed on a monthly basis and is not deductible. An employee eligible for Medicaid who leaves the employer’s coverage to enroll in Medicaid is not counted for penalty purposes.

An employer is a large employer if it has at least 50 full-time employees during the preceding calendar year. Related controlled group employers are aggregated under section 414(b), (c), (m), or (o) to determine whether they are large employers.

*Not offering coverage:* The penalty for any month is based on the number of full-time employees (over a 30-employee threshold per controlled group). The amount of the penalty for each month is equal to the number of full-time employees (whether or not they are receiving premium assistance) x 1/12 of \$2,000. The penalty is assessed monthly. After 2014, the penalty

increases based on a formula using average per capita premiums.

*“Unaffordable” coverage / less than 60% of the premium paid by the employer:* The penalty is based on each employee who actually receives the premium tax credit under the State exchange plans times 1/12 of \$3,000 for each month during which the employees receive the credit. The monthly penalty is capped at an amount equal to the total number of full-time employees (over the 30-employee threshold) times 1/12 of \$2,000.

*Example:* Employer has 100 full-time employees and provides health care for them. Twenty (20) employees receive a premium tax credit from a State exchange plan. For 2014, Employer pays \$3,000 x 20 employees, or \$60,000. The cap would be \$2,000 x (100 – 30) = \$140,000 and thus a penalty of \$60,000 amount is due.

After 2014 the penalty amounts will be increased.

Unaffordable coverage is defined as coverage with a premium charged to employees that is more than 9.5% (indexed) of the employee’s household income.

Salary reduction payments by employees to flexible spending arrangements (FSAs) or other pre-tax plans do not generally count as employer-provided care in determining whether care is unaffordable. However, if the employer reimburses the employee for State exchange premiums, including using a salary reduction arrangement in a cafeteria plan, the coverage is considered employer-provided, and the employee may not be eligible for the premium tax credits. Doing so may thus reduce or eliminate the employer penalty. Also see the discussion on offering health plans through cafeteria plans below.

Notices as provided under other provisions of the Act provide the employer with information concerning which employees are receiving premium tax credits.

Effective: For months after 2013.

#### *Offering of Qualified Health Plans Through Cafeteria Plans*

A “qualified employer” (generally a small employer that does not provide health coverage but elects to make all its employees eligible for a “small group market” State exchange plan) can allow its employees to pay for the premiums through a cafeteria plan (as a qualified pre-tax benefit).

A large employer cannot offer to reimburse an employee for State exchange plan premiums using a qualified pre-tax contribution through a cafeteria plan.

#### ***KPMG Observation***

It is not completely clear how this provision works with the provision above, that provides that salary reduction payments for State exchange premiums are considered employer contributions. It is possible that the salary reduction for State exchange premium provision only applies to small employers.

Effective: Tax years beginning after 2013.

### *Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans*

The Act provides that the maximum amount available for reimbursement for medical expenses under a health flexible spending account (FSA) is \$2,500 (indexed for inflation).

Effective: Tax years beginning after 2012.

### *Free Choice Vouchers*

Employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage must provide “qualified employees” a voucher that can be used to buy health benefit coverage through a State exchange plan.

An employee receiving a voucher is not eligible for any tax creditor or cost-sharing credit for the purchase of a plan in a State exchange.

The voucher value must equal the dollar value of the employer contributions to the employer-offered plan (assuming the employee would choose the plan for which the employer would pay the largest percentage of the premium cost). The voucher value is determined for self-only coverage, but the employee can use it to help buy family coverage in the State exchange plan. The employee is allowed to keep any excess over the amount needed to pay State exchange plan premiums, but the excess is included in the employee’s gross income.

#### ***KPMG Observation***

It is not clear which party is responsible for reporting any excess amount as the employee’s gross income. It is also not clear whether this income is subject to payroll taxes.

A “qualified employee” is one who would be required to pay more than 8% but less than 9.5% of household income to participate in the employer’s plan. The employee must NOT participate in the employer’s plan, and the total household income may not exceed 400% of the federal poverty line for the family.

Effective: For years after December 31, 2013.

#### ***KPMG Observation***

Combining these provisions, it appears that a large employer that has a plan for which it pays at least 60% of the benefit but for which some employees will pay more than 8% of household income:

- Will provide free vouchers to employees who would have to pay more than 8% but no more than 9.5% of household income and will not be assessed the penalty for those employees.
- Will be assessed a penalty for almost every full time employee who would have to pay 9.5% of household income.

