TECHNICAL EXPLANATION OF THE REVENUE PROVISIONS CONTAINED IN H.R. 3962, THE "AFFORDABLE HEALTH CARE FOR AMERICA ACT," AS AMENDED

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CONTENTS

Page

INTRODUCTION 1

DIVISION A − AFFORDABLE HEALTH CARE CHOICES 2

TITLE I − IMMEDIATE REFORMS 2

A. Requiring the Option of Extension of Dependent Coverage for Uninsured Young Adults (sec. 105 of the bill and new sec. 9804 of the Code) 2
B. Limitations on Preexisting Condition Exclusions in Group Health Plans in Advance of Applicability of New Prohibition of Preexisting Condition Exclusion (sec. 106 of the bill and sec. 9801 of the Code) 4
C. Prohibiting Acts of Domestic Violence From Being Treated as Preexisting Conditions (sec. 107 of the bill and sec. 9801(d)(3) of the Code) 6
D. Ending Health Insurance Denials and Delays of Necessary Treatment for Children With Deformities (sec. 108 of the bill and new sec. 9814 of the Code) 8
E. Elimination of Lifetime Limit (sec. 109 of the bill and new sec. 9815 of the Code) 10
F. Extension of COBRA Continuation Coverage (sec. 113 of the bill) 12

TITLE IV − SHARED RESPONSIBILITY 15

A. Individual Responsibility (sec. 401 of the bill) 15
B. Employer Health Coverage Participation Requirements (sec. 411 of the bill) 16
C. Employer Responsibility to Contribute Towards Employee and Dependant Coverage (sec. 412 of the bill) 18
D. Employer Contributions in Lieu of Coverage (sec. 413 of the bill) 20
E. Authority Related to Improper Steering (sec. 414 of the bill) 22
F. Satisfaction of Health Coverage Participation Requirements Under the Internal Revenue Code of 1986 (sec. 422 of the bill) 23
G. Additional Rules Relating to Health Coverage Participation Requirements (sec. 424 of the bill) 24

TITLE V − AMENDMENTS TO INTERNAL REVENUE CODE OF 1986 25

A. Tax on Individuals Without Acceptable Health Care Coverage (sec. 501 of the bill and new sec. 59B of the Code) 25
B. Election to Satisfy Health Coverage Participation Requirements (sec. 511 of the bill and new sec. 4980H of the Code) 28
C. Responsibilities of Nonelecting Employers (sec. 512 of the bill and sec. 3111(c) of the Code) 31
D. Credit For Small Business Employee Health Coverage Expenses (sec. 521 of the bill and new sec. 45R of the Code) 34
E. Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin (sec. 531 of the bill and secs. 105, 106, 220, and 223 of the Code) 38

F. Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans (sec. 532 of the bill and sec. 125 of the Code) ... 40
G. Increase in Additional Tax on Distributions from HSAs Not Used for Medical Expenses (sec. 533 of the bill and sec. 223 of the Code) ... 43
H. Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans (sec. 534 of the bill) ... 45
I. Disclosures to Carry Out Health Insurance Exchange Subsidies (sec. 541 of the bill and sec. 6103(l)(21) of the Code) ... 47
J. Offering of Exchange-Participating Health Benefit Plans Through Cafeteria Plans (sec. 542 of the bill and sec. 125 of the Code) ... 49
K. Exclusion From Gross Income of Payments Made Under Reinsurance Program For Retirees (sec. 543 of the bill and sec. 139A of the Code) ... 52
L. CLASS Program Treated in Same Manner as Long-Term Care Insurance (sec. 544 of the bill and sec. 7702B of the Code) ... 54
M. Exclusion From Gross Income for Medical Care Provided for Indians (sec. 545 of the bill and new sec. 139D of the Code) ... 57
N. Surcharge on High-Income Individuals (sec. 551 of the bill and new sec. 59C of the Code) ... 60
O. Excise Tax on Medical Devices (sec. 552 of the bill and new sec. 4061 of the Code) ... 62
P. Require Information Reporting on Payments to Corporations (sec. 553 of the bill and sec. 6041 of the Code) ... 65
Q. Repeal of Worldwide Allocation of Interest (sec. 554 of the bill and sec. 864(f) of the Code) ... 67
R. Second Generation Biofuel Producer Credit (sec. 555 of the bill and secs. 40 and 168(l) of the Code) ... 71
S. Limitation on Treaty Benefits for Certain Deductible Payments (sec. 561 of the bill and sec. 894 of the Code) ... 75
T. Codification of Economic Substance Doctrine; Penalties (sec. 562 of the bill and sec. 7701 of the Code) ... 80
U. Certain Large or Publicly Traded Persons Made Subject to a More Likely Than Not Standard for Avoiding Penalties on Underpayments (sec. 563 of the bill and secs. 6662 and 6664 of the Code) ... 95
V. Certain Health Related Benefits Applicable to Spouses and Dependents Extended to Eligible Designated Beneficiaries (sec. 571 of the bill and secs. 105, 106, 162, 501, 3121, 3306, and 3401 of the Code) ... 102

DIVISION B − MEDICARE AND MEDICAID IMPROVEMENTS ... 105

TITLE VIII − REVENUE-RELATED PROVISIONS ... 105

A. Disclosures to Facilitate Identification of Individuals Likely to be Ineligible for Low-Income Subsidies Under the Medicare Prescription Drug Program to Assist Social Security Administration's Outreach to Eligible Individuals (sec. 1801 of the bill and sec. 6103(l)(19) of the Code) ... 105
B. Comparative Effectiveness Research Trust Fund; Financing for Trust Fund (sec. 1802 of the bill and new secs. 4375, 4376, 4377, and 9511 of the Code) ... 108

INTRODUCTION

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a technical explanation of the revenue provisions contained in H.R. 3962, the "Affordable Health Care for America Act," as amended.[2]

[1] This document may be cited as follows: Joint Committee on Taxation, *Technical Explanation of the Revenue Provisions Contained in H.R. 3962, the "Affordable Health Care for America Act," as amended* (JCX-47-09), November 5, 2009. This document can also be found on our website at www.jct.gov.

[2] Except as otherwise noted, all references to sections in this document are to sections of the Internal Revenue Code of 1986 ("the Code"), as amended.

DIVISION A − AFFORDABLE HEALTH CARE CHOICES

TITLE I − IMMEDIATE REFORMS

A. Requiring the Option of Extension of Dependent Coverage for Uninsured Young Adults (sec. 105 of the bill and new sec. 9804 of the Code)

Present Law

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"[3]) imposes a number of requirements with respect to group health coverage that are designed to provide protections to health plan participants. The requirements are enforced through the Internal Revenue Code of 1986, as amended (the "Code"), the Employee Retirement Income Security Act of 1974 ("ERISA"),[4] and the Public Health Service Act ("PHSA").[5]

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.[6]

The Code imposes an excise tax on group health plans which fail to meet these requirements.[7] 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[8] 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 amends the Code and the parallel provisions of ERISA and the PHSA to provide that a group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for dependent children is required to make such coverage available, at the election of participants, to their qualified children. A qualified child is defined

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[3] Pub. L. No. 104-191.

[4] Pub. L. No. 93-406.

[5] 42 U.S.C. 6A.

[6] The requirements do not apply to any governmental plan or any group health plan that has fewer than two participants who are current employees.

[7] Sec. 4980D.

[8] In this document, the term "Secretary of the Treasury" means the Secretary or his delegate.

as an individual under the age of 27 who would, but for his or her age, be treated as a dependent child of the participant under the plan and who is not enrolled as a participant, beneficiary or enrollee under any health insurance coverage or group health plan.

The provision does not prevent a group health plan or health insurance issuer from increasing premiums otherwise required for coverage provided to a qualified child, consistent with standards established by the Secretary of Health and Human Services based on family size.

The provision further amends the PHSA to apply the rules regarding the extension of dependent coverage to health insurance coverage offered by a health insurance issuer in the individual market.

Effective Date

The provision applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 2010. The provision applies with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2010.

B. Limitations on Preexisting Condition Exclusions in Group Health Plans in Advance of Applicability of New Prohibition of Preexisting Condition Exclusions (sec. 106 of the bill and sec. 9801 of the Code)

Present Law

HIPAA 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 and the prohibition of discrimination on the basis of health status. The requirements are enforced through the Code, ERISA, and the PHSA.

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.[9]

In general, HIPAA provides that a pre-existing condition exclusion may be imposed with respect to a participant or beneficiary only if: (1) the exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date ("look-back period"); (2) the exclusion extends for a period of not more than 12 months after the enrollment date ("pre-existing condition exclusion period"); and (3) the period of any pre-existing condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant as of the enrollment date.[10]

The Code imposes an excise tax on group health plans which fail to meet the HIPAA requirements.[11] 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 amends the Code to reduce the permissible look-back period and the pre-existing condition exclusion period during the period of time prior to the date the prohibition on

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[9] The HIPAA requirements do not apply to any governmental plan or any group health plan that has fewer than two participants who are current employees.

[10] Sec. 9801(a).

[11] Sec. 4980D.

pre-existing condition exclusions under section 211 of the bill[12] takes effect. Under the provision, the permissible look-back period is reduced to a thirty-day period ending on the enrollment date and the permissible pre-existing condition exclusion period is reduced to three months after the enrollment date.

The provision further amends the Code to provide that, as of the date the prohibition on pre-existing condition exclusions under section 211 of the bill apply to a group health plan, the current law provisions that permit the plan to impose a limited pre-existing condition exclusion period no longer apply to such plan.

Parallel changes are made to ERISA and the PHSA.

Effective Date

The provision applies to group health plans for plan years beginning on or after January 1, 2010. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before the date of enactment of the bill, the provision does not apply to plan years beginning before the earlier of the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after the bill's date of enactment) or three years after the date of enactment.

[12] Section 211 of the bill provides that a qualified health benefits plan (including a health benefit plan) may not impose any pre-existing condition exclusion. Section 211 is effective for periods beginning after December 31, 2012.

C. Prohibiting Acts of Domestic Violence From Being Treated as Preexisting Conditions (sec. 107 of the bill and sec. 9801(d)(3) of the Code)

Present Law

HIPAA 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 and the prohibition of discrimination on the basis of health status. The requirements are enforced through the Code, ERISA, and the PHSA.

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.[13]

In general, HIPAA provides that a pre-existing condition exclusion may be imposed with respect to a participant or beneficiary only if: (1) the exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date; (2) the exclusion extends for a period of not more than 12 months after the enrollment date; and (3) the period of any pre-existing condition exclusion is reduced by the length of the aggregate of the periods of creditable coverage (if any) applicable to the participant as of the enrollment date.[14] Under current law, pregnancy may not be treated as a pre-existing condition.

Present law does not preclude treating conditions arising out of acts of domestic violence as a pre-existing condition. However, HIPPA does provide that a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on health factors in relation to the individual or a dependent of the individual. One of these factors is evidence of insurability (including conditions arising out of acts of domestic violence).

The Code imposes an excise tax on group health plans which fail to meet the HIPAA requirements.[15] 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)

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[13] The HIPAA requirements do not apply to any governmental plan or any group health plan that has fewer than two participants who are current employees.

[14] Sec. 9801(a).

[15] Sec. 4980D.

$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 amends the Code, and the parallel provisions of ERISA and the PHSA, to provide that a group health plan may not impose any pre-existing condition exclusion on the basis of domestic violence. In addition, the provision amends the PHSA to provide that a health insurance issuer in the individual market may not impose any pre-existing condition exclusion on the basis of domestic violence.

Effective Date

The provision applies to group health plans, and health insurance issuers offering group health insurance coverage, for plan years beginning on or after January 1, 2010. The provision applies with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

D. Ending Health Insurance Denials and Delays of Necessary Treatment for Children With Deformities (sec. 108 of the bill and new sec. 9814 of the Code)

Present Law

HIPAA imposes a number of requirements with respect to group health coverage that are designed to provide protections to health plan participants. The requirements are enforced through the Code, ERISA, and the PHSA.

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.[16]

The Code imposes an excise tax on group health plans which fail to meet these requirements.[17] 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 amends the Code, and the parallel provisions of ERISA and the PHSA, to provide that a group health plan, and a health insurance issuer offering group health insurance coverage, that provides coverage for surgical benefits is required to provide coverage for outpatient and inpatient diagnosis and treatment of a minor child's congenital or developmental deformity, disease, or injury. A minor child is any individual who is 21 years of age or younger.

For purposes of the provision, treatment includes reconstructive surgical procedures (procedures that are generally performed to improve function, but may also be performed to approximate a normal appearance) that are performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. Procedures covered by the provision include those that do not materially affect the function of the body part being treated and procedures for secondary conditions and follow-up treatment. Treatment does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

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[16] The HIPAA requirements do not apply to any governmental plan or any group health plan that has fewer than two participants who are current employees.

[17] Sec. 4980D.

Each participant and beneficiary of a group health plan must be given notice of the coverage required by the provision. Notice must be provided in writing and prominently positioned in any literature or correspondence made available or distributed by the plan sponsor or issuer and is required to be provided in the next mailing made by the plan or issuer to the participant or beneficiary or as part of any yearly informational packet sent to the participant or beneficiary.

The provision further amends the PHSA to apply the above coverage and notice requirements to health insurance coverage offered by a health insurance issuer in the individual market.

Effective Date

The provision applies to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after January 1, 2010. The provision applies with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

E. Elimination of Lifetime Limit
(sec. 109 of the bill and new sec. 9815 of the Code)

Present Law

HIPAA imposes a number of requirements with respect to group health coverage that are designed to provide protections to health plan participants. The requirements are enforced through the Code, ERISA, and PHSA.

There is no rule under HIPAA or other present law preventing a group health plan from imposing a lifetime limit on benefits. However, a group health plan is not permitted to establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan which include limitations or restrictions on the amount, level, extent, or nature of benefits or coverage based on health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, or evidence of insurability (including conditions arising out of acts of domestic violence or disability).[18] This does not prevent a plan from establishing limitations or restrictions on the amount, level, extent or nature of benefits or coverage with respect to similarly situated individuals (generally on a bona fide employment-based classification basis other than a health factor) enrolled in the plan or coverage.[19] However, if a group health plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not impose any aggregate lifetime limit on mental health or substance use disorder benefits.[20]

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.[21]

The Code imposes an excise tax on group health plans which fail to meet the HIPAA requirements.[22] 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.

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[18] Sec. 9802(a) and Treas. Reg. Sec. 54.9802-1(b).

[19] Sec. 9802(a)(2)(B) and Treas. Reg. sec. 54.9802-1(d). Health factors may only be taken into account to provde more favorable treatment under a group health plan to individuals with adverse health factors.

[20] Sec. 9812(a)(1)(A). This rule applies to plan years beginning after October 3, 2009.

[21] The HIPAA requirements do not apply to any governmental plan or any group health plan that has fewer than two participants who are current employees.

[22] Code sec. 4980D.

Explanation of Provision

Under the provision, a group health plan is not permitted to impose an aggregate lifetime limit with respect to benefits payable under the plan. The term "aggregate lifetime limit" means, with respect to benefits under a group health plan, a dollar limitation on the total amount that may be paid with respect to an individual (or other coverage unit) on a lifetime basis.

Effective Date

The provision applies with respect to group health plans for plan years beginning on or after January 1, 2010.

F. Extension of COBRA Continuation Coverage (sec. 113 of the bill)

Present Law

In general

The Code contains rules that require certain group health plans to offer certain individuals ("qualified beneficiaries") the opportunity to continue to participate for a specified period of time in the group health plan ("continuation coverage") after the occurrence of certain events that otherwise would have terminated such participation ("qualifying events").[23] These continuation coverage rules are often referred to as "COBRA continuation coverage" or "COBRA," which is a reference to the acronym for the law that added the continuation coverage rules to the Code.

Plans subject to COBRA

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, and others associated or formerly associated with the employer in a business relationship, or their families. A group health plan includes coverage under a health flexible spending arrangement under a cafeteria plan (within the meaning of section 125). The term group health plan does not, however, include a plan under which substantially all of the coverage is for qualified long-term care services.

Qualifying events and qualified beneficiaries

A qualifying event that gives rise to COBRA continuation coverage includes, with respect to any covered employee, the following events which would result in a loss of coverage of a qualified beneficiary under a group health plan (but for COBRA continuation coverage): (1) death of the covered employee; (2) the termination (other than by reason of such employee's gross misconduct), or a reduction in hours, of the covered employee's employment; (3) divorce or legal separation of the covered employee; (4) the covered employee becoming entitled to Medicare benefits under title XVIII of the Social Security Act; (5) a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan; and (6) a proceeding in a case under the U.S. Bankruptcy Code commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

A "covered employee" is an individual who is (or was) provided coverage under the group health plan on account of the performance of services by the individual for one or more persons maintaining the plan and includes a self-employed individual. A "qualified beneficiary" means, with respect to a covered employee, any individual who on the day before the qualifying event for the employee is a beneficiary under the group health plan as the spouse or dependent

[23] Sec. 4980B.

child of the employee. The term qualified beneficiary also includes the covered employee in the case of a qualifying event that is a termination of employment or reduction in hours.