### *Excise Tax on High Cost Employer-Sponsored Health Coverage*

The Act imposes a 40% excise tax on insurers if the aggregate value of employer-sponsored health insurance coverage for any employee (including any former employee, surviving spouse, and any other primary insured individual) exceeds a threshold amount.

For 2018, the threshold amount is \$10,200 for individual coverage and \$27,500 for family coverage (\$11,850 and \$30,950, respectively, for retirees and employees in high risk professions) multiplied by the “health cost adjustment percentage” and increased by the age and gender adjusted excess premium amount.

An employer may reduce the cost of the coverage for purposes of applying the tax if the employer’s age and gender demographics are not representative of the age and gender demographics of a national risk pool.

#### *Employer-Sponsored Health Insurance Coverage*

Employer-sponsored health insurance coverage includes both fully-insured and self-insured health coverage excludable from the employee’s gross income. The term includes any coverage under any group health plan offered by an employer to an employee, whether the employer provides the coverage or the employee pays for the coverage with after-tax dollars. For self-employed individuals, the term includes coverage under any plan for which a deduction is allowable to the self-employed individual under Code section 162(l).

#### *Aggregate Value of Employer-Sponsored Health Insurance Coverage*

Generally, the aggregate value of all employer-sponsored health insurance coverage, including any supplementary health insurance coverage not excluded from such value, is calculated based on applicable premiums for the tax year for the employee under COBRA continuation coverage rules. If a plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, separate calculations are required for each type of coverage.

With respect to salary reduction health FSAs, the value of employer-sponsored health insurance coverage is equal to the dollar amount of the aggregate salary reduction contributions for the year. Employer contributions in excess of the employee’s salary reduction are generally determined in the same manner as applicable premiums for COBRA continuation coverage.

#### *Liability for Excise Tax*

The excise tax applies on a pro rata basis to “issuers” of the insurance. If an employer contributes to an HSA or Archer MSA, the employer is the insurer. For a self-insured employer plan, the plan administrator (which may be the employer) must pay the excise tax. Self-insured plans include regular health plans as well as health FSA or an HRA.

Each insurer is responsible for the excise tax attributable to the percentage of the employer-sponsored health insurance coverage provided by that insurer in relation to the aggregate value of all employer-sponsored health insurance coverage provided to the employee.

Targeted health insurance (such as cancer insurance) paid exclusively with after-tax employee payroll deductions are not counted for this calculation.

## *Reporting*

The employer must calculate the amount subject to the excise tax allocable to each insurer and plan administrator, and must report these amounts to each insurer, plan administrator, and the Secretary of the Treasury, in such form and at such time as the Secretary may prescribe. A penalty applies if the employer underreports such amounts.

Each insurer must then calculate, report, and pay the excise tax to the IRS on such forms and at such time as the Secretary may prescribe.

Effective: The provision is effective for tax years beginning after December 31, 2017.

## ***Deductions***

### *Limitation on Deduction for Remuneration Paid by Health Insurance Providers*

The Act provides that a “covered health insurance provider”—whether or not public—will be subject to rules similar to the TARP executive compensation deduction restrictions. This limitation will apply to all officers, employees, directors, and all other service providers (such as consultants). As with the TARP rules, there are no exceptions for performance-based compensation or commissions. Thus, compensation deductions will generally be limited to \$500,000 for a given person with regard to a given year.

#### ***KPMG Observation***

As with the TARP rules, if an amount is earned in one year but not paid until another year (under a broad definition of “deferred compensation”), it appears that the limitation will look back to the year in which the compensation is earned, and the limit for the earning year is applied counting both the regular compensation for the year and any compensation earned in the year but paid after that year, even if the employee is no longer an applicable employee. Thus, even retirement or termination does not eliminate this loss-of-deduction rule.

An insurance company is a covered health insurance provider under this rule if at least 25% of the provider’s gross premium income from health business is derived from health insurance plans that meet the minimum creditable coverage requirements. A company is under these rules if it meets this definition for any portion of the tax year.

Employers with self-insured plans are excluded from the definition of covered health insurance provider.

### *Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans*

Companies that sponsor qualified retiree prescription drug plans receive a 28% HHS subsidy based on the gross cost of the prescriptions. The subsidy is currently not included in employer income. Employers are generally allowed to deduct any amount contributed to such a plan.

The Act provides that the employer’s contribution deduction is reduced by the amount of the subsidy received.

Effective: Tax years beginning after 2012.

### ***Information Reporting and Payroll Provisions***

#### *Inclusion of Cost of Employer-Sponsored Health Coverage on W-2*

Under the Act, an employer is required to disclose on each employee's Form W-2 the value of the employee's health insurance coverage under any employer-sponsored plans in which the employee is enrolled.

The reportable value is the aggregate premium for all such plans in which the employee is enrolled (excluding the value of a health FSA), based on applicable premiums for the tax year for the employee under the rules for COBRA continuation coverage, including the special rule for self-insured plans. If the plan provides for the same COBRA continuation coverage premium for both individual coverage and family coverage, separate calculations are required for each type of coverage.

Effective: Tax years beginning after 2010.

#### *Reporting of Health Insurance Coverage*

The Act requires insurers (including employers who self-insure) to report certain health insurance coverage information both to any individual to whom the insurer provides minimum essential coverage during a calendar year and to the IRS.

The IRS is required to provide a notice—no later than by June 30 of each year—to each individual who files an income tax return and fails to enroll in minimal essential coverage.

An insurer who fails to comply with these new reporting requirements is subject to penalties for failure to file an information return and failure to provide a payee statement.

Effective: For calendar years beginning after 2013.

#### *Reporting of Employer Health Insurance Coverage*

The Act requires certain employers to report specified health insurance coverage information both to their full-time employees and to the IRS.

This requirement applies to each applicable large employer (generally an employer that employs an average of at least 50 full-time employees during the preceding calendar year) subject to the new employer responsibility provisions, and to each "offering employer."

An "offering employer" is an employer who offers minimum essential coverage to its employees under an eligible employer-sponsored plan and who pays any portion of the costs of such plan if the required employer contribution for any employee exceeds 8% (indexed in years after 2014) of the wages paid by the employer to the employee.

An employer that fails to comply with these new reporting requirements is subject to the penalties that apply for failure to file an information return and failure to furnish payee statements.

The Secretary of the Treasury may provide that any such information return or payee statement

may be required to be provided as part of any return or statement required under other provisions in the Act.

Effective: Periods beginning after 2013.

### ***Plan Structural Changes***

#### *Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin*

Under the Act, the cost of over-the-counter medicines may not be reimbursed with excludible income through a Health FSA, Health Retirement Account (HRA), Health Savings Account (HSA), or Archer Medical Savings Account (MSA) unless the medicine is prescribed by a physician.

Effective: For expenses incurred after 2010.

#### *Increase in Additional Tax on Distributions from HSAs or Archer MSAs Not Used for Medical Expenses*

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

#### *Establishment of SIMPLE Cafeteria Plans for Small Businesses*

The Act provides that an eligible small employer is provided 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 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 nondiscrimination rules if the cafeteria plan satisfies minimum eligibility and participation requirements and minimum contribution requirements.

Under the Act, an eligible small employer is an employer who employed an average of 100 or fewer employees on business days during either of the two preceding years. If an employer was an eligible employer for any year and maintained a SIMPLE cafeteria 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 the prior year.

The eligibility requirement for the safe harbor 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.

The minimum contribution requirement is met if the employer provides a minimum contribution for each non-highly compensated employee in addition to any salary reduction contribution made by the employee. The contribution must be available toward the cost of any qualified benefit (other than a taxable benefit) offered under the plan. The minimum contribution under the non-elective contribution method is an amount equal to a uniform percentage (not less than 2%) of each eligible employee's compensation—determined without regard to whether the employee made any salary reduction under the plan. The minimum matching contribution is the lesser of:

- 100% of the amount of the salary reduction contribution elected to be made by the employee for the plan year, or
- 6% of the employee's compensation for the plan year

Effective: Tax years beginning after 2010.

*Expansion of Adoption Credit and the Exclusion from Gross Income for Employer-Provided Adoption Assistance*

The Act provides that the expiration of the adoption credit is delayed for one year until after 2011. The maximum exclusion is increased to \$13,170 per eligible child (indexed for inflation after 2010).

Effective: Tax years beginning after 2009.

*Adult Dependents*

The Act extends 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 tax year.

Effective: Date of enactment.

*Conforming Amendments*

Group health plans and health insurance issuers providing health insurance coverage in connections with group health plans are subject to new section 9815. Under this change, it appears that such plans are subject to a number of additional rules.