Length of continuation coverage

The maximum required period of continuation coverage for a qualified beneficiary (i.e., the minimum period for which continuation coverage must be offered) depends upon a number of factors, including the specific qualifying event that gives rise to a qualified beneficiary's right to elect continuation coverage. In the case of a qualifying event that is the termination, or reduction of hours, of a covered employee's employment, the minimum period of coverage that must be offered to the qualified beneficiary is coverage for the period beginning with the loss of coverage on account of the qualifying event and ending on the date that is 18 months[24] after the date of the qualifying event. If coverage under a plan is lost on account of a qualifying event but the loss of coverage actually occurs at a later date, the minimum coverage period may be extended by the plan so that it is measured from the date when coverage is actually lost.

The minimum coverage period for a qualified beneficiary generally ends upon the earliest to occur of the following events: (1) the date on which the employer ceases to provide any group health plan to any employee, (2) the date on which coverage ceases under the plan by reason of a failure to make timely payment of any premium required with respect to the qualified beneficiary, or (3) the date on which the qualified beneficiary first becomes (after the date of election of continuation coverage) either (i) covered under any other group health plan (as an employee or otherwise) which does not include any exclusion or limitation with respect to any preexisting condition of such beneficiary or (ii) entitled to Medicare benefits under title XVIII of the Social Security Act. Mere eligibility for another group health plan or Medicare benefits is not sufficient to terminate the minimum coverage period. Instead, the qualified beneficiary must be actually covered by the other group health plan or enrolled in Medicare. Coverage under another group health plan or enrollment in Medicare does not terminate the minimum coverage period if such other coverage or Medicare enrollment begins on or before the date that continuation coverage is elected.

Explanation of Provision

The provision extends COBRA coverage periods for covered individuals until the individual becomes eligible for (a) acceptable coverage (as defined in section 302(d)(2) of the bill), or (b) health insurance coverage through the Health Insurance Exchange ("Exchange") (or a State-based Health Insurance Exchange operating in a State or group of States). The extension of the COBRA continuation coverage period applies only to individuals whose coverage period is due to end because of the expiration of a specified number of months; there is no extension of the COBRA continuation coverage period in the case of other terminating events (e.g. failure to

[24] In the case of a qualified beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled during the first 60 days of continuation coverage, the 18 month minimum coverage period is extended to 29 months with respect to all qualified beneficiaries if notice is given before the end of the initial 18 month continuation coverage period.

make timely payment of premiums). The extension of COBRA coverage continuation periods is not available for health flexible spending arrangements.

The Secretary of Labor must provide rules for giving prompt notice to eligible individuals about the extension of COBRA coverage. In developing such rules the Secretary of Labor must consult with the Secretary of the Treasury, the Secretary of Health and Human Services, and the administrators of group health plans (or other entities) that provide or administer COBRA coverage.

The extension of COBRA continuation coverage supersedes any State law limiting access by COBRA beneficiaries to State health benefits risk pools recognized by the Health Choices Commissioner.

Effective Date

The provision is effective on the bill's date of enactment.

TITLE IV − SHARED RESPONSIBILITY

A. Individual Responsibility (sec. 401 of the bill)

Present Law

Federal law does not require individuals to have health insurance.

Explanation of Provision

The provision cross-references the shared responsibility provisions of section 59B of the Code (as added by section 501 of the bill), which provide for a tax on an individual (or a husband and wife in the case of a joint return) who does not maintain coverage under acceptable health insurance for themselves and each of their qualifying children.[25]

Effective Date

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

[25] Under section 152(c), a child generally is a qualifying child of a taxpayer if the child satisfies each of five tests: (1) the child has the same principal place of abode as the taxpayer for more than one half 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. The provision includes a special rule under which a child is treated as a qualifying child of an individual for purposes of the provision (and not the qualifying child of any other individual) if such individual is required to provide health care coverage for the child pursuant to a child support order.

B. Employer Health Coverage Participation Requirements (sec. 411 of the bill)

Present Law

For employers that currently choose to provide health coverage for their employees, the cost to an employer of providing health coverage to its employees is generally deductible as an ordinary and necessary business expense for employee compensation.[26] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[27]

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.[28] In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from the gross income of the employee.[29] Employees participating in a cafeteria plan may be able to pay their share of premiums on a pre-tax basis through salary reduction.[30] Such salary reduction contributions are treated as employer contributions and thus are also excluded from gross income.

ERISA 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 with certain rules 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 (along with the PHSA and the Code) by COBRA and HIPAA, 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.

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[26] 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.

[27] Secs. 3121(a)(2) and 3306(b)(2).

[28] Sec. 106.

[29] Sec. 105(b).

[30] Sec. 125.

The Code imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements. The excise tax generally is equal to $100 per day per failure during the period of noncompliance and generally is imposed on the employer sponsoring the plan.[31]

Explanation of Provision

Employers offering health benefit plans are required to offer individual and family coverage under a qualified health benefits plan[32] (or under certain grandfathered plans) and to make contributions to help discharge the coverage costs of employees enrolled in the employer-provided plan.

Beginning in the second year after the general effective date of the market reforms of the bill, employers are required to make contributions to the Exchange for employees who decline employer-provided coverage and instead enroll in an Exchange-participating plan. However contributions are not required if the employee declines coverage because the employee is enrolled in family coverage in the Exchange as a spouse or dependent of another insured.

Effective Date

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

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[31] Secs. 4980B and 4980D.

[32] Pursuant to Title II of the bill, in order for a plan to be a "qualified health benefits plan" it needs to meet certain minimum coverage requirements, but it need not be offered through the Exchange.

C. Employer Responsibility to Contribute Towards Employee and Dependant Coverage (sec. 412 of the bill)

Present Law

For employers who choose to offer health insurance coverage to their employees, the cost to the employer of providing such coverage, including the cost of employer contributions towards health coverage premiums, is generally deductible as an ordinary and necessary business expense for employee compensation. In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[33]

Explanation of Provision

Contribution requirements

Employers that offer health benefit plans are required to offer individual and family coverage under a qualified health benefit plan[34] (or certain grandfathered health insurance plans) and to make contributions to help discharge the coverage costs of employees (and their spouses and qualifying children, if any) enrolled in the employer-provided plan.

For full time employees, the contribution amount is required to be at least 72.5 percent of the lowest cost plan offered by the employer which meets the requirements of the essential benefits package[35] (the contribution amount is 65 percent for eligible employees electing family coverage).[36] For part time employees, the contribution amount is a fraction (as determined in accordance with rules of the Health Choices Commissioner and the Secretaries of Labor, Health and Human Services, and the Treasury, as applicable) of the minimum contributions made for full time employees, with such fraction being equal to a ratio of the average weekly hours worked by the employee compared to the minimum weekly hours specified by the Health Choices Commissioner. An employer cannot satisfy the minimum contribution requirement through a salary reduction arrangement with the employee.

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[33] Secs. 3121(a)(2) and 3306(b)(2).

[34] Pursuant to Title II of the bill, in order for a plan to be a "qualified health benefits plan" it needs to meet certain minimum coverage requirements, but it need not be offered through the Health Insurance Exchange.

[35] The essential benefits package includes certain specified limits on required cost sharing, bans annual or life time limits on covered health care items or services and certain specified minimum services, and imposes certain requirements as to network adequacy as determined by the Health Choices Commissioner.

[36] There is a special rule for determining the lowest cost plan with respect to coverage of an employee under an Exchange participating health benefits plan. In that case the lowest cost plan is the reference premium used for determining the amount of affordability credits.

Automatic enrollment for employer-provided health benefits

An employer that elects to offer health benefit plans must provide each employee with a 30-day opt-out period after the employee becomes eligible for employer-provided coverage in which to either decline coverage entirely or affirmatively enroll in a health plan. At the end of the 30-day period, if the employee does not make an affirmative election with respect to health coverage, the employer must automatically enroll the employee for individual (not family) coverage in the employer-provided health benefit plan with the lowest applicable employee premium.

Employers are required, within a reasonable period before the beginning of each plan year, to provide employees with written notice of employees' rights and obligations relating to automatic enrollment. The notice must be both comprehensive in scope (for example, it must explain opt-out and affirmative election rights) and easily understood by the average employee to whom it pertains. Specifically, the notice must explain an employee's right to make an affirmative election as to health coverage rather than being automatically enrolled; and, if more than one level of benefits or employee premium is offered by the employer, the notice must explain in which level of benefits and employee premium the employee will be automatically enrolled absent an affirmative election.

Provision of information to multiple agencies

Employers that offer health benefit plans are required to provide the Health Choices Commissioner, and the Secretaries of Labor, Health and Human Services, and the Treasury with information required by the Health Choices Commissioner to ascertain compliance with the provision's requirements.

Effective Date

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

D. Employer Contributions in Lieu of Coverage (sec. 413 of the bill)

Present Law

For employers who choose to offer health insurance coverage to their employees, the cost to the employer of providing such coverage, including the cost of employer contributions towards health coverage premiums, is generally deductible as an ordinary and necessary business expense for employee compensation.[37] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[38]

Explanation of Provision

Beginning in the second year after enactment of the provision, employers are required to make contributions to the Exchange for employees who decline employer-provided coverage and instead enroll in an Exchange-participating plan. Subject to certain exceptions for small employers, discussed below, the contribution amount is equal to eight percent of the average wages paid by the employer to its employees during the time the employee was enrolled in the non-employer-provided plan.[39] The amount of an employer's average wages will be calculated according to rules specified by the Health Choices Commissioner.

There are special rules for small employers, defined as any employer whose annual payroll for the preceding calendar year was less than or equal to $750,000. Employers with annual payrolls not exceeding $500,000 during the preceding calendar year are not subject to the tax. Employers with annual payrolls between $500,000 and $750,000 during the preceding calendar year are subject to a reduced rate, as follows: two percent if the annual payroll does not exceed $585,000; four percent if the annual payroll exceeds $585,000 but does not exceed $670,000; and six percent if the annual payroll exceeds $670,000 but does not exceed $750,000. Annual payroll is defined as the aggregate wages (as defined in section 3121(a)) paid by the employer with respect to employment (as defined in section 3121(b)) during the calendar year. Determination of whether an employer is a small employer is made on an annual basis.[40]

Employer contributions are paid to the Health Choices Commissioner and deposited into the Health Insurance Exchange Trust Fund. The contributions are not tied to a particular employee (i.e., the contribution does not subsidize an employee's premium liability). This

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[37] 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.

[38] Secs. 3121(a)(2) and 3306(b)(2).

[39] The Health Choices Commissioner will provide rules for the appropriate aggregation of related employers and predecessors.

[40] Related employers and predecessors are treated as a single employer for purposes of determining annual payrolls.

contribution requirement parallels the payroll tax equal to eight percent of wages that applies to nonelecting employers.[41]

Effective Date

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

[41] See section 512 of the bill.

E. Authority Related to Improper Steering (sec. 414 of the bill)

Present Law

No provision.

Explanation of Provision

The Health Choices Commissioner (in coordination with the Secretaries of Labor, Health and Human Services, and the Treasury) has the authority to set standards for determining whether employers, in the course of offering coverage, are undertaking any actions to affect the risk pool within the Exchange by inducing employees to enroll in Exchange-participating health plans rather than in employer-provided plans. An employer found to be violating these standards is treated as not meeting the bill's coverage requirements.

Effective Date

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

F. Satisfaction of Health Coverage Participation Requirements Under the Internal Revenue Code of 1986 (sec. 422 of the bill)

Present Law

No provision.

Explanation of Provision

This provision cross-references the satisfaction of health coverage participation requirements in section 3111(c) of the Code (as added by section 512 of the bill) and the excise tax provisions relating to failures of electing employers to comply with coverage requirements in section 4980H of the Code (as added by section 511 of the bill).

Effective Date

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

G. Additional Rules Relating to Health Coverage Participation Requirements (sec. 424 of the bill)

Present Law

No provision.

Explanation of Provision

The Health Choices Commissioner and the Secretaries of Labor, Health and Human Services, and the Treasury are required to execute an interagency memorandum of understanding to ensure coordination with respect to regulations, rulings, interpretations, and enforcement of the employer responsibility requirements relating to the offering of health insurance set forth in the Code and the parallel provisions in ERISA and the PHSA. The interagency memorandum must provide that in the case of multiemployer group health plans[42] the health coverage participation requirements apply to the plan sponsor and the contributing sponsors of the plan.[43]

The Secretaries of Labor and Health and Human Services are also required to conduct periodic audits of employers in order to discover any noncompliance with health coverage participation requirements. The Secretaries of Labor, Health and Human Services, and the Treasury, and the Health Choices Commissioner are all informed of audit results.

Effective Date

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

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[42] A multiemployer plan is a collectively bargained plan maintained by more than one employer, usually within the same or related industries, and a labor union. ERISA sec. 3(37).

[43] Under section 423 of the bill, the Secretaries of Labor and Health and Human Services are required to conduct periodic audits of employers in order to discover any noncompliance with health coverage participation requirements. The Secretaries of Labor, Health and Human Services, and the Treasury, and the Health Choices Commissioner are all informed of audit results.

TITLE V − AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

A. Tax on Individuals Without Acceptable Health Care Coverage (sec. 501 of the bill and new sec. 59B of the Code)

Present Law

No provision.

Explanation of Provision

Maintenance of health insurance coverage

An individual (or a husband and wife in the case of a joint return) who, at any point during the taxable year, does not maintain acceptable health insurance coverage for themselves and each of their qualifying children[44] is subject to an additional tax. The tax is equal to the lesser of (a) the national average premium for single or family coverage, as applicable, for the taxable year, as determined by the Secretary of Treasury in coordination with the Health Choices Commissioner,[45] or (b) 2.5 percent of the excess of the taxpayer's modified adjusted gross income ("MAGI") for the taxable year over the threshold amount of income required for income tax return filing for that taxpayer under section 6012(a)(1).[46] For purposes of calculating the tax, a taxpayer's MAGI is calculated by adding any tax-exempt interest or foreign earned income to the individual's adjusted gross income. For taxpayers who maintain acceptable health insurance coverage for only part of the year, the tax is calculated and then pro-rated for the duration of time when coverage was not maintained. This tax is in addition to both the regular income tax and the alternative minimum tax.

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[44] Under section 152(c), a child generally is a qualifying child of a taxpayer if the child satisfies each of five tests: (1) the child has the same principal place of abode as the taxpayer for more than one half 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. The provision includes a special rule under which a child is treated as a qualifying child of an individual for purposes of the provision (and not the qualifying child of any other individual) if such individual is required to provide health care coverage for the child pursuant to a child support order.

[45] Under the non-revenue provisions of the provision, a new independent agency is established called the Health Choices Administration which is headed by a Health Choices Commissioner. The Health Choices Commissioner would establish qualified plan standards, establish and operate the Health Insurance Exchange, administer the Individual Affordability Credits and perform other functions.

[46] Generally, in 2009, 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-2008-117, Oct. 16, 2008.

Under the provision, acceptable coverage includes coverage under a qualified health plan, a grandfathered plan,[47] Medicare, Medicaid, Tricare (and other Armed Services coverage), Veterans Administration coverage,[48] Indian Health Service and other coverage approved by the Secretary of the Treasury in coordination with the Health Choices Commissioner. Any individual who is a bona fide resident of a possession of the United States (as determined under section 937(a)) (and any qualifying child residing with that individual) is treated as having acceptable coverage. Enrolled members of a Federally recognized Indian tribe are treated as having acceptable coverage for purposes of the additional tax due to eligibility for health care services provided by an Indian health care provider.[49]

A qualified health plan generally is a health plan that covers at least an essential benefits package and that includes certain specified limits on required cost sharing, no annual or lifetime limit on covered health care items or services, certain specified minimum services, and certain requirements as to network adequacy as determined by the Health Choices Commissioner.[50] A grandfathered plan generally is a health insurance plan purchased in the individual market in which the taxpayer was enrolled prior to date of enactment and the terms or conditions of which are not changed subsequent to the date of enactment other than to reflect area changes.[51] Certain group coverage in effect on the date of enactment also qualifies as grandfathered coverage, but only for the five-year period following the date of enactment.

Exceptions

The additional tax applies to United States citizens and resident aliens.[52] The additional tax does not apply to non-resident aliens or U.S. citizens and residents who satisfy the definition of a qualified individual, as defined by section 911(d). The additional tax does not apply if the maintenance of acceptable coverage would result in a hardship to the individual, or if the

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[47] As defined in subsection (a) of section 202 of the bill.

[48] Veterans Administration coverage is acceptable coverage only if the coverage is not less than a level specified by the Secretary of the Treasury and the Secretary of Veteran's Affairs, in coordination with the Health Choices Commissioner, based on the individual's priority for services.

[49] The term "Indian health care provider" means a health care program operated by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization as such terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

[50] These requirements are detailed in the non-revenue provisions of the bill.

[51] The definition of a grandfathered plan is set forth in section 202(a) of the non-revenue provisions of the provision. No new enrollment is permitted in grandfathered plans (other than dependents of individuals already enrolled).

[52] Under section 7701(b)(1)(A), an alien is considered a resident of the United States if the individual: (1) is a lawful permanent U.S. resident (the "green card test") at any time during the relevant year; (2) is present in the United States for 31 or more days during the current calendar year and has been present in the United States for a substantial period of time − during a three-year period, 183 or more days weighted toward the present year (the "substantial presence test"); or (3) makes a "first-year election" to be treated as a resident of the United States (a numerical formula under which an alien may pass the substantial presence test one year earlier than under normal rules).

person's income is below the threshold for filing a Federal income tax return. The additional tax also does not apply to any individual (or any qualifying child of the individual) if the individual has in effect an exemption which certifies that the individual is a member of a religious sect described in section 1402(g)(1) and an adherent of established tenets of such sect or division described in section 1402(g)(1).[53] Lastly, the additional tax does not apply to an individual if the individual is properly claimed as a dependent on the income tax return of another taxpayer for the taxable year. However, parents or guardians claiming qualified children as dependents on their Federal income tax returns are required to maintain coverage for these dependents.

Delegation of regulatory authority

The provision delegates authority to the Secretary of the Treasury to issue regulations or other guidance as necessary to carry out the purposes of the provision. The provision specifically directs the Secretary to issue guidance to provide an exemption from the tax for de minimis lapses of acceptable coverage and a process for applying for a waiver of the requirement to maintain coverage in cases of hardship (due to cost, or otherwise). In developing guidance in these two specific areas, the Secretary of the Treasury is directed to coordinate with the Health Choices Commissioner.

Information reporting

The new additional tax for failure to maintain health insurance is accompanied by new reporting requirements for providers of insurance coverage. The provider of acceptable coverage is required to report the name, address and taxpayer identification numbers of all individuals receiving insurance under the policy, as well as any other information required by the Secretary of the Treasury, to the Secretary of the Treasury, at such time and in such form as the Secretary may prescribe. The provider is further required to report this information, as well as the name, address and phone number of the provider to the primary insured by January 31 of the year following the calendar year for which the insurance was provided. Failure to file the required information return or to include complete and correct information on the required return is subject to the failure to file correct information returns penalty of section 6721.

Effective Date

The provision is effective for taxable years beginning after December 31, 2012. The information reporting requirements are effective for calendar years beginning after December 31, 2012.

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[53] Sections 1402(g) and 3127 (incorporating section 1402(g) by reference) provide a process for individuals (and employers for themselves and their employees) to file for an exemption from the self-employment tax and the Federal Insurance Contributions Act ("FICA") tax if they are members of a recognized religious sect that has established tenets or teachings by which individuals are conscientiously opposed to the acceptance of any private or public insurance which makes payments in the event of death, disability, old age, retirement or makes payments toward the cost of, or provides services for, medical care.

B. Election to Satisfy Health Coverage Participation Requirements (sec. 511 of the bill and new sec. 4980H of the Code)

Present Law

The Code does not require employers to provide health insurance to employees, and it does not provide a tax credit for any employer that does provide health coverage for its 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.[54] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[55]

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.[56] In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from the gross income of the employee.[57] Employees participating in a cafeteria plan may be able to pay their share of premiums on a pre-tax basis through salary reduction.[58] Such salary reduction contributions are treated as employer contributions and thus are also excluded from gross income.

ERISA 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 with certain rules 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 (along with the PHSA and the Code) by COBRA and HIPAA, 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.

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[54] 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.

[55] Secs. 3121(a)(2) and 3306(b)(2).

[56] Sec. 106.

[57] Sec. 105(b).

[58] Sec. 125.

The Code imposes an excise tax on group health plans that fail to meet HIPAA and COBRA requirements. The excise tax generally is equal to $100 per day per failure during the period of noncompliance and generally is imposed on the employer sponsoring the plan.[59]

Explanation of Provision

Elections

Under the provision, employers are required to make an affirmative election regarding whether to offer health benefit plans to employees. Employers electing to offer health benefit plans must meet certain minimum benefit and contribution requirements. Employers choosing not to offer health benefit plans, or offering plans that do not meet the minimum benefit and contribution requirements, are subject to a payroll tax (as described in section 512 of the bill).[60]

The Secretary of the Treasury must prescribe rules for employer elections regarding coverage, including rules for the time, manner and form of elections, and the treatment of affiliated groups of employers, separate lines of business, and full versus part time employees.[61] Employers are required to provide verification of their compliance with the provision's health coverage participation requirement to the Health Choices Commissioner and to the Secretaries of Labor, Health and Human Services, and the Treasury.

Parallel provisions for this election (including termination of the election) are provided in ERISA and the PHSA.[62] The Secretary of the Treasury shares authority for providing rules for employers making this election, and authority to terminate the election, with the Secretaries of Labor and Health and Human Services.

Aggregation rules

For affiliated groups of employers, the identity of the employer is generally determined by applying the employer aggregation rules in section 414(b), (c), (m), and (o).[63] The same

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[59] Secs. 4980B and 4980D.

[60] There is an exception for certain small employers. Employers with annual payrolls not exceeding $500,000 during the preceding calendar year are not subject to the tax. Employers with annual payrolls between $500,000 and $750,000 during the preceding calendar year are subject to a reduced rate.

[61] Employers electing to offer health benefit plans are to be treated as having established and maintained a group health plan for purposes of ERISA and the Public Health Service Act ("PHSA") (42 U.S.C. 6A) and the provision's health coverage participation requirements are deemed to be part of the terms and conditions of the employer-provided plan.

[62] 42 U.S.C. 6A.

[63] 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), under which employees of an affiliated service group (as defined in that section) are treated as employed by a single

election must apply to all employers in the aggregated group. Employers are able to make separate elections for employees in separate lines of business, or for full time employees and part time employees.

Noncompliance with coverage requirements

Employers who elect to provide coverage but whose health benefit plans fail to meet the bill's health coverage participation requirement (as described in sections 411 through 414 of the bill) are subject to an excise tax of $100 per day for each employee to whom the failure applies.[64] The excise tax does not apply to (1) periods during which the Secretary determines that the employer neither knew, nor, using reasonable diligence, would have known of any failures, and (2) failures that are corrected within 30 days of discovery (but only if such failures are due to reasonable cause and not willful neglect). Excise taxes imposed on employers for unintentional failures (i.e., due to reasonable cause and not willful neglect) are limited to the lesser of 10 percent of the aggregate amount paid or incurred by the employer during the preceding taxable year for group health plans, or $500,000. There are parallel civil penalties provided in ERISA and the PHSA.[65] The excise tax with respect to any failure is reduced (but not below zero) by the amount of any civil penalty collected under these parallel provisions. The Secretary is also able to terminate an employer's election (and thus subject the employer to the payroll tax imposed on employers that do not offer coverage) if it is determined that the employer was substantially noncompliant with health coverage participation requirements.

Effective Date

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

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employer. Section 414(o) authorizes the Treasury to issue regulations to prevent avoidance of the requirements under section 414(m).

[64] Under the provision, there is created within the Treasury of the United States a trust fund known as the "Health Insurance Exchange Trust Fund" which consists of such amount as may be appropriated or credited to the trust fund. Under the provision, an amount equal to these excise taxes received from noncompliant employers is automatically appropriated to, and thus used to fund, the new Health Insurance Exchange Trust Fund.

[65] The provision permits the penalties to be assessed through an excise tax or through a civil penalty under ERISA or the PHSA. Penalties for any particular failure are not to be duplicated, however. The Secretary of Labor or Health and Human Services, as appropriate, is required to give advance written notification of failure to employers prior to the assessment of a penalty. The Secretary of Health and Human Services is able to bring civil actions in Federal court to collect civil penalties assessed under the PHSA.

C. Responsibilities of Nonelecting Employers (sec. 512 of the bill and sec. 3111(c) of the Code)

Present Law

In general

An employer's payroll tax obligations are not affected by its determination whether to offer health insurance coverage to its employees.

Under the Federal Insurance Contributions Act ("FICA"), separate taxes are imposed on every employer and employee with respect to wages paid by the employer to the employee.[66] These two taxes are commonly referred to as the employer's and the employee's share of FICA. The employee's share of FICA is collected by means of payroll withholding by the employee's employer.

For both the employer and the employee's share of FICA, the tax consists of two parts: (1) old age, survivor, and disability insurance ("OASDI"), which correlates to the Social Security program that provides monthly benefits after retirement, disability, or death;[67] and (2) Medicare hospital insurance ("HI").[68] The OASDI tax rate is 6.2 percent on both the employee and employer (for a total rate of 12.4 percent). The OASDI tax rate applies to wages up to the OASDI wage base ($106,800 for 2009). The HI tax rate is 1.45 percent on both the employee and the employer (for a total rate of 2.9 percent). Unlike the OASDI tax, the HI tax is not limited to a specific amount of wages, but applies to all wages.

For purposes of the employer's and employee's share of FICA, wages generally means all remuneration for employment including the cash value of all remuneration paid in a medium other than cash. However, the general definition of wages is subject to a number of special rules and exceptions.[69]

Employment for FICA purposes generally means any service of whatever nature performed by an employee for the employer (irrespective of the citizenship or residence of either) within the United States. In the case of service outside the United States, employment also includes service performed by a United States citizen or resident as an employee for an American employer. As in the case of the definition of wages, the definition of employment is

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[66] Secs. 3101-3128 (FICA). Sections 3501-3510 provide additional rules.

[67] Pursuant to sec. 201(a) and (b) of the Social Security Act, 42 USC 401(a) and (b), these OASDI payroll taxes fund the Federal Old and Survivor Insurance Trust Fund and the Federal Disability Trust Fund, respectively. For each fiscal year, an amount equal to the OASDI payroll taxes collected is appropriated for these trust funds.

[68] Pursuant to Sec. 1817 of the Social Security Act, 42 USC 1395i, the HI payroll taxes fund the Federal Hospital Insurance Trust Fund. For each fiscal year, an amount equal to the HI payroll taxes collected is appropriated for this trust fund.

[69] Sec. 3121(a).

also subject to a number of exceptions and special rules.[70] An American employer is defined as an employer which is: (1) the United States or any instrumentality thereof; (2) an individual who is a resident of the United States; (3) a partnership, if at least two-thirds of the partners are United States residents; (4) a trust, if all of the trustees are United States residents; or (5) a corporation organized under the laws of the United States or any of the States.[71]

Explanation of Provision

Employers that elect not to provide health benefit plans to their employees are subject to an additional payroll tax equal to eight percent of wages.[72] The provision's definitions of the terms wages, employment, and employer, are generally the same as under present FICA provisions. The provision, however, differs from present law in several respects. First, the tax is imposed as a result of a voluntary election by the employer not to offer an eligible health plan and not to make the required contribution toward each employee's premium for the plan. Second, as is currently the case for HI, there is no taxable wage base for purposes of the new payroll tax. Third, the definition of employment includes services performed by certain foreign agricultural workers, aliens performing services pursuant to certain nonimmigrant visas, and government workers, among others who are carved out under current law.

Employers are permitted to make separate elections for separate lines of business, or full-time employees and part-time employees. The new payroll tax applies only to wages paid to employees who are not offered health benefits by their employers.

There is an exception and a reduced rate structure for certain small employers. Employers with annual payrolls not exceeding $500,000 during the preceding calendar year are not subject to the tax. Employers with annual payrolls between $500,000 and $750,000 during the preceding calendar year are subject to a reduced rate, as follows: two percent if the annual payroll does not exceed $585,000; four percent if the annual payroll exceeds $585,000 but does not exceed $670,000; and six percent if the annual payroll exceeds $670,000 but does not exceed $750,000. Annual payroll is defined as the aggregate wages (as defined in section 3121(a)) paid by the employer with respect to employment (as defined in section 3121(b)) during the calendar year.

A parallel payroll tax, including the exception and a reduced rate structure for small employers, applies to railroad carriers.

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[70] Sec. 3121(b). For example, employment for FICA purposes includes certain service with respect to American vessels or aircrafts and also includes service that is designated as employment under an agreement entered into under section 233 of the Social Security Act.

[71] Sec. 3121(h).

[72] Under the provision, there is created within the Treasury of the United States a trust fund known as the "Health Insurance Exchange Trust Fund" which consists of such amount as may be appropriated or credited to the trust fund. Under the provision, an amount equal to these payroll taxes received from employers electing not to provide health benefits is automatically appropriated to, and thus used to fund, the new Health Insurance Exchange Trust Fund.

Territories and possessions of the United States are not treated as States for purposes of the new payroll tax.

Effective Date

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

D. Credit For Small Business Employee Health Coverage Expenses (sec. 521 of the bill and new sec. 45R of the Code)

Present Law

Deduction of employer contributions for health coverage for employees

The Code does not provide a tax credit to any employer for the provision of health coverage for its 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.[73] In addition, compensation in the form of employer-provided health insurance is not subject to payroll taxes.[74]

Employer contributions for 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.[75] In addition, medical care provided under an accident or health plan for employees, their spouses, and their dependents is excluded from gross income of the employee.[76] Employees participating in a cafeteria plan may be able to pay their share of premiums on a pre-tax basis through salary reduction.[77] Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

Explanation of Provision

General rule

The provision generally provides a tax credit to a qualified small employer for up to 50 percent of its qualified health coverage expenses for the taxable year. Qualified employee health coverage expenses are, with respect to any employer for any taxable year, the aggregate amount paid or incurred by the employer for coverage of any qualified employee of the employer (including any family coverage which covers the employee) under qualified health coverage. However, for this purpose, amounts paid by the employer do not include amounts based on a salary reduction election made by an employee under a cafeteria plan (although such amounts are generally treated as an employer contribution). The credit is a general business credit, eligible to be carried back for one year and carried forward for 20 years.

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[73] 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.

[74] Secs. 3121(a)(2) and 3306(b)(2).

[75] Sec. 106.

[76] Sec. 105(b).

[77] Sec. 125.

Credit only allowed for two taxable years

No credit is allowed under this provision with respect to any taxable year unless the employer elects to have the credit apply. An employer cannot elect the tax credit with respect to more than two years.

Qualified small employer

A qualified small employer for purposes of the provision is an employer with less than 25 qualified employees employed during the employer's taxable year, and whose average annual employee compensation is less than $40,000. However, the full amount of the credit (50 percent of qualified health coverage expenses) is available only to an employer with no more than 10 qualified employees and whose average annual employee compensation does not exceed $20,000. Average annual employee compensation is determined by dividing the total aggregate compensation for the taxable year of all qualified employees by the number of qualified employees.

Under the provision, an employee is a qualified employee of an employer for a taxable year if the employee receives at least $5,000 of compensation from the employer during the taxable year for services as an employee of a trade or business. Self-employed individuals, including partners and sole proprietors, are treated as employees with respect to a business or partnership that generates net earnings from self employment for the individual but only if the business or partnership also has common law employees who are qualified employees.

For a common law employee, compensation means wages for purposes of income tax withholding plus elective deferrals within the meaning of section 402(g) and compensation deferred under an eligible deferred compensation plan under section 457. For a self-employed individual, compensation means net earnings from self employment, including any elective contributions. These definitions of compensation[78] are used to determine both whether an individual is a qualified employee and to determine average annual employee compensation.

Qualified health coverage and expenses

Qualified health coverage includes two elements. First, the coverage must be acceptable coverage as defined for purposes of the tax on individuals without acceptable health coverage.[79] Second, the coverage must be provided by the employer pursuant to its election to satisfy the employer responsibility requirement by offering coverage, and the employer's contribution toward the cost of the coverage must be at least the minimum required for that purpose.[80] The

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[78] The provision specifies that compensation has the same meaning as the definition of compensation for simple plans under section 408(p)(6)(A).

[79] Section 501 of the bill provides the tax on individuals without acceptable health coverage.