## OTHER PROVISIONS AFFECTING BUSINESSES

### ***Codification of Economic Substance Doctrine and Imposition of Penalties***

Under the Act, a 40% penalty applies to tax understatements attributable to transactions lacking economic substance (20% with adequate disclosure) or failing to meet the requirements of any similar rule of law. There is no reasonable cause and good faith exception to the penalty.

A transaction is treated as having economic substance only if:

- The transaction changes in a meaningful way (apart from federal income tax effects) the taxpayer's economic position, and
- The taxpayer has a substantial purpose (apart from federal income tax effects) for entering into the transaction.

A transaction's profit potential is not taken into account in evaluating whether the transaction has economic substance unless the present value of the reasonably expected pre-tax profit is substantial in relation to the present value of the expected net tax benefits arising from the transaction. Fees and other transaction expenses are treated as expenses in determining pre-tax profit. In addition, the Secretary of the Treasury is to issue regulations requiring foreign taxes to be treated as expenses in determining pre-tax profit in appropriate cases.

Any State or local income tax effect that is related to a federal income tax effect is treated as a federal income tax effect in evaluating whether a transaction has economic substance under the provision. Further, a purpose of achieving a financial accounting benefit is not taken into account in determining whether a taxpayer has a substantial non-tax purpose for a transaction if the origin of the financial accounting benefit is a reduction of federal income tax.

#### ***KPMG Observation***

The new provision applies only if the economic substance doctrine is considered relevant under the taxpayer's particular facts and circumstances. It appears that this determination is to be made on a case-by-case basis under historic judicial principles. The provision is not intended to:

- Disallow tax benefits that are consistent with congressional intent; and
- Alter the tax treatment of certain basic business transactions that are respected under longstanding judicial and administrative practice, merely because the choice between meaningful economic alternatives is largely or entirely based on comparative tax advantages. These basic transactions include:
  - (1) The choice between capitalizing a business enterprise with debt or equity;
  - (2) A U.S. person's choice between utilizing a foreign corporation or a domestic corporation to make a foreign investment;
  - (3) The choice to enter into a transaction or series of transactions that constitute a corporate organization or reorganization under subchapter C of the Internal Revenue Code; and

(4) The choice to utilize a related-party entity in a transaction, provided that the arm's length standard of section 482 and other applicable concepts are satisfied.

Under the Act, any excessive amount of a claim for credit or refund due to a transaction lacking in economic substance is deemed to lack a reasonable basis and, therefore, is subject to the 20% penalty under section 6676.

Effective: For transactions entered into after the date of enactment.

***Require Information Reporting on Payments to Corporations***

Under the Act, 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 regulations issued 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 new rules do not override specific provisions in the Code that except certain payments from reporting, such as securities or broker transactions.

Effective: For payments made after 2011.

***Investment Credit for Qualifying Therapeutic Discovery Projects***

The Act establishes a 50% 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 of the Treasury, in consultation with the Secretary of HHS, will award certifications for qualified investments. The credit is available only to companies with 250 or fewer employees.

A qualifying therapeutic discovery project is a project designed to develop a product, process, or therapy to diagnose, treat, or prevent diseases or afflictions by:

- Conducting pre-clinical activities, clinical trials, clinical studies, and research protocols
- Developing technology or products designed to diagnose diseases and conditions, including molecular and companion drugs and diagnostics, or to further delivery or administration of therapeutics

The qualified investment for any tax year is the aggregate amount of the costs paid or incurred in that year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project. The qualified investment does not include certain remuneration costs, interest expense, facility maintenance expenses, service costs, or any other expenditure determined by the Secretary of the Treasury as appropriate to carry out the purposes of the provision.

Companies must apply to the Secretary of the Treasury to obtain certification for qualifying investments. The Secretary will consider only those projects that show reasonable potential to:

- Result in new therapies to treat areas of unmet medical need or to prevent, detect, or treat chronic or acute disease and conditions
- Reduce long-term health care costs

Significantly advance the goal of curing cancer within a 30-year period

In addition, the Secretary will take into consideration projects which would have the greatest potential to create and sustain high-quality high-paying jobs in the United States, and to advance U.S. 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. 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. Expenditures taken into account in determining the amount of the credit are nondeductible to the extent of the credit claimed that is attributable to the expenditures.

Taxpayers may elect to receive credits that have been allocated to them in the form of Treasury grants equal to 50% of the qualifying investment. The grant is not includible in the taxpayer's gross income. Treasury may not make grants to certain entities, including governmental agencies or certain tax-exempt organizations.

Effective: For expenditures paid or incurred after 2008, in tax years beginning after 2008.