[80] Under the provision, for employers that elect to provide coverage rather than pay an additional payroll tax, employers are required to make contributions to help discharge the coverage costs of employees enrolled in the employer-provided plan. For example, for full-time employees, the contribution amount is required to be at least

credit is only available for qualified health expenses paid or incurred by the employer for the purchase of health care coverage.

Phase out of the credit

If an employer's average annual employee compensation exceeds $20,000, the credit percentage phases out from the maximum available credit of 50 percent. The percentage is reduced by one percentage point for each $400 by which average annual employee compensation exceeds $20,000. For example, a firm with average compensation of $24,000 and 10 or fewer employees is entitled to a 40-percent credit. In general, if such firm had qualified employee health coverage expenses of $50,000, the credit amount would equal 40 percent of $50,000, or $20,000.

The credit amount determined above is subject to a further phaseout for employers with more than 10 qualified employees. For employers with more than 10 qualified employees, the credit amount is reduced by an amount which bears the same ratio to the amount of the credit as the number of qualified employees of the employer in excess of 10 bears to 15.[81] For example, if a firm has 16 qualified employees, the credit amount is reduced by 40 percent.[82] In the example above, the $20,000 credit is thus reduced by $8,000 (40 percent of $20,000) to a credit of $12,000.

Special rules

The employer is determined by applying the employer aggregations rules in section 414(b), (c), (m), and (o) and treating the aggregated group of employers as a single employer.[83] Thus, all employees of the aggregated group are taken into account in determining if the employer is a qualified small employer. The employer includes any predecessor of such employer. Thus if a predecessor employer claims the credit for a year, that year is treated as a year that the employer claimed the credit for purposes of applying the two year limit.

Under the provision, any deduction otherwise allowed with respect to amounts paid or incurred for health insurance coverage shall be reduced by the amount of the credit claimed under this provision. Thus, under the provision, the employer generally is allowed a deduction

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72.5 percent of the lowest cost plan meeting the requirements of the essential benefits package (reduced to 65 percent for eligible employees electing family coverage).

[81] This translates into a reduction of 6.67 percent for every employee in excess of 10.

[82] (16-10)/15 = 40 percent.

[83] 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), 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 of section 414(m).

under section 162 for qualified employee health coverage expenses equal to total health coverage expenses minus the dollar amount of the credit

The credit is not available with respect to qualified employee health coverage expenses for any employee if the employee's compensation for the taxable year exceeds $80,000. The $5,000 compensation threshold for identifying qualified employees, the $20,000 average annual compensation limit, and the $80,000 compensation amount are indexed to changes in the consumer price index for all urban consumers ("CPI-U"). However, in each case, if the resulting amount is not a multiple of $50, the amount is rounded down to the next lowest multiple of $50.

Effective Date

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

E. Distributions for Medicine Qualified Only if for Prescribed Drug or Insulin (sec. 531 of the bill 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").[84] 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.[85] 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.[86] 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.[87]

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.[88] 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.[89] 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 arrangement called a health reimbursement arrangement ("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.[90] Thus, under an HRA or under a Health

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[84] Sec. 213(a).

[85] 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.

[86] Sec. 213(b).

[87] Rev. Rul. 2003-58, 2003-1 CB 959.

[88] Sec 106.

[89] Sec. 105(b).

[90] 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).

FSA, amounts paid for prescription and over-the-counter 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").[91] Subject to certain limitations,[92] 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.[93] The general definition of medical care without the explicit limitation on medicine also applies for purposes of this exclusion.[94] Similar rules apply for another type of medical savings arrangement called an Archer MSA.[95] 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. 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.

Effective Date

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

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[91] Sec. 223.

[92] 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.

[93] Sec. 223(f).

[94] Sec. 223(d)(2).

[95] Sec. 220.

F. Limitation on Health Flexible Spending Arrangements Under Cafeteria Plans (sec. 532 of the bill 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.[96] 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.[97] 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.[98]

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.[99]

Flexible spending arrangement under a cafeteria plan

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 of the salary reduction contributions made available for use in reimbursing the employee for his or her medical expenses.[100] Health FSAs are subject to the general requirements for cafeteria plans, including a requirement that

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[96] 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.

[97] Sec. 105(b).

[98] 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.

[99] Sec. 106.

[100] Sec. 125 and proposed Treas. Reg. sec. 1.125-5.

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").[101] 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.[102] 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 excludible qualified benefits (but not as cash or a taxable benefit).[103]

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 reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.[104]

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 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 the end of the year may be carried forward to be used to reimburse medical expenses in following years.[105]

Explanation of Provision

Under the provision, salary reduction contributions by an employee for a taxable year for purposes of coverage under a Health FSA under a cafeteria plan are limited to $2,500.[106] Under the provision, a Health FSA is not a qualified benefit under a cafeteria plan unless the plan includes this limitation. Thus, when an employee is given the option under a cafeteria plan to

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[101] Sec. 125(d)(2) and proposed Treas. Reg. sec. 1.125-5(c).

[102] Notice 2005-42, 2005-1 C.B. 1204 and proposed Treas. Reg. sec. 1.125-1(e).

[103] Proposed Treas. Reg. sec. 1-125-5(b).

[104] Sec. 106(c)(2) and proposed Treas. Reg. sec. 1.125-5(a).

[105] 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.

[106] 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.

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 must be limited to $2,500 for a taxable year. 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. 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.

G. Increase in Additional Tax on Distributions from HSAs Not Used for Medical Expenses (sec. 533 of the bill and sec. 223 of the Code)

Present Law

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").[107] 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 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.

A high deductible health plan is a health plan that has an annual deductible that is at least $1,150 for self-only coverage or $2,300 for family coverage for 2009 (increasing to $1,200 and $2,400 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 $5,800 in the case of self-only coverage and $11,600 in the case of family coverage for 2009 (increasing to $5,950 and $11,900 for 2010).

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[107] 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,[108] 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.

Explanation of Provision

The additional tax on distributions from an HSA 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.

[108] Sec. 408.

H. Repeal Business Deduction for Federal Subsidies for Certain Retiree Prescription Drug Plans (sec. 534 of the bill)

Present Law

In general

Sponsors[109] of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of Health and Human Services with respect to a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").[110] A qualified retiree prescription drug plan is employment-based retiree health coverage[111] 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.[112] 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).[113]

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 drug plan ("PDP") or a Medicare Advantage-Prescription Drug ("MA-PD") plan, but who is

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[109] The identity of the plan sponsor is determined in accordance with section 16(B) of the Employee Retirement Income Security Act of 1974 ("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.

[110] Sec. 1860D-22 of the Social Security Act (SSA), 42 USC Sec. 1395w-132.

[111] 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.

[112] 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 Health and Human Services' 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 USC 1395w-132(a)(2).

[113] Sec. 139A.

covered under a qualified retiree prescription drug plan. Generally 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.[114] 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 ($295 in 2009) and the cost limit was $5,000 in 2006 ($6,000 in 2009).[115]

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.[116] 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.

Effective Date

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

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[114] For purposes of calculating allowable retiree costs, actual costs paid are net of discounts, chargebacks, and average percentage rebates, and exclude administrative costs.

[115] Patricia M. Davis, "Medicare Part D Prescription Drug Benefit," Congressional Research Service. June 1, 2009. The cost threshold is indexed in the same manner as the Medicare Part D annual deductible, while the cost limit is indexed in the same manner as the Medicare Part D annual out-of-pocket threshold.

[116] Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

I. Disclosures to Carry Out Health Insurance Exchange Subsidies (sec. 541 of the bill and sec. 6103(l)(21) 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.[117]

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.[118] 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.[119] 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.[120] An action for civil damages also may be brought for unauthorized disclosure.[121]

Explanation of Provision

The bill creates within the Exchange to facilitate the purchase of health insurance. A State has the option of forming its own health insurance exchange at the State level that must be approved for operation by the Federal government ("approved State Exchange"). The bill provides for "affordability credits," administered by the Exchanges, which subsidize the purchase of health insurance through the Exchanges and the cost of paying for medical care. The affordability credits generally are available on a sliding scale for persons and families with incomes between Medicaid eligibility and 400 percent of the poverty level. To ensure the appropriate level of subsidy is delivered the bill allows for the disclosure of certain tax return information to the Exchange, or approved State Exchange to administer the affordability credits.

Specifically, upon receipt of a valid written request from the Health Choices Commissioner or the head of the approved State Exchange, the IRS is authorized to disclose

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[117] Sec. 6103(l)(20).

[118] Sec. 6103(p)(4)(D).

[119] Sec. 7213.

[120] Sec. 7213A.

[121] Sec. 7431.

limited return information of any taxpayer whose income is relevant in determining the amount of the affordability credit(s). Such return information is limited to: (1) taxpayer identity information, (2) filing status, (3) modified adjusted gross income, (4) the number of dependents of the taxpayer, (5) such other information as is prescribed by the Secretary by regulation as might indicate that the taxpayer is eligible for such affordability credit(s) (and the amount thereof), and (6) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

The return information disclosed is to be used by officers and employees of the Health Choices Administration, or approved State Exchange, only for the purposes of and to the extent necessary in establishing and verifying the appropriate amount of any affordability credit and providing for the repayment of any such credit that was in excess of the appropriate amount.

The general rule of confidentiality applies to the information disclosed, as well as the safeguard requirements, penalties, and civil damage remedies for unauthorized disclosure or inspection.

Effective Date

The provision is effective on the date of enactment.

J. Offering of Exchange-Participating Health Benefit Plans Through Cafeteria Plans (sec. 542 of the bill 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.[122] In addition, employer-provided health insurance coverage is generally not included in an employee's gross income.[123]

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.[124] 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.[125] 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

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[122] 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.

[123] Sec. 106.

[124] Sec. 125(a).

[125] Proposed Treas. Reg. sec. 1.125-1(b).

nonqualified benefits. Examples of nonqualified benefits include scholarships[126]; employer-provided meals and lodging;[127] educational assistance;[128] and fringe benefits.[129] A plan offering any nonqualified benefit is not a cafeteria plan.[130]

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.[131] 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.[132] This reimbursement for individual health insurance premiums can also be paid for through salary reduction under a cafeteria plan.[133] This offer to reimburse individual health insurance premiums constitutes a group health plan.

Explanation of Provision

Under the bill, all individuals are eligible to obtain coverage through enrollment in an Exchange-participating health benefits plan offered through the Exchange unless such individuals are enrolled in certain types of coverage, such as Medicare, Medicaid, or certain employer-sponsored coverage. An employer that is an "Exchange-eligible employer" is eligible to enroll its employees (and their dependents) in Exchange-participating health benefits plans through the Exchange.[134]

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[126] Sec. 117.

[127] Sec. 119.

[128] Sec.127.

[129] Sec. 132.

[130] 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.

[131] Sec. 125.

[132] Rev. Rul. 61-146 (1961-2 CB 25).

[133] Proposed Treas. Reg. sec.1.125-1(m).

[134] Section 302 of the bill provides definitions of the terms: Exchange participating health benefits plan, qualified health benefits plan, and acceptable coverage. Section 302 of the bill also provides rules for when an employer is an exchange eligible employer.

Under the provision, health insurance coverage under any Exchange-participating health benefits plan is not a qualified benefit under a cafeteria plan. However, this rule does not apply to a cafeteria plan maintained by an employer that is an Exchange-eligible employer. Thus, employees who are not employed by an Exchange-eligible employer may not pay for Exchange-participating health benefit plan premiums on a pre-tax basis through salary reduction under a cafeteria plan. However, if an employer reimburses an employee for the premiums for an Exchange-participating health benefits plan purchased by the employee and the reimbursement is not through a cafeteria plan, the reimbursement is excludible from the employee's gross income whether or not the employer is an Exchange-eligible employer.[135]

Effective Date

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

[135] Sec. 106 and Rev. Rul. 61-146 (1961-2 CB 25).

K. Exclusion From Gross Income of Payments Made Under Reinsurance Program For Retirees (sec. 543 of the bill and sec. 139A of the Code)

Present Law

Exclusion for Federal Subsidies for prescription drug plans

In general

Sponsors[136] of qualified retiree prescription drug plans are eligible for subsidy payments from the Secretary of Health and Human Services with respect to a portion of each qualified covered retiree's gross covered prescription drug costs ("qualified retiree prescription drug plan subsidy").[137] A qualified retiree prescription drug plan is employment-based retiree health coverage[138] 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.[139] Under section 139A 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).[140]

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.[141] Thus, expenses or amount paid or incurred

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[136] 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.

[137] Sec. 1860D-22 of the Social Security Act ("SSA"), 42 USC Sec. 1395w-132.

[138] 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 (and 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.

[139] In addition to meeting the actuarial value standard, the plan sponsor must also maintain and provide the Secretary of Health and Human Services 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 USC 1395w-132(a)(2).

[140] Sec. 139A.

[141] Sec. 265(a) and Treas. Reg. sec. 1.265-1(a).

with respect to a qualified retiree prescription drug plan subsidy 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.

Payments to Reinsurance Programs for Retiree Health Benefits

There is no provision in present law for reinsurance payments to employers providing health benefits to retirees.

Explanation of Provisions

Description of Reinsurance Program for Retiree Health Benefits

Under section 111 of the bill, the Secretary of Health and Human Services is instructed to establish a temporary reinsurance program to assist participating employment-based plans with the cost of providing health benefits to retirees, eligible spouses, surviving spouses and dependents not later than 90 days after the date of enactment. The Secretary of Health and Human Services must reimburse the plan for 80 percent of the portion of annual costs for an eligible individual that exceed $15,000 but are less than $90,000.

Tax Treatment of Payments to Reinsurance Program for Retiree Health Benefits

The provision amends section 139A to provide that a rule similar to the exclusion rule for qualified retiree prescription drug plan subsidies applies to payments made under the reinsurance program for retirees established under section 111 of the bill. Thus, these payments are also excludable from gross income for the purposes of regular income tax and alternative minimum tax (including the adjustment for adjusted current earnings). As a result of the exclusion from gross income for these payments, no deduction is allowable for any expense or amount which would otherwise be allowable as a deduction if such expense or amount is allocable to the payments made under the reinsurance program.[142]

Effective Date

The provision is effective in tax years ending after the date of enactment.

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[142] Effective for taxable years beginning after December 31, 2012, section 534 of the bill eliminates the present law rule under which 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.

L. CLASS Program Treated in Same Manner as Long-Term Care Insurance (sec. 544 of the bill and sec. 7702B of the Code)

Present Law

Present law provides certain tax subsidies for qualified long-term care insurance contracts and expenses for qualified long-term care services.

A qualified long-term care insurance contract is defined as any insurance contract that provides only coverage for qualified long-term care services, and that meets additional requirements set forth in section 7702B of the Code.[143] Per diem-type and reimbursement-type contracts are eligible for treatment as qualified long-term care insurance contracts. In addition, a plan established and maintained by a State government for the benefit of its employees, former employees and their spouses, and certain qualifying relatives, may be treated as a qualified long-term care insurance contract if it provides only coverage for qualified long-term care services, and meets the additional requirements of section 7702B (other than the requirement that benefits be provided under an "insurance contract").[144]

Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services that are required by a chronically ill individual and that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.[145]

A qualified long-term care insurance contract is treated as an accident and health insurance contract.[146] Amounts received under the contract generally are treated as amounts received for personal injuries or sickness, and are treated as reimbursements for expenses actually incurred for medical care (as defined in section 213(d)).[147] Thus these amounts are excludible from gross income.[148] In the case of per diem contracts, the excludable amount is subject to a dollar cap per day ($280 for 2009), as indexed. If payments under such contracts exceed the dollar cap, then the excess is excludable only to the extent of actual costs in excess of the dollar cap that are incurred for long-term care services.

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[143] Sec. 7702B(b). For example, the contract is not permitted to provide for a cash surrender value or other money that can be paid, assigned or pledged as collateral for a loan, or borrowed (and any premium refunds must be applied as a reduction in future premiums or to increase future benefits).

[144] Sec. 7702B(f).

[145] Sec. 7702B(c)(1). A chronically ill individual is generally one who has been certified within the previous 12 months by a licensed health care practitioner as being unable to perform (without substantial assistance) at least two activities of daily living (ADLs) for at least 90 days due to a loss of functional capacity (or meeting other definitional requirements). Sec. 7702B(c)(2).

[146] Sec. 7702B(a)(1).

[147] Sec. 7702B(a)(2).

[148] Secs. 104(a)(3), 105, and 106.

An employer's plan that provides employees with coverage under a long-term care insurance contract generally is treated in the same manner as employer-provided health care. As a result, the employer's premium payments are generally excludable from income and wages, and benefits payable under the contract generally are excludable from the recipient's income.[149] However, employer provided-coverage for qualified long-term care services provided through a flexible spending or similar arrangement, whether or not under a cafeteria plan, is not excludible from an employee's gross income.[150] Further, a cafeteria plan is not permitted to offer as a qualified benefit any product which is advertised, marketed, or offered as long-term care insurance.[151] As a result, while health insurance can be offered by a cafeteria plan as a tax-favored option, long-term care coverage cannot be offered as a choice under a cafeteria plan.

Self-employed individuals may deduct qualified long-term care insurance premiums for the individual and his or her spouse and dependents.[152]

For individuals who purchase their own qualified long-term care insurance, premiums paid for a qualified long-term care insurance contract and unreimbursed expenses for qualified long-term care services are treated as medical expenses for purposes of the itemized deduction for medical care (subject to the floor of 7.5 percent of adjusted gross income). The amount of qualified long-term care insurance premiums that may be taken into account in determining the amount allowed as an itemized deduction is limited as follows (for 2009): $320 in the case of an individual 40 years old or less; $600 in the case of an individual who is more than 40 but not more than 50; $1,190 in the case of an individual who is more than 50 but not more than 60; $3,180 in the case of an individual who is more than 60 but not more than 70; and $3,980 in the case of an individual who is more than 70.[153] These dollar limits are indexed for inflation.

Unreimbursed expenses for qualified long-term care services provided to the taxpayer or the taxpayer's spouse or dependent also are treated as medical expenses for purposes of the itemized deduction.

Explanation of Provision

Under the provision, for purposes of the Code, the CLASS program established under section 2581 of the bill will be treated as a qualified long-term care insurance contract, so long as

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[149] Secs. 105, 106, and 3121(a)(2).

[150] Section 106(c)(2) defines a flexible spending arrangement for health coverage generally as a benefit program which provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.

[151] Sec. 125(f).

[152] Sec. 162(l). The deduction for long-term care insurance expenses of self-employed individuals is not available for any month in which the taxpayer is eligible to participate in a subsidized health plan maintained by the employer of the taxpayer or the taxpayer's spouse.

[153] Sec. 213(d)(10); Rev. Proc. 2008-66, 2008-45 IRB 1107.

the program would satisfy the requirements of section 7702B if the program were an insurance contract.

Effective Date

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

M. Exclusion From Gross Income for Medical Care Provided for Indians (sec. 545 of the bill and new sec. 139D of the Code)

Present Law

Present law generally provides that gross income includes all income from whatever source derived.[154] 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.[155] 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.[156] 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.[157] 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.[158] Such salary reduction contributions are treated as employer contributions and thus also are excluded from gross income.

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[154] Sec. 61.

[155] Sec 106.

[156] Sec. 105(b).

[157] 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.

[158] 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.[159]

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.[160] 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.[161] The representative further expressed the view that

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[159] 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).

[160] 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).

[161] 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.[162]

Explanation of Provision

The provision provides an exclusion from gross income for the value of specified Indian tribe health 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;[163] (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;[164] (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 that supplements, replaces, or substitutes for the programs and services provided by the Federal government to Indian tribes or Indians.

No change made by the provision is intended to create an inference as to the tax treatment of health benefits covered by the provision prior to the effective date. Additionally, no inference is intended with respect to the tax treatment of other benefits provided by Indian tribes not covered by this provision.

Effective Date

The provision is effective for health benefits and coverage provided after the date of enactment.

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[162] *Ibid*.

[163] 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(l) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(1)).

[164] The terms "accident or health insurance" and "accident or health plan" have the same meaning as when used in sections 104 and 106. 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).

N. Surcharge on High-Income Individuals (sec. 551 of the bill and new sec. 59C of the Code)

Present Law

In general

An income tax is imposed on individual citizens and residents of the United States.[165] The tax is based on an individual's taxable income. An individual computes his or her taxable income by reducing gross income by the sum of (i) the deductions allowable in computing adjusted gross income, (ii) the standard deduction (or itemized deductions, at the election of the taxpayer), and (iii) the deduction for personal exemptions. Graduated tax rates are then applied to a taxpayer's taxable income to determine his or her income tax liability. Lower rates apply to net capital gain and qualified dividend income. A taxpayer may also be subject to an alternative minimum tax. A taxpayer may reduce his or her income tax liability by certain tax credits.

Gross income

Gross income means "income from whatever source derived" other than certain items excluded from gross income. Sources of gross income generally include, among other things, compensation for services, interest, dividends, capital gains, rents, royalties, alimony and separate maintenance payments, annuities, income from life insurance and endowment contracts (other than certain death benefits), pensions, gross profits from a trade or business, income in respect of a decedent, and income from S corporations, partnerships,[166] and trusts or estates.[167] Exclusions from gross income include death benefits payable under a life insurance contract, interest on certain State and local bonds, employer-provided health insurance, employer-provided pension contributions, and certain other employer-provided benefits.

Adjusted gross income

An individual's AGI is determined by subtracting certain allowable deductions from gross income. These deductions are known as "above-the line" deductions. These deductions are generally the deductions incurred to produce gross income. For example, these deductions

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[165] Foreign tax credits generally are available against U.S. income tax imposed on foreign source income to the extent of foreign income taxes paid on that income. A nonresident alien generally is subject to the U.S. individual income tax only on income with a sufficient nexus to the United States.

[166] In general, partnerships and S corporations are treated as pass-through entities for Federal income tax purposes. Thus, no Federal income tax is imposed at the entity level. Rather, income of these entities is passed through and taxed to the partners and shareholders.

[167] In general, estates and trusts (other than grantor trusts) pay an individual income tax on the taxable income of the estate or trust. Items of income which are distributed or required to be distributed under governing law or under the terms of the governing instrument generally are included in the income of the beneficiary and not the estate or trust. These entities determine their tax liability using a special tax rate schedule and may be subject to the alternative minimum tax. Certain trusts are treated as being owned by grantors in whole or in part for tax purposes; in such cases, the grantors are taxed on the income of the trust.

include trade or business deductions (other than certain deductions for services performed as an employee), losses from the sale or exchange of property, deductions attributable to rents and royalties, contributions to pensions and other retirement plans, and moving expenses. Thus, AGI generally is an approximation of a taxpayer's "economic income."

Some deductions are not allowable in computing AGI. These deductions generally are referred to as "itemized deductions." The principal itemized deductions are the deductions for interest on a personal residence and investment interest, taxes, charitable contributions, nonbusiness casualty and theft losses, investment expenses, medical and dental expenses, and certain employee expenses. An individual who does not elect to deduct itemized deductions is allowed a standard deduction, which also is not allowable in computing AGI.

Explanation of Provision

The bill imposes a surcharge on high income individuals. In the case of married individuals filing a joint return or a surviving spouse, a tax at the rate of 5.4 percent is imposed on so much of modified AGI as exceeds $1,000,000. In the case of other taxpayers, a 5.4 percent tax is imposed on so much of modified AGI as exceeds $500,000.

Modified AGI is the taxpayer's AGI reduced by the itemized deduction for investment interest.

In the case of a nonresident alien, only amounts taken into account in computing taxable income under section 871(b) are taken into account in computing this tax.

The dollar amount applicable to a taxpayer ($1,000,000 or $500,000, as the case may be) is reduced by the excess (if any) of the amount excluded from gross income under section 911 (relating to income earned outside the United States) over the amount of any related deductions and exclusions disallowed under section 911(d)(6).

No credits are allowed against this tax and this tax is not taken into account in computing alternative minimum tax liability.

Effective Date

The provision applies to taxable years beginning after December 31, 2010.

O. Excise Tax on Medical Devices
(sec. 552 of the bill and new sec. 4061 of the Code)

Present Law

Chapters 31 and 32 impose excise taxes on certain retail sales and 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.

The following sales are generally exempt from certain manufacturer and retail sale excise taxes: (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.[168] If an article is sold free of tax for resale 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.[169] 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.[170]

The lease of an article is generally considered to be a sale of such article.[171] 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.[172]

There are also rules for determining the price of an article on which excise tax is imposed.[173] These rules provide for: (1) including container, 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.

A credit or refund is generally allowed for overpayment of manufacturers or retail excise taxes.[174] Overpayments may occur when tax-paid articles are sold for export and for certain

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[168] Sec. 4221(a).

[169] Sec. 4221(b).

[170] Sec. 4221(a).

[171] Sec. 4217(a).

[172] Sec. 4218.

[173] Sec. 4216.

[174] Sec. 6416.

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 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.[175]

Explanation of Provision

Under the provision, a tax equal to 2.5 percent of the sale price is imposed on the first taxable sale of a medical device. A medical device is any device, as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act,[176] intended for humans.

Under the provision, the first taxable sale is the first sale, for a purpose other than for resale, after production, manufacture, or importation. So, for example, the sale of a device by a manufacturer to a wholesaler for the purpose of resale is not the first taxable sale and is not subject to the tax. The subsequent sale of the device by the wholesaler to the hospital for use by the hospital is the first taxable sale and is subject to the tax. A sale of a medical device for use in connection with the provision of health care services to an individual is not treated as a sale for the purpose of resale, even if the device is resold to the individual.

A sale of a medical device at a retail establishment is excluded from tax if the sale is made on terms that are available to the general public, and the device is of a type and purchased in a quantity that would be purchased by the general public. A sale of a medical device over the internet may be considered a sale at a retail establishment if the sale is made on terms that are available to the general public, and the device is of a type and purchased in a quantity that would be purchased by the general public.

The provision provides for tax-free treatment of sales of medical devices for further manufacture and for export under rules similar to those governing such exemptions under present law for manufactures and retail taxes.[177] The provision also provides for registration

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[175] Sec. 6416(a).

[176] 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.

[177] The provision incorporates rules similar to the rules of section 4221, other than subsection (a) paragraphs (3), (4), (5) and (6).

requirements as a condition of exemption similar to present law and extends the authority of the Secretary of the Treasury to require registration of retail establishments for purposes of the exclusion from tax for sales of medical devices from such retail establishments.[178]

Under the provision, a lease of a medical device by the manufacturer, producer, or importer is considered a sale of the device for purposes of the imposition of the tax.[179] Additionally, under the provision, a person using a medical device prior to the first taxable sale is liable for tax in the same manner as if the use were the first taxable sale of the device. This rule does not apply if such use is material in the manufacture or production of, or as a component part of, another medical device to be manufactured or produced by the person using the device. This rule also does not apply if the use of the medical device occurs after the device was sold in an exempt sale at a retail establishment.

The provision adopts rules for determining the sale price for purposes of computing the amount of tax due on the first taxable sale of a medical device.[180] In addition, if a medical device is sold, other than through an arm's length transaction, at less than the fair market price, or if a person is liable for tax for use of a medical device, the tax under the provision is computed on the price for which such device or similar devices are sold in the ordinary course of trade.

The provision includes a special rule allowing recovery of tax paid by the seller of the medical device from the producer, manufacturer, or importer where there is a specified contract sale. A specified contract sale is the first taxable sale of a device where the seller is not the producer, manufacturer, or importer of the device, and the price at which the device is sold in the first taxable sale is determined in accordance with a contract between the producer, manufacturer, or importer of the device and the person to whom the device is sold. Where there has been a recovery of tax under this provision, a refund or credit of the tax paid is allowed only if the seller files, with the Secretary of the Treasury, a written consent of the producer, manufacturer, or importer from whom the tax was recovered, in addition to any other applicable requirements of section 6416. Additionally, if a refund or credit is allowed under section 6416, then the recovery amount allowable from the producer, manufacturer, or importer is reduced by such refund or credit.

Effective Date

The provision applies to sales, and leases and uses treated as sales, of medical devices after December 31, 2012.

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[178] The provision incorporates rules similar to the rules of section 4222.

[179] The provision incorporates rules similar to the rules in section 4217.

[180] The provision incorporates rules similar to the rules of subsections (a) (relating to containers, packing and transportation charges), (c) (relating to partial payments), and (d) relating to sales of installment accounts) of section 4216.

P. Require Information Reporting on Payments to Corporations (sec. 553 of the bill and sec. 6041 of the Code)

Present Law

Present law imposes a variety of information reporting requirements on participants in certain transactions.[181] 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.[182] 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.[183] 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.[184] The regulations generally except from reporting, payments to corporations, exempt organizations, governmental entities, international organizations, or retirement plans.[185] However, the following types of payments to corporations must be reported: medical and healthcare payments;[186] fish purchases for cash;[187] attorney's fees;[188] gross proceeds paid to an attorney;[189] substitute payments in lieu of dividends or tax-exempt interest;[190] and payments by a Federal executive agency for services.[191]

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[181] Secs. 6031 through 6060.

[182] 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).

[183] 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.

[184] Sec. 6041(d).

[185] 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.

[186] Sec. 6050T.

[187] Sec. 6050R.

[188] Sec. 6045(f)(1) and (2); Treas. Reg. secs. 1.6041-1(d)(2) and 1.6045-5(d)(5).

[189] *Ibid*.

[190] Sec. 6045(d).

[191] Sec. 6041(d)(3).

Failure to comply with the information reporting requirements results in penalties, which may include a penalty for failure to file the information return,[192] and a penalty for failure to furnish payee statements[193] or failure to comply with other various reporting requirements.[194]

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).[195] 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.[196] 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 prior to the date of enactment. The payments to be reported include gross proceeds paid in consideration for property or services.

Effective Date

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

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[192] 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.

[193] 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.

[194] 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.

[195] Secs. 6042 (dividends), 6045 (broker reporting) and 6049 (interest) and the Treasury regulations thereunder.

[196] See Treas. Reg. sec. 31.3406(h)-3.

Q. Repeal of Worldwide Allocation of Interest (sec. 554 of the bill and sec. 864(f) of the Code)

Present Law

In general

To compute the foreign tax credit limitation, a taxpayer must determine the amount of its taxable income from foreign sources. Thus, the taxpayer must allocate and apportion deductions between items of U.S.-source gross income, on the one hand, and items of foreign-source gross income, on the other.

In the case of interest expense, the rules generally are based on the approach that money is fungible and that interest expense is properly attributable to all business activities and property of a taxpayer, regardless of any specific purpose for incurring an obligation on which interest is paid.[197] For interest allocation purposes, all members of an affiliated group of corporations generally are treated as a single corporation (the so-called "one-taxpayer rule") and allocation must be made on the basis of assets rather than gross income. The term "affiliated group" in this context generally is defined by reference to the rules for determining whether corporations are eligible to file consolidated returns.

For consolidation purposes, the term "affiliated group" means one or more chains of includible corporations connected through stock ownership with a common parent corporation that is an includible corporation, but only if: (1) the common parent owns directly stock possessing at least 80 percent of the total voting power and at least 80 percent of the total value of at least one other includible corporation; and (2) stock meeting the same voting power and value standards with respect to each includible corporation (excluding the common parent) is directly owned by one or more other includible corporations.

Generally, the term "includible corporation" means any domestic corporation except certain corporations exempt from tax under section 501 (for example, corporations organized and operated exclusively for charitable or educational purposes), certain life insurance companies, corporations electing application of the possession tax credit, regulated investment companies, real estate investment trusts, and domestic international sales corporations. A foreign corporation generally is not an includible corporation.

Subject to exceptions, the consolidated return and interest allocation definitions of affiliation generally are consistent with each other.[198] For example, both definitions generally exclude all foreign corporations from the affiliated group. Thus, while debt generally is

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[197] However, exceptions to the fungibility principle are provided in particular cases, some of which are described below.

[198] One such exception is that the affiliated group for interest allocation purposes includes section 936 corporations (certain electing domestic corporations that have income from the active conduct of a trade or business in Puerto Rico or another U.S. possession) that are excluded from the consolidated group.

considered fungible among the assets of a group of domestic affiliated corporations, the same rules do not apply as between the domestic and foreign members of a group with the same degree of common control as the domestic affiliated group.

Banks, savings institutions, and other financial affiliates

The affiliated group for interest allocation purposes generally excludes what are referred to in the Treasury regulations as financial corporations.[199] A financial corporation includes any corporation, otherwise a member of the affiliated group for consolidation purposes, that is a financial institution (described in section 581 or section 591), the business of which is predominantly with persons other than related persons or their customers, and which is required by State or Federal law to be operated separately from any other entity that is not a financial institution.[200] The category of financial corporations also includes, to the extent provided in regulations, bank holding companies (including financial holding companies), subsidiaries of banks and bank holding companies (including financial holding companies), and savings institutions predominantly engaged in the active conduct of a banking, financing, or similar business.[201]

A financial corporation is not treated as a member of the regular affiliated group for purposes of applying the one-taxpayer rule to other non-financial members of that group. Instead, all such financial corporations that would be so affiliated are treated as a separate single corporation for interest allocation purposes.