#### ***Elimination of Unintended Application of Cellulosic Biofuel Producer Credit***

An income tax credit is allowed for qualified cellulosic biofuel that is produced by the taxpayer. The cellulosic biofuel producer credit is \$1.01 per gallon, reduced in the case of an alcohol cellulosic biofuel by the allowable alcohol credits. Cellulosic biofuel is defined as any liquid fuel that (1) is produced in the United States and used as fuel in the United States; (2) is produced from any lignocellulosic or hemicellulosic matter that is available on a renewable or recurring basis; and (3) meets the Environmental Protection Agency (EPA) registration requirements for fuels and fuel additives.

The cellulosic biofuel must be either (1) sold by its producer for use by the purchaser in the production of a qualified cellulosic biofuel mixture in the purchaser's trade or business, for use by the purchaser as a fuel in its trade or business, or for retail sale by the purchaser to another person (and delivery into the other person's fuel tank); or (2) used by the producer for any purpose described in (1). A qualified cellulosic biofuel mixture is a mixture of cellulosic biofuel and either gasoline or any other fuel suitable for use in an internal combustion engine that is sold by the person producing the mixture for use as a fuel or is used as a fuel by the person producing the mixture.

The credit is allowed only against the producer's income tax liability (including alternative minimum tax liability). The credit expires on December 31, 2012.

Certain liquid byproducts derived from the processing of paper or pulps (known as "black liquor") are produced from lignocellulosic or hemicellulosic matter available on a renewable or recurring basis. Thus, any such liquid byproducts that meet the EPA registration requirements would qualify as cellulosic biofuel.

The Act excludes from the definition of cellulosic biofuel any fuels that (1) are more than 4% (by weight) water or sediment in any combination, or (2) have an ash content of more than 1% (by weight). This change would exclude black liquor from eligibility for the credit.

Effective: For fuels sold or used after 2009.

***Time for Payment of Corporate Estimated Taxes***

The Act increases by 15.75 percentage points the required corporate estimated tax payments factor for payments due in July, August or September of 2014 by corporations with assets of at least \$1 billion.

Effective: Date of enactment.

## PROVISIONS AFFECTING TAX-EXEMPT ORGANIZATIONS

### ***Tax Exemption for Certain Member-Run Health Insurance Issuers***

The Act authorizes \$6 billion in federal funds for the establishment of the Consumer Operated and Oriented Plan (the “COOP program”) to foster the creation of qualified nonprofit health insurance issuers that will offer qualified health plans in individual and small group markets. The federal funds are to be distributed as loans to assist with start-up costs and grants to assist in meeting state solvency requirements. An entity receiving a loan or grant under the COOP program must enter into an agreement with HHS requiring the recipient to meet the requirements for being treated as a qualified nonprofit health insurance issuer.

A qualified nonprofit health insurance issuer must meet the following requirements:

- The organization must be organized as a nonprofit, member corporation under State law.
- Substantially all of the organization’s activities must 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.
- Neither the organization, a related entity, nor a predecessor may have been a health insurance issuer as of July 16, 2009.
- The organization may not be sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.
- Governance of the organization must be subject to a majority vote of its members.
- The organization’s governing documents must incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference.
- 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 HHS.
- 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.
- The organization must meet 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, and must coordinate with certain other State insurance reforms under the Act; and
- The organization must not offer a health plan in a State until that State has in effect (or HHS has implemented for the State) the market reforms required by Part A of the *Public Health Service Act*.

An organization that receives a grant or loan under the COOP program and that is in compliance with the above requirements and the terms of any program grant or loan agreement

qualifies is eligible to apply for exemption from federal income tax under new section 501(c)(29) of the Code. Such organizations also are subject to certain organizational and operational requirements applicable to certain section 501(c) organizations, including prohibitions on private inurement and political activities, limitations on lobbying activities, taxation of excess benefit transactions, and tax on unrelated business taxable income, and return-filing requirements.

Effective: Date of enactment.

### ***Tax Exemption for Entities Established Pursuant to Transitional Reinsurance Program***

Under the Act, issuers of health benefit plans that are offered in the individual market are generally 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 Act requires each State 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. An “applicable reinsurance entity” is a nonprofit 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 in the State, and (2) the duties of which are to carry out the reinsurance program by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program. An applicable reinsurance entity is generally exempt from federal income tax, except for taxes on unrelated business taxable income.

Effective: Date of enactment.