Worldwide interest allocation

In general

The American Jobs Creation Act of 2004 ("AJCA")[202] modified the interest expense allocation rules described above (which generally apply for purposes of computing the foreign tax credit limitation) by providing a one-time election (the "worldwide affiliated group election") under which the taxable income of the domestic members of an affiliated group from sources outside the United States generally is determined by allocating and apportioning interest expense of the domestic members of a worldwide affiliated group on a worldwide-group basis (i.e., as if all members of the worldwide group were a single corporation). If a group makes this election, the taxable income of the domestic members of a worldwide affiliated group from sources outside the United States is determined by allocating and apportioning the third-party interest expense of those domestic members to foreign-source income in an amount equal to the excess (if any) of (1) the worldwide affiliated group's worldwide third-party interest expense multiplied

[199] Treas. Reg. sec. 1.861-11T(d)(4).

[200] Sec. 864(e)(5)(C).

[201] Sec. 864(e)(5)(D).

[202] Pub. L. No. 108-357, sec. 401.

by the ratio that the foreign assets of the worldwide affiliated group bears to the total assets of the worldwide affiliated group,[203] over (2) the third-party interest expense incurred by foreign members of the group to the extent such interest would be allocated to foreign sources if the principles of worldwide interest allocation were applied separately to the foreign members of the group.[204]

For purposes of the new elective rules based on worldwide fungibility, the worldwide affiliated group means all corporations in an affiliated group as well as all controlled foreign corporations that, in the aggregate, either directly or indirectly,[205] would be members of such an affiliated group if section 1504(b)(3) did not apply (i.e., in which at least 80 percent of the vote and value of the stock of such corporations is owned by one or more other corporations included in the affiliated group). Thus, if an affiliated group makes this election, the taxable income from sources outside the United States of domestic group members generally is determined by allocating and apportioning interest expense of the domestic members of the worldwide affiliated group as if all of the interest expense and assets of 80-percent or greater owned domestic corporations (i.e., corporations that are part of the affiliated group, as modified to include insurance companies) and certain controlled foreign corporations were attributable to a single corporation.

Financial institution group election

Taxpayers are allowed to apply the bank group rules to exclude certain financial institutions from the affiliated group for interest allocation purposes under the worldwide fungibility approach. The rules also provide a one-time financial institution group election that expands the bank group. At the election of the common parent of the pre-election worldwide affiliated group, the interest expense allocation rules are applied separately to a subgroup of the worldwide affiliated group that consists of (1) all corporations that are part of the bank group, and (2) all financial corporations. For this purpose, a corporation is a financial corporation if at least 80 percent of its gross income is financial services income (as described in section 904(d)(2)(C)(i) and the regulations thereunder) that is derived from transactions with unrelated persons.[206] For these purposes, items of income or gain from a transaction or series of transactions are disregarded if a principal purpose for the transaction or transactions is to qualify any corporation as a financial corporation.

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[203] For purposes of determining the assets of the worldwide affiliated group, neither stock in corporations within the group nor indebtedness (including receivables) between members of the group is taken into account.

[204] Although the interest expense of a foreign subsidiary is taken into account for purposes of allocating the interest expense of the domestic members of the electing worldwide affiliated group for foreign tax credit limitation purposes, the interest expense incurred by a foreign subsidiary is not deductible on a U.S. return.

[205] Indirect ownership is determined under the rules of section 958(a)(2) or through applying rules similar to those of section 958(a)(2) to stock owned directly or indirectly by domestic partnerships, trusts, or estates.

[206] See Treas. Reg. sec. 1.904-4(e)(2).

In addition, anti-abuse rules are provided under which certain transfers from one member of a financial institution group to a member of the worldwide affiliated group outside of the financial institution group are treated as reducing the amount of indebtedness of the separate financial institution group. Regulatory authority is provided with respect to the election to provide for the direct allocation of interest expense in circumstances in which such allocation is appropriate to carry out the purposes of these rules, to prevent assets or interest expense from being taken into account more than once, or to address changes in members of any group (through acquisitions or otherwise) treated as affiliated under these rules.

Effective date of worldwide interest allocation

The common parent of the domestic affiliated group must make the worldwide affiliated group election. It must be made for the first taxable year beginning after December 31, 2010, in which a worldwide affiliated group exists that includes at least one foreign corporation that meets the requirements for inclusion in a worldwide affiliated group.[207] The common parent of the pre-election worldwide affiliated group must make the election for the first taxable year beginning after December 31, 2010, in which a worldwide affiliated group includes a financial corporation. Once either election is made, it applies to the common parent and all other members of the worldwide affiliated group or to all members of the financial institution group, as applicable, for the taxable year for which the election is made and all subsequent taxable years, unless revoked with the consent of the Secretary of the Treasury.

Phase-in rule

HERA also provided a special phase-in rule in the case of the first taxable year to which the worldwide interest allocation rules apply. For that year, the amount of the taxpayer's taxable income from foreign sources is reduced by 70 percent of the excess of (1) the amount of its taxable income from foreign sources as calculated using the worldwide interest allocation rules over (2) the amount of its taxable income from foreign sources as calculated using the present-law interest allocation rules. For that year, the amount of the taxpayer's taxable income from domestic sources is increased by a corresponding amount. Any foreign tax credits disallowed by virtue of this reduction in foreign-source taxable income may be carried back or forward under the normal rules for carrybacks and carryforwards of excess foreign tax credits.

Explanation of Provision

The provision repeals the worldwide interest allocation rules.

Effective Date

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

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[207] As originally enacted under AJCA, the worldwide interest allocation rules were effective for taxable years beginning after December 31, 2008. However, the Housing and Economic Recovery Act of 2008 ("HERA") delayed the implementation of the worldwide interest allocation rules for two years, until taxable years beginning after December 31, 2010. Pub. L. No. 110-289, sec. 3093.

R. Second Generation Biofuel Producer Credit
(sec. 555 of the bill and secs. 40 and 168(l) of the Code)

Present Law

Cellulosic biofuel producer credit

Section 15332 of the Food, Conservation, and Energy Act of 2008 (Pub. L. No 110-234) added a new component to section 40 of the Code, the "cellulosic biofuel producer credit." This 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.[208]

"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 cellusic 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 with the IRS as a producer of cellulosic biofuel.

Cellulosic biofuel eligible for the section 40 credit may not include biodiesel and renewable diesel determined under section 40A, or alternative fuel under section 6426 for purposes of the applicable income tax credit, excise tax credit, or payment provisions relating to those fuels.[209]

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 lignin and the spent chemicals used to break down the wood. The amount

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[208] 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.

[209] See secs. 40A(d)(1), 40A(f)(3), and 6426(h).

of the biomass in black liquor varies. The black liquor that is not consumed as a fuel source for the paper mills is recycled back into the papermaking process. Black liquor has ash content (mineral and other inorganic matter) significantly above that of other fuels.

In an informal Chief Counsel Advice, 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.[210] A taxpayer cannot claim both the alternative fuel mixture credit and the cellulosic biofuel producer credit. The alternative fuel credits and payment provisions expire December 31, 2009.

Bonus depreciation for cellulosic biofuel plant property

Section 168(l) allows an additional first-year depreciation deduction equal to 50 percent of the adjusted basis of qualified cellulosic biofuel plant property. In order to qualify, the property generally must be placed in service before January 1, 2013.

Qualified cellulosic biofuel plant property means property used in the U.S. solely to produce cellulosic biofuel. For this purpose, cellulosic biofuel means biofuel derived from any lignocellulosic or hemicellulosic matter that is available on a renewable or recurring basis. For example, lignocellulosic or hemicellulosic matter that is available on a renewable or recurring basis includes bagasse (from sugar cane), corn stalks, and switchgrass.

The additional first-year depreciation deduction is allowed for both regular tax and alternative minimum tax purposes for the taxable year in which the property is placed in service. The additional first-year depreciation deduction is subject to the general rules regarding whether an item is subject to capitalization under section 263 or section 263A. The basis of the property and the depreciation allowances in the year of purchase and later years are appropriately adjusted to reflect the additional first-year depreciation deduction. In addition, there is no adjustment to the allowable amount of depreciation for purposes of computing a taxpayer's alternative minimum taxable income with respect to property to which the provision applies. A taxpayer is allowed to elect out of the additional first-year depreciation for any class of property for any taxable year.

In order for property to qualify for the additional first-year depreciation deduction, it must meet the following requirements. The original use of the property must commence with the taxpayer on or after December 20, 2006. The property must be acquired by purchase (as defined under section 179(d)) by the taxpayer after December 20, 2006, and placed in service before

[210] IRS CCA 200941011, 2009 WL 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.

January 1, 2013. Property does not qualify if a binding written contract for the acquisition of such property was in effect on or before December 20, 2006.

Property that is manufactured, constructed, or produced by the taxpayer for use by the taxpayer qualifies if the taxpayer begins the manufacture, construction, or production of the property after December 20, 2006, and the property is placed in service before January 1, 2013 (and all other requirements are met). Property that is manufactured, constructed, or produced for the taxpayer by another person under a contract that is entered into prior to the manufacture, construction, or production of the property is considered to be manufactured, constructed, or produced by the taxpayer.

Property any portion of which is financed with the proceeds of a tax-exempt obligation under section 103 is not eligible for the additional first-year depreciation deduction. Recapture rules apply if the property ceases to be qualified cellulosic biofuel plant property.

Property with respect to which the taxpayer has elected 50 percent expensing under section 179C is not eligible for the additional first-year depreciation deduction.[211] In addition, property eligible for bonus depreciation under section 168(k) is not eligible for the additional first-year deduction[212] nor is property to which the alternative depreciation system applies (unless such depreciation system was elected by the taxpayer under section 168(g)(7)).[213]

Explanation of Provision

Second generation biofuel producer credit

The provision modifies the cellulosic biofuel producer credit in several respects. First, the provision renames the credit the "second generation biofuel credit." In addition to liquid fuel made from cellulosic feedstocks, the provision expands present law to include liquid fuel made from certain aquatic feedstocks, specifically cultivated algae (including diatoms), cyanobacteria and lemna. The credit is available only for liquid fuel derived solely from the qualified feedstocks.[214] The provision defines liquid fuel to mean a fuel that would be liquid at room temperature if the water content were removed.[215] The provision precludes eligibility for any fuels that (1) were derived from co-processing a qualified feedstock with any feedstock that is not a qualified feedstock, (2) are more than four percent (determined by weight) water and

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[211] Sec. 168(l)(8).

[212] Sec. 168(l)(4)(A).

[213] Sec. 168(l)(4)(B).

[214] As under present law, the fuel also must be produced in the United States and used as fuel in the United States, and meet the registration requirements for fuels and fuel additives established by the EPA under section 211 of the Clean Air Act. The second generation biofuel producer credit cannot be claimed unless the taxpayer is registered with the IRS as a producer of such biofuel.

[215] The same definition applies for purposes of other credits determined under sections 40 and 40A.

sediment in any combination, or (3) have an ash content of more than one percent (determined by weight).

Instead of a $1.01 per gallon for every second generation biofuel, the amount of the credit varies based on the BTU (British thermal unit) content of the fuel using a formula under which the applicable amount is determined in the same ratio as $1.01 bears to the BTU content of ethanol. The Secretary, in consultation with the Department of Energy, is to prescribe a table setting forth the BTU content of second generation biofuels. Until such table is prescribed, each second generation biofuel is treated as having the BTU content of ethanol and thus eligible for the full $1.01. For second generation biofuel that is alcohol, the amount of the credit continues to be reduced as under present law. Under the provision, persons seeking to claim the credit are required to provide such information as specified by the Secretary to establish the type, feedstocks, and BTU content of the fuel as part of the second generation biofuel producer registration process. The Secretary may require such other information as the Secretary deems appropriate.

Bonus depreciation for second generation biofuel

The provision changes the definition of qualified property to include second generation biofuel as described above.

Effective Date

In general, the provision is effective for fuel sold or used after the date of enactment. For the bonus depreciation, the provision is effective for property placed in service after the date of enactment.

S. Limitation on Treaty Benefits for Certain Deductible Payments (sec. 561 of the bill and sec. 894 of the Code)

Present Law

In general

The United States taxes foreign corporations only on income that has a sufficient nexus to the United States. Thus, a foreign corporation is generally subject to net-basis U.S. tax only on income that is effectively connected with the conduct of a trade or business in the United States. Such effectively connected income generally is taxed in the same manner and at the same rates as the income of a U.S. corporation. An applicable tax treaty may limit the imposition of U.S. tax on business operations of a foreign corporation to cases in which the business is conducted through a permanent establishment in the United States.

In addition, foreign corporations generally are subject to a gross-basis U.S. tax at a flat 30-percent rate on the receipt of interest, dividends, rents, royalties, and certain similar types of income derived from U.S. sources, subject to certain exceptions. The tax ("U.S. withholding tax") generally is collected by means of withholding by the person making the payment. U.S. withholding tax may be reduced or eliminated under an applicable tax treaty, subject to the conditions discussed below.

Tax treaties

A foreign corporation may not benefit from a provision of a U.S. tax treaty with a foreign country that eliminates or reduces U.S. withholding tax unless the foreign corporation is both a resident of such foreign country and qualifies under any limitation-on-benefits provision contained in the U.S. tax treaty with such foreign country. In general, a foreign corporation is a resident of a foreign country under a U.S. tax treaty with that foreign country if it is liable to tax in that country by reason of its domicile, residence, citizenship, place of management, place of incorporation, or other criterion of a similar nature.[216]

Limitation-on-benefits provisions generally

Limitation-on-benefits provisions in income tax treaties are intended to deny treaty benefits in certain cases of treaty shopping or income stripping engaged in by third-country residents. Treaty shopping is said to occur when an entity that is resident in a country with respect to which there is no relevant tax treaty in force (or there is such a treaty in force but the taxpayer desires better benefits than those offered under that treaty) becomes resident in a treaty country or conducts a transaction in such a country for the purpose of qualifying for treaty benefits. For example, treaty shopping by a third-country resident may involve organizing in a treaty country a corporation that is entitled to the benefits of the treaty. Alternatively, a third-country resident eligible for favorable treatment under the tax rules of its country of residency may attempt to reduce the income base of a related treaty-country resident by having that treaty

[216] United States Model Income Tax Convention of November 15, 2006, Art. 4, par. 1.

country resident pay to it, directly or indirectly, interest, royalties, or other amounts that are deductible in the treaty country from which the payments are made.

U.S. tax treaties contain a variety of limitation-on-benefits provisions due to the continued and recently accelerated development of limitation-on-benefits concepts, and the negotiated nature of tax treaties in general. Although many older U.S. tax treaties may lack limitation-on-benefits provisions[217] or lack the refinements now thought essential to such provisions, the U.S. model income tax treaty, as most recently revised in 2006 ("U.S. model treaty"),[218] and the newer U.S. treaties include limitation-on-benefits provisions that limit treaty benefits to resident taxpayers that meet certain detailed requirements intended to minimize these abuses. Present Treasury Department policy, which has been repeatedly ratified by the Senate, is broadly to revise older treaties by tightening limitation-on-benefits provisions to prevent treaty shopping.

The limitation-on-benefits rules included in U.S. income tax treaties and protocols signed since 2001 generally correspond with the limitation-on-benefits provisions of the U.S. model treaty. Certain features of the limitation-on-benefits provisions in recent treaties and protocols, however, differ from the rules in the U.S. model treaty, and some recent treaties and protocols include additional limitation-on-benefits rules not included in the U.S. model treaty. Some of the additions and differences make limitation-on-benefits provisions more restrictive than the rules in the U.S. model treaty, and others make the provisions less restrictive.

The U.S. model treaty limitation-on-benefits provision

The limitation-on-benefits rules of the U.S. model treaty include three provisions under which a resident of a treaty country may qualify for treaty benefits. First, a treaty-country resident may qualify for all treaty benefits if it has any one of several listed attributes. Second, a treaty-country resident that does not have one of the listed attributes may qualify for treaty benefits for income items that are derived from the other treaty country and that are related to a trade or business carried on in the residence country. Third, a treaty-country resident that would not be eligible for treaty benefits under either of the preceding two provisions may qualify for treaty benefits at the discretion of the competent authority of the other treaty country. These three provisions are described in more detail below.

Listed attributes qualifying a treaty-country resident for treaty benefits

A treaty-country resident may qualify for treaty benefits under the U.S. model treaty if it has one of the following attributes: it is (1) an individual; (2) a contracting state or a political subdivision or a local authority of the contracting state; (3) a company that satisfies either a public trading or ownership test described below; (4) a pension fund or other tax-exempt

[217] U.S. income tax treaties with Greece, Hungary, Pakistan, the Philippines, Poland, and Romania are examples of such treaties, each of which entered into force more than 25 years ago. The United States recently concluded negotiations for a new income tax treaty with Hungary that contains a modern limitation-on-benefits provision; the U.S. Senate must still ratify that treaty before it may enter into force.

[218] United States Model Income Tax Convention of November 15, 2006, Art. 22.

organization (if, in the case of a pension fund, more than 50 percent of the fund's beneficiaries, members, or participants are individuals resident in either treaty country); or (5) a person other than an individual that satisfies the ownership and base erosion test described below.

Public trading and ownership tests

A company satisfies the public trading test if its principal class of shares (and any disproportionate class of shares) is regularly traded on one or more recognized stock exchanges and either its principal class of shares is primarily traded on one or more recognized stock exchanges located in the treaty country in which the company is a resident or the company's primary place of management and control is in its country of residence. A company may satisfy the ownership test if at least 50 percent of the aggregate vote and value of the company's shares (and at least 50 percent of any disproportionate class of the company's shares) is owned directly or indirectly by five or fewer companies entitled to benefits under the public trading test described above. This ownership test may be satisfied by indirect ownership only if each intermediate owner is a resident of either treaty country.

Ownership and base erosion test

A resident of a treaty country satisfies the ownership prong of the ownership and base erosion test if on at least half the days of the taxable year, persons that are residents of that country and that are entitled to treaty benefits as individuals, governments, companies that satisfy the public trading test, or pension funds or other tax-exempt organizations own, directly or indirectly, stock representing at least 50 percent of the aggregate voting power and value (and at least 50 percent of any disproportionate class of shares) of the resident for whom treaty benefit eligibility is being tested. This ownership requirement may be satisfied by indirect ownership only if each intermediate owner is a resident of the country of residence of the person for which entitlement to treaty benefits is being tested. A resident of a treaty country satisfies the base erosion prong of the ownership and base erosion test if less than 50 percent of the person's gross income for the taxable year, as determined in the person's country of residence, is paid or accrued, directly or indirectly, in the form of deductible payments to persons who are not residents of either treaty country entitled to treaty benefits as individuals, governments, companies that satisfy the public trading test, or pension funds or other tax-exempt organizations (other than arm's-length payments in the ordinary course of business for services or tangible property).

Items of income derived from an active trade or business

Under the U.S. model treaty, a resident of a treaty country that is not eligible for all treaty benefits under any of the rules described above may be entitled to treaty benefits with respect to a particular item of income derived from the other treaty country. A resident is entitled to treaty benefits for such an income item if the resident is engaged in the active conduct of a trade or business in its country of residence (other than the business of making or managing investments for the resident's own account, unless these activities are banking, insurance, or securities activities carried on by a bank, an insurance company, or a registered securities dealer) and the income derived from the other treaty country is derived in connection with, or is incidental to, that trade or business. If a resident of a treaty country derives an item of income from a trade or

business activity that it conducts in the other treaty country, or derives an income item arising in that other country from a related person, the income item eligibility rule just described is considered satisfied for that income item only if the trade or business activity carried on by the resident in its country of residence is substantial in relation to the trade or business activity carried on by the resident or the related person in the other country. The determination whether a trade or business activity is substantial is based on all the facts and circumstances.

Discretionary grant of benefits by competent authority

A resident of a treaty country not otherwise eligible for treaty benefits under the U.S. model treaty may be eligible for the benefits of the treaty generally or eligible for the benefits with respect to a specific item of income, based on a determination by the competent authority of the other treaty country. The competent authority may grant such benefits if it determines that the establishment, acquisition, or maintenance of the person for whom treaty benefits eligibility is being tested, and the conduct of that person's operations, did not have as one of its principal purposes the obtaining of benefits under the treaty.

Explanation of Provision

The provision limits tax treaty benefits with respect to U.S. withholding tax imposed on deductible related-party payments. Under the provision, the amount of U.S. withholding tax imposed on deductible related-party payments may not be reduced under any U.S. income tax treaty unless such withholding tax would have been reduced under a U.S. income tax treaty if the payment were made directly to the foreign parent corporation of the payee. A payment is a deductible related-party payment if it is made directly or indirectly by any entity to any other entity, it is allowable as a deduction for U.S. tax purposes, and both entities are members of the same foreign controlled group of entities.

For purposes of the provision, a foreign controlled group of entities is a controlled group of corporations as defined in section 1563(a)(1), modified as described below, in which the common parent company is a foreign corporation. Such common parent company is referred to as the "foreign parent corporation." A controlled group of corporations consists of a chain or chains of corporations connected through direct stock ownership of at least 80 percent of the total combined voting power of all classes of stock entitled to vote or at least 80 percent of the total value of shares of all classes of stock of each of the corporations. For purposes of the provision, the relevant ownership threshold is lowered from "at least 80 percent" to more than 50 percent, certain members of the controlled group of corporations that would otherwise be treated as excluded members are not treated as excluded members,[219] and insurance companies are not

[219] Under section 1563(b)(2), a corporation that is a member of a controlled group of corporations on December 31 of a taxable year is treated as an excluded member of the group for the taxable year that includes such December 31 if such corporation ─

(A) is a member of the group for less than one-half the number of days in such taxable year which precedes such December 31;

(B) is exempt from taxation under section 501(a) for such taxable year;

treated as members of a separate controlled group of corporations. In addition, a partnership or other noncorporate entity is treated as a member of a controlled group of corporations if such entity is controlled by members of the group.

The Secretary may prescribe regulations that are necessary or appropriate to carry out the purposes of the provision, including regulations providing for the treatment of two or more persons as members of a foreign controlled group of entities if such persons would be the common parent of such group if treated as one corporation, and regulations providing for the treatment of any member of a foreign controlled group of entities as the common parent of that group if such treatment is appropriate taking into account the economic relationships among the group entities.

For example, under the provision, a deductible payment made by a U.S. entity to a foreign entity with a foreign parent corporation that is resident in a country with respect to which the United States does not have an income tax treaty is always subject to the statutory U.S. withholding tax rate of 30 percent, irrespective of whether the payee qualifies for benefits under a tax treaty. If, instead, the foreign parent corporation is a resident of a country with respect to which the United States does have an income tax treaty that would reduce the withholding tax rate on a payment made directly to the foreign parent corporation (regardless of the amount of such reduction), and the payment would qualify for benefits under that treaty if the payment were made directly to the foreign parent corporation, then the payee entity will continue to be eligible for the reduced withholding tax rate under the U.S. income tax treaty with the payee entity's residence country (even if such reduced treaty rate is lower than the rate that would be imposed on a hypothetical direct payment to the foreign parent corporation).

Effective Date

The provision is effective for payments made after the date of enactment.

(C) is a foreign corporation subject to tax under section 881 for such taxable year;

(D) is an insurance company subject to taxation under section 801; or

(E) is a franchised corporation (as defined in section 1563(f)(4)).

T. Codification of Economic Substance Doctrine; Penalties (sec. 562 of the bill and sec. 7701 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.[220]

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[220] See, e.g., *ACM Partnership v. Commissioner*, 157 F.3d 231 (3d Cir. 1998), *aff'g* 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" whose only purpose was to create the deductions). 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 (Oct. 23, 2009).

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 − 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.[221]

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.[222]

Application by the courts

Elements of the doctrine

There is a lack of uniformity regarding the proper application of the economic substance doctrine.[223] 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.[224] A narrower approach used by some courts is to conclude that either a business purpose or economic

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[221] *ACM Partnership v. Commissioner*, 73 T.C.M. at 2215.

[222] See, *ACM Partnership v. Commissioner*, 157 F.3d at 256 n.48.

[223] "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).

[224] 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).

substance is sufficient to respect the transaction.[225] A third approach regards economic 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.[226]

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.[227] 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."[228]

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[225] 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 out of tax considerations (the 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.

[226] 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'.").

[227] *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).

[228] 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.

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.[229] Several courts have denied tax benefits on the grounds that the subject transactions lacked profit potential.[230] 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.[231] 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.[232] 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 one court has concluded that financial accounting benefits arising from tax savings do not qualify as a non-tax business purpose.[233] However, based on court decisions that

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[229] 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 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).

[230] 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).

[231] 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").

[232] 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).

[233] 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).

recognize the importance of financial accounting treatment, taxpayers have asserted that financial accounting benefits arising from tax savings can satisfy the business purpose test.[234]

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 a particular type of transaction did not satisfy the economic substance doctrine.[235] 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.[236]

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.[237] Except in the case of tax shelters,[238] 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

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[234] 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.

[235] See, e.g., *ACM Partnership v. Commissioner,* 157 F.3d 231 (3d Cir. 1998), *aff'g* 73 T.C.M. (CCH) 2189 (1997), *cert. denied* 526 U.S. 1017 (1999).

[236] 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 (Oct. 23, 2009).

[237] Sec. 6662.

[238] 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).

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 that the taxpayer acted in good faith.[239] 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.[240] 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.[241]

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[242] (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

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[239] Sec. 6664(c).

[240] Treas. Reg. sec. 1.6662-4(g)(4)(i)(B); Treas. Reg. sec. 1.6664-4(c).

[241] 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.

[242] Sec. 6662A(b)(2).

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.[243] A listed transaction is defined as a reportable transaction which is the same as, or substantially similar to, a transaction specifically identified by the Secretary as a tax avoidance transaction for purposes of the reporting disclosure requirements.[244]

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.[245] 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.[246]

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.[247] 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.[248] 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.[249]

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[243] Sec. 6707A(c)(1).

[244] Sec. 6707A(c)(2).

[245] Sec. 6662A(a).

[246] Section 6664(d)(3)(B) would not allow a reasonable belief to be based on a "disqualified opinion" or on an opinion from a "disqualified tax advisor".

[247] Sec. 6662A(c).

[248] Sec. 6664(d).

[249] Sec. 6707A(d).

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 shall specify. 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 taxpayer has exhausted its administrative and judicial remedies with respect to the penalty (or if earlier, when paid).[250]

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);[251] 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 shall 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.[252]

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;[253] (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

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[250] Sec. 6707A(e).

[251] 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, shall be treated as an increase in taxable income. Sec. 6662A(b).

[252] Sec. 6662A(e)(3).

[253] See the previous discussion regarding the penalty for failing to disclose a reportable transaction.

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.[254]

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 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[255] 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[256] 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.[257] 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

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[254] Sec. 6664(d).

[255] 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).

[256] 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.

[257] 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.

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, finding or agreements of the taxpayer or any other person; (3) does not identify and consider all relevant facts; or (4) fails to meet any other requirement prescribed by the Secretary.

Coordination with other penalties

To the extent a penalty on an understatement is imposed under section 6662A, that same amount of understatement is not also subject to the accuracy-related penalty under section 6662(a) or to the valuation misstatement penalties under section 6662(e) or 6662(h). However, such amount of understatement is included for purposes of determining whether any understatement (as defined in sec. 6662(d)(2)) is a substantial understatement as defined under section 6662(d)(1) and for purposes of identifying an underpayment under the section 6663 fraud penalty.

The penalty imposed under section 6662A does not apply to any portion of an understatement to which a fraud penalty is applied under section 6663.

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.[258]

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 a 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).

Explanation of Provision

The provision clarifies and enhances the application of the economic substance doctrine. Under the provision, in the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if (1) the

[258] Sec. 6667.

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.[259] 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 shall be made in the same manner as if the provision had never been enacted. Thus, the provision does not change current law standards in determining when to utilize an economic substance analysis.[260]

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[261] these basic transactions are (1) the choice between capitalizing a business enterprise with debt or equity;[262] (2) a U.S. person's choice between utilizing a foreign corporation or a domestic corporation to make a foreign investment;[263] (3) the choice to enter a transaction or series of transactions that constitute a corporate organization or reorganization under subchapter C;[264] 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.[265] Leasing transactions, like all other types of transactions, will continue to be

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[259] In applying these tests, any State or local income tax effect which is related to a Federal income tax effect shall be treated in the same manner as a Federal income tax effect.

[260] If the tax benefits are clearly consistent with all applicable provisions of the Code and the purposes of such provisions, it is not intended that such tax benefits be disallowed if the only reason for such disallowance is that the transaction fails the economic substance doctrine as defined in this provision. See, e.g., Treas. Reg. sec. 1.269-2, stating that characteristic of circumstances in which a deduction otherwise allowed will be disallowed 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.

[261] The examples are illustrative and not exclusive.

[262] 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).

[263] 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).

[264] See, e.g., *Rev. Proc. 2009-3 2009-1 I.R.B. 108, Secs. 3.01(38), (39), and (41)* (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).

[265] 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).

analyzed in light of all the facts and circumstances.[266] As under present law, whether a particular transaction meets the requirements for specific treatment under any of these provisions can be a question of facts and circumstances. Also, the fact that a transaction does meet 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.[267]

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.[268]

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., 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[269] for entering into such transaction, in order to satisfy the economic substance doctrine. 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

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[266] See, e.g., *Frank Lyon v. Commissioner*, 435 U.S. 561 (1978); *Hilton v. Commissioner*, 74 T.C. 305, *aff'd*, 671 F. 2d 316 (9th 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).

[267] 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).

[268] 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.").

[269] For purposes of these tests, any State or local income tax effect that is related to a Federal income tax effect is treated in the same manner as a Federal income tax effect.

change in economic position or a non-tax business purpose (without having both) is sufficient to satisfy the economic substance doctrine.[270]

Non-Federal-tax business purpose

Under the provision, a taxpayer's non-Federal-income-tax purpose for entering into a transaction (the second prong in the analysis) must be "substantial."[271] For purposes of this analysis, any State or local income tax effect which is related to a Federal income tax effect shall be 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 to be 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.[272]

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-tax purpose for entering into such 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

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[270] 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.

[271] 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]

[272] 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 F3d 737 (6th Cir. 2003).

benefits that would be allowed if the transaction were respected.[273] Fees and other transaction expenses and foreign taxes are taken into account as expenses in determining pre-tax profit.

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

The Secretary is to prescribe such regulations as may be necessary or appropriate to carry out the purposes of the provision.

No inference is intended as to the proper application of the economic substance doctrine under present law. In addition, the provision does not 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 the provision should be construed as being additive to any such other rule of law.

Penalty for understatements attributable to transactions lacking economic substance

The provision imposes a new strict liability penalty under section 6662 for an understatement attributable to any disallowance of claimed tax benefits by reason of a transaction lacking economic substance, as defined in new section 7701(p),[274] or failing to meet the requirements of any similar rule of law.[275] 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). Except as provided in regulations, an amended return or supplement to a return 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

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[273] 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.").

[274] That provision generally provides that in any case in which a court determines that the economic substance doctrine is relevant, a transaction has 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. Specific other rules also apply. See "Description of Proposal" for the immediately preceding provision, "Clarification of the economic substance doctrine."

[275] For example, the penalty applies to a transaction that is disregarded as a result of the application of the same 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.

of any similar rule of law. Similarly, a claim for refund 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.[276] The new 40-percent penalty for nondisclosed transactions is added to the penalties to which section 6662A will not also apply.[277]

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(p), or failing to meet the requirements of any similar rule of law. In addition, the exception of present law section 6664(c)(1) does not apply to any tax shelter (as defined in present law section 6662(d)(2)(C)). 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(p), or failing to meet the requirements of any similar rule of law, or to any tax shelter (as defined in present law section 6662(d)(2)(C)).

Effective Date

The provision applies to transactions entered into after the date of enactment. Additionally, the provision applies to underpayments, understatements, and refunds and credits attributable to transactions entered into after the date of enactment.

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[276] I.e., section 6662(b) of present law applies to the new penalty as well.

[277] 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.

U. Certain Large or Publicly Traded Persons Made Subject to a More Likely Than Not Standard for Avoiding Penalties on Underpayments (sec. 563 of the bill and secs. 6662 and 6664 of the Code)

Present Law

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.[278] Except in the case of tax shelters,[279] the amount of any understatement is reduced by any portion of the understatement 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 that the taxpayer acted in good faith.[280] Treasury regulations provide that reasonable cause exists where the understatement is attributable to a tax shelter 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.[281] For transactions other than tax shelters, Treasury 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,

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[278] Sec. 6662.

[279] 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).

[280] Sec. 6664(c).

[281] Treas. Reg. sec. 1.6662-4(g)(4)(i)(B); Treas. Reg. sec. 1.6664-4(c).

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.[282]

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[283] (a "reportable avoidance transaction"). The penalty rate and defenses available to avoid the penalty vary depending on whether the transaction was adequately disclosed.