### ***New Requirements for Tax-Exempt Hospitals***

The Act establishes new requirements applicable to section 501(c)(3) organizations that operate one or more hospital facilities. For this purpose, a hospital facility includes any facility that is, or is required to be, licensed, registered or similarly recognized by a State as a hospital, and any other facility or organization determined to have the provision of hospital care as its principal purpose. Under the Act, a hospital organization will not be treated as tax-exempt under section 501(c)(3) unless the organization:

- Conducts a community health needs assessment at least once every three years, adopts an implementation strategy to meet the needs identified in the assessment, and submits with its annual information return (Form 990) a description of how it is addressing such needs (or, if not, why). The needs assessments must be made publicly available. Failure to complete a community needs assessment in any applicable three-year period results in an excise tax of up to \$50,000.
- Adopts, implements, and widely publicizes a written financial assistance policy that meets certain requirements.
- Limits charges to patients that qualify for financial assistance under the financial assistance policy to no more than the amount generally billed to individuals who have insurance.
- Makes reasonable efforts to determine whether an individual is eligible for assistance under its financial assistance policy before undertaking certain “extraordinary” collection actions (e.g.,

liens) against such individual.

If an organization operates more than one hospital, the organization is required to satisfy the above four requirements with respect to each hospital. An organization is not treated as tax exempt under section 501(c)(3) with respect to any hospital that does not separately meet such requirements.

A hospital organization is required to submit copies of its audited financial statements with its annual information return. The IRS is required to review the community benefits activities of each hospital at least once every three years.

The Act also requires the Secretary of the Treasury, in consultation with the Secretary of HHS, to submit to Congress reports on levels and trends in 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.

Effective: Provisions pertaining to tax-exempt hospitals generally are effective for tax years beginning after the date of enactment, except that the community health needs assessment requirement is effective for tax years beginning after the date which is two years after the date of enactment.

#### ***Restriction on Section 833 Deduction for Blue Cross and Blue Shield Organizations***

The Act limits eligibility for the rules of section 833 (generally applicable to certain Blue Cross or Blue Shield organizations) to those organizations meeting a medical loss ratio standard of 85% for the tax year. Thus, an organization that does not meet the 85% standard is not allowed the 25% deduction and the exception from the 20% 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 tax year.

Effective: Tax years beginning after 2009.

## MISCELLANEOUS PROVISIONS

### ***Disclosures to Carry Out Eligibility Requirements for Certain Programs***

Individuals will submit income information to an exchange as part of an application process to claim the cost-sharing reduction and the tax credit on an advance basis. The Department of Health and Human Services (HHS) serves as the centralized verification agency for this information.

Under the Act, the IRS is permitted to disclose certain tax return data to substantiate the accuracy of income information that the taxpayer provides to HHS for determining eligibility for the cost-sharing reduction or tax credit (or for participation in a specified State health subsidy program, such as a State Medicaid program). HHS is permitted to disclose to an exchange or its contractors (or to a State agency or its contractors) any inconsistency between the information submitted by the taxpayer and IRS records. Recipients of the confidential return information are subject to safeguards protecting the confidentiality of the information and civil and criminal penalties for unauthorized disclosure and inspection. Special rules apply to the disclosure of information to contractors. The IRS is required to account for all disclosures.

Effective: Date of enactment.

### ***Disclosures to Carry Out the Reduction of Medicare Part D Subsidies for High Income Beneficiaries***

Upon written request from the Commissioner of Social Security, the IRS may disclose certain tax return information for purposes of—and to the extent necessary in—establishing the appropriate amount of any Medicare Part D premium subsidy adjustment.

The Social Security Administration may re-disclose certain information to the Department of Health and Human Services, Department of Justice, Centers for Medicare and Medicaid, Office of Personnel Management, and the Railway Retirement Board.

Effective: Date of enactment.

### ***Other Provisions***

Other provisions in the Act include:

- An exclusion from gross income for assistance provided to participants in State student loan repayment programs for certain health professionals
- An exclusion from gross income for the value of certain Indian tribe health care benefits
- A 10% excise tax on certain indoor tanning services
- A required study and report by the Secretary of Veterans Affairs on the effect, if any, on the cost of medical care for veterans and veterans' access to branded prescription drugs and medical devices of the fees assessed on manufacturers and importers of branded prescription drugs and medical devices, and the fees on health insurance providers .
- A required study and report by the Secretary of HHS on the feasibility and implication of adjusting the application of the federal poverty level (FPL) under the provisions of the Act for different geographical areas so as to reflect disparities in the cost of living



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