Section 6707A(c) imposes a penalty for failure adequately to report listed transactions and reportable 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.[284] A listed transaction is defined as a reportable transaction which is the same as, or substantially similar to, a transaction specifically identified by the Secretary as a tax avoidance transaction for purposes of the reporting disclosure requirements.[285] For reportable transactions, the penalty is $10,000 for natural persons and $50,000 in any other case. The penalty for a listed transaction is $100,000 for natural persons and $200,000 in any other case.[286] The Commissioner of the IRS may rescind all or any portion of any penalty imposed under section 6707A if the violation is with respect to a reportable transaction other than a listed transaction and rescinding the penalty would promote compliance with the requirements of this title and effective tax administration.[287]

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[282] 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.

[283] Sec. 6662A(b)(2).

[284] Sec. 6707A(c)(1).

[285] Sec. 6707A(c)(2).

[286] Sec. 6707A(b).

[287] Sec. 6707A(d).

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.[288] The only exception to the penalty is if the taxpayer satisfies a more stringent reasonable cause and good faith exception ("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 must 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.[289]

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.[290] However, a taxpayer will be treated as having adequately disclosed a transaction for this purpose if the Commissioner of the IRS has separately rescinded the separate penalty under section 6707A for failure to disclose a reportable transaction.[291]

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 Securities and Exchange Commission ("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 taxpayer has exhausted its administrative and judicial remedies with respect to the penalty (or if earlier, when paid).[292]

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

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[288] Sec. 6662A(a).

[289] Section 6664(d)(3)(B) would not allow a reasonable belief to be based on a "disqualified opinion" or on an opinion from a "disqualified tax advisor".

[290] Sec. 6662A(c).

[291] Sec. 6664(d).

[292] Sec. 6707A(e).

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);[293] and (2) the amount of any decrease in the aggregate amount of credits which results from the 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 may 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.[294]

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;[295] (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.[296]

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 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[297] and who participates in the organization, management, promotion, or sale of the transaction or is related

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[293] 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, shall be treated as an increase in taxable income. Sec. 6662A(b).

[294] Sec. 6662A(e)(3).

[295] See the previous discussion regarding the penalty for failing to disclose a reportable transaction.

[296] Sec. 6664(d).

[297] 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,

(within the meaning of section 267(b) or 707(b)(1)) to any person who so participates; (2) is compensated directly or indirectly[298] 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.[299] 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, finding or agreements of the taxpayer or any other person; (3) does not identify and consider all relevant facts; or (4) fails to meet any other requirement prescribed by the Secretary.

Coordination with other penalties

To the extent a penalty on an understatement is imposed under section 6662A, that same amount of understatement is not also subject to the accuracy-related penalty under section 6662(a) or to the valuation misstatement penalties under section 6662(e) or section 6662(h). However, such amount of understatement is included for purposes of determining whether any

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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).

[298] 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.

[299] 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.

understatement (as defined in section 6662(d)(2)) is a substantial understatement as defined under section 6662(d)(1) and for purposes of identifying an underpayment under the section 6663 fraud penalty.

The penalty imposed under section 6662A does not apply to any portion of an understatement to which a fraud penalty is applied under section 6663.

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.[300]

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).

Explanation of Provision

Under the provision, in the case of a "specified person," the reasonable cause and good faith exception of present law section 6664(c)(1) applies to a portion of an underpayment only if the taxpayer has a reasonable belief that the tax treatment is more likely than not the proper treatment of the item. This reasonable belief exception is not available to any portion of the underpayment that is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)), transactions lacking economic substance or failing to meet the requirements of any similar rule of law, or reportable transaction understatements which are attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions lacking economic substance.

A specified person is defined as (i) any person required to file periodic or other reports under section 13 of the Securities and Exchange Act of 1934, and (ii) any corporation with gross receipts in excess of $100 million for the taxable year involved.[301]

In the case of a specified person, it is no longer the case that a substantial understatement (as defined in section 6662(d)(1)) is reduced if there is or was substantial authority for the

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[300] Sec. 6667.

[301] For purposes of this rule, all persons treated as a single employer under section 52(a) are treated as one person.

taxpayer's treatment, or if the relevant facts were disclosed and there is a reasonable basis for the taxpayer's tax treatment.

Effective Date

The provision applies to underpayments and understatements attributable to transactions entered into after the date of enactment.

V. Certain Health Related Benefits Applicable to Spouses and Dependents Extended to Eligible Designated Beneficiaries (sec. 571 of the bill and secs. 105, 106, 162, 501, 3121, 3306, and 3401 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.[302] In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents (as defined in section 152) generally are excluded from gross income.[303] 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) stepfather or stepmother; (5) niece or nephew; (6) aunt or uncle; (7) in-law; or (8) certain other

[302] Sec 106.

[303] Sec. 105(b).

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.[304]

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.

A similar rule excludes employer provided health insurance coverage and reimbursements for medical expenses for employees, their spouses, and their dependents from the employees' wages for payroll tax purposes.[305] The same definition of dependent applies for purposes of this exclusion.

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 voluntary employees' beneficiary association ("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.[306] 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.

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[304] 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.

[305] Sec. 3121(a)(2), and 3306(a)(2).

[306] Secs. 419(e) and 501(c)(9).

Explanation of Provision

Exclusion for employer-provided health coverage

The provision amends sections 105 and 106 to extend the general exclusion for employer-provided health coverage to "eligible beneficiaries."[307] The parallel provisions for excluding employer-provided health care from payroll taxes are also amended.[308] An eligible beneficiary is defined as any individual who is eligible to receive benefits or coverage under an accident or health plan. The provision does not place a limit on the number of eligible beneficiaries an individual is able to claim for purposes of the exclusion.

The provision directs the Secretary of the Treasury to issue guidance providing that eligibility for reimbursements from FSAs and HRAs is extended to otherwise qualifying medical expenses of any eligible beneficiary.

A parallel change is made for VEBAs.

Deduction for Health Insurance Premiums of Self-Employed Individuals

The provision amends section 162(l) to permit self-employed individuals to take a deduction for an individual who meets the following criteria: (1) younger than age 19 (24 for full-time students); (2) has the same principal abode as the taxpayer and is a member of the taxpayer's household for the taxable year; and (3) receives more than one-half of his or her support from the taxpayer for the calendar year in which the taxable year begins. The provision does not place a limit on the number of such individuals a taxpayer is able to claim for purposes of the deduction.

The provision also permits a self-employed individual to take a deduction for an individual who is (1) older than age 19 (or 24 for students); (2) has the same principal abode as the taxpayer and is a member of the taxpayer's household for the taxable year; and (3) is not the individual's spouse, qualifying child or qualifying relative. Individuals may only take a deduction for one such individual in any tax year.

Effective Date

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

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[307] The provision does not modify the present-law dependency exemption.

[308] Secs. 3121(a)(2), 3231(e)(1), 3306(b)(2), and 3401(a)(24).

DIVISION B − MEDICARE AND MEDICAID IMPROVEMENTS

TITLE VIII − REVENUE-RELATED PROVISIONS

A. Disclosures to Facilitate Identification of Individuals Likely to be Ineligible for Low-Income Subsidies Under the Medicare Prescription Drug Program to Assist Social Security Administration's Outreach to Eligible Individuals (sec. 1801 of the bill and sec. 6103(l)(19) of the Code)

Present Law

Outreach efforts to increase awareness of the availability of Part D subsidies for low-income individuals

Under Medicare Part D (the prescription drug program), beneficiaries with incomes and assets below certain levels may be eligible for Low Income Subsidy ("LIS") benefits. Section 1144 of the Social Security Act requires the Commissioner of Social Security to conduct outreach efforts to inform potential LIS beneficiaries about the additional premium and cost-sharing subsidies. The Social Security Administration ("SSA"), from its own records and other non-tax records available to SSA, is able to determine a potential pool of LIS beneficiaries, but such pool includes many persons ineligible for the LIS benefits due to excess income or resources.

For example, prior to the beginning of the Part D program, SSA identified and conducted outreach to 18.6 million potentially eligible individuals; of these, 6.2 million applied by March 2007 and 2.2 million were found to be eligible. The Centers for Medicare and Medicaid Services ("CMS") believes that some of the remaining 12.4 million that did not apply could be eligible for LIS benefits. The SSA has contacted these individuals a number of times, but has had limited success identifying additional potentially eligible individuals and securing applications from them.

Confidentiality of returns and return information

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, the Code provides for the disclosure of returns and return information to the SSA for several nontax administration purposes. For purposes of administering the Social Security Act, section 6103(l)(1)(A) authorizes the disclosure to the SSA of returns and return information relating to self-employment taxes, FICA taxes, and taxes withheld at the source on wages.[309] Section 6103(l)(5) provides for the disclosure to the SSA of certain information

[309] Documents which may be disclosed under this provision include but are not limited to:

returns for purposes of carrying out an effective return processing program, the Combined Annual Wage Reporting Program, and for providing mortality status of individuals for certain epidemiological and similar research.[310] In addition, the Code provides for the disclosure of certain return information for purposes of establishing the appropriate amount of any Medicare Part B Premium Subsidy Adjustment.[311]

A December 2008 Treasury study conducted jointly with the SSA found that certain income information in IRS's possession, and, through imputation, some asset information, could be used to narrow the pool of potentially eligible LIS beneficiaries identified by the SSA, thereby allowing the SSA to better target its outreach efforts. Specifically, tax information could be used to screen out some individuals whose income or resources make them likely to be ineligible for LIS benefits.[312]

Explanation of Provision

Under the provision, upon written request from the Commissioner of Social Security, officers and employees of the SSA will have access to the following information (including information available under sections 6103(l)(1) and (l)(5)) with respect to any individual identified by the Commissioner of Social Security:

1. return information for the applicable year from returns with respect to wages and payments of retirement income;

2. unearned income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the applicable year;

- Schedule C, Form 1040, *Profit (or Loss) from Business or Profession*
- Schedule E, Form 1040, *Supplemental Income Schedule-Part III, Income or Loss from Partnerships*
- Schedule F, Form 1040, *Farm Income and Expenses*
- Schedule SE, Form 1040, *Computation of Social Security Self-Employment Tax*
- Form 1065, *U.S. Partnership Return of Income*
- Form 941, *Employer's Quarterly Federal Tax Return*
- Form 942, *Employer's Quarterly Tax Return for Household Employees* or portions Schedule H
- Form 1040
- Form 943, *Employer's Annual Tax Return for Agricultural Employees*
- Form W-2, *Wage and Tax Statement*.

See Internal Revenue Service, Internal Revenue Manual, sec. 11.3.29.3 - Administration of the Social Security Act - Social Security Administration (May 27, 2005).

[310] The information returns that may be disclosed under section 6103(l)(5) are those filed under Part III, Subchapter A, Chapter 61 of the Code. These include, primarily, Form W-2, Form W-3, and Form 1099-R. See Internal Revenue Service, Internal Revenue Manual, sec. 11.3.29.3.2 - Disclosure of Information Returns to Social Security Administration (May 27, 2005).

[311] Sec. 6103(l)(20).

[312] Department of the Treasury, Office of Tax Analysis, *Value of IRS Information for Determining Eligibility for the Low Income Subsidy Program (LIS) of the Medicare Prescription Drug Program (Medicare Part D)* (December 2008) at 1 and 3.

3. if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from farming, and income from self employment on such return;

4. if the taxpayer's return status was married filing separately, the social security number of the taxpayer's spouse;

5. if the taxpayer filed a joint return, the social security number, unearned income information, and income information from partnerships, trusts, estates, and Subchapter S corporations of the taxpayer's spouse; and

6. such other return information relating to the taxpayer (and, in the case of a joint return, the taxpayer's spouse) as is prescribed by the Secretary by regulation as might indicate that the taxpayer is likely to be ineligible for a low-income prescription drug subsidy under section 1860D-14 of the Social Security Act.

For purposes of the provision, "applicable year" means the most recent taxable year for which information is available in the IRS's taxpayer information records. Under the provision, the SSA may only request tax information with respect to individuals the SSA has identified, through the use of all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1860D-14 of the Social Security Act and who have not applied for such subsidy. In the case of an identified individual whose return status was married filing separately and whose spouse was not identified by the SSA as likely to be eligible for a low-income prescription drug subsidy, the SSA may make a separate request for information related to such spouse.

The information disclosed under the provision can only be used by the SSA for purposes of identifying those individuals likely to be ineligible for a low-income prescription drug subsidy for purposes of its outreach efforts under section 1144 of the Social Security Act.

Effective Date

The provision is effective for disclosures made after the date that is 12 months after the date of enactment.

B. Comparative Effectiveness Research Trust Fund; Financing for Trust Fund (sec. 1802 of the bill and new secs. 4375, 4376, 4377, and 9511 of the Code)

Present Law

No provision.

Explanation of Provision

In general

The provision establishes the Health Care Comparative Effectiveness Research Trust Fund (''CERTF'') to carry out the provisions in the bill relating to comparative effectiveness research.

The following amounts are appropriated to the CERTF: $90,000,000 for fiscal year 2010; $100,000,000 for fiscal year 2011; and $110,000,000 for fiscal year 2012. For each fiscal year beginning with fiscal year 2013, the amount appropriated to the CERTF is (1) an amount equal to the net revenues received in the Treasury from the fees imposed on health insurance and self-insured plans under new Code sections 4375, 4376 and 4377 for such fiscal year, and (2) amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount for the fiscal year multiplied by the average number of individuals entitled to benefits under Medicare Part A, or enrolled under Medicare Part B, for such fiscal year. The amount transferred under (2) is limited to $90,000,000. Net revenues means the amount, as estimated by the Secretary of the Treasury, equaling the excess of the fees received in the Treasury on account of the new fees on health insurance and self-insured plans under new Code sections 4375, 4376 and 4377, over the decrease in tax imposed by chapter one of the Code relating to the fees imposed by such sections.

The amounts appropriated for fiscal years 2011 through 2013, as well as the amounts transferred under (2), above, are subject to section 9601,[313] except that the amounts are to be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, and from the Medicare Prescription Drug Account within such Trust Fund, in proportion to the total expenditures during such year that are made under Medicare from the respective trust fund or account. The amounts appropriated for fiscal years 2011 through 2013 are not subject to any fiscal year limitation.

The fair share per capita amount for a fiscal year is an amount computed by the Secretary of Health and Human Services for such fiscal year that will result in revenues to the CERTF of $375,000,000 for the fiscal year. If the Secretary of Health and Human Services is unable to compute the fair share per capita amount for a fiscal year, a default amount is used. The default

[313] Sec. 9601 provides that amounts appropriated by any sections of Subchapter A of any trust fund established under by such subchapter shall be transferred at least monthly to such trust fund on the basis of estimates made by the Secretary of the Treasury of the amounts referred to in such section.

amount is $2 for fiscal year 2013. For a subsequent year, the default amount is equal to the default amount for the preceding fiscal year increased by the annual percentage increase in the medical care component of the Consumer Price Index for the 12-month period ending with April of the preceding fiscal year. Beginning not later than December 31, 2011, the Secretary of Health and Human Services must submit to Congress an annual recommendation for a fair share per capita amount for purposes of funding the CERTF.[314]

The provision requires that, at a minimum, the following amounts in the CERTF must be available to carry out the activities of the Comparative Effectiveness Research Commission established under the bill: $7,000,000 for fiscal year 2010; $9,000,000 for fiscal year 2011; and 2.6 percent of the total amount appropriated to the CERTF for each fiscal year beginning with 2012.

Financing CERTF from fees on health plans

As discussed above, the CERTF is funded in part from fees imposed on health plans under new Code sections 4375 through 4377. Under the provision, a fee is imposed on each specified health insurance policy equal to the fair share per capita amount multiplied by the average number of lives covered under the policy. The issuer of the policy is liable for payment of the fee. A specified health insurance policy includes any accident or health insurance policy[315] issued with respect to individuals residing in the United States, except that 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).[316] 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 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.

In the case of an applicable self-insured health plan, a fee is imposed equal to the fair share per capita amount multiplied by the average number of lives covered under the plan. 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 of more employers and one or more employee organizations, (2) a multiple

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[314] This requirement is in section 1401 of the bill.

[315] 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.

[316] Under the provision, the United States includes any possession of the United States.

employer welfare arrangement, or (3) a VEBA in Code section 501(c)(9), 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 described in section 501(c)(9) of the Code, (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) of ERISA), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA).

Governmental entities are not exempt from the fees imposed under the provision except in the case of certain exempt governmental programs. Exempt governmental programs include Medicare, Medicaid, SCHIP, and any program established by Federal law for proving 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 procedure and administration rules under the Code, the fee imposed under the provision is treated as a tax.

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.