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## MEMORANDUM

Date: June 9, 2010

Re: 2010 Health Care Act

As we are sure you know, Congress has approved and President Obama has signed into law comprehensive health care reform legislation that raises nearly \$438 billion over 10 years through tax increases on high-income individuals, excise taxes on high-cost group health plans, and a number of other taxes. The Patient Protection and Affordable Care Act became law on March 23, 2010, and the Reconciliation Act of 2010, a companion package of "fixes" to the larger health care bill, was enacted on March 30, 2010.

We are writing to give you a brief overview of the key tax changes in the Patient Protection and Affordable Care Act, as modified by the Reconciliation Act of 2010 (collectively referred to herein as "the Act"). Also included is an overview of the mandate requiring individual coverage and the penalty on employers for failure to offer coverage.

Because of the breadth and complexity of the Act, we have provided below a list of the provisions we are covering in this letter so that you can focus on the issues of most interest to you at this time.

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**I. Penalties on Individuals for Remaining Uninsured**

The health care overhaul legislation contains an "individual mandate" — a requirement that U.S. citizens and legal residents have qualifying health coverage or be subject to a tax penalty. Under the new law, effective for tax years beginning after December 31, 2013, non-exempt U.S. citizens and legal residents will be required to maintain "minimum essential coverage" or pay a penalty. "Minimum essential coverage" includes coverage under any employer-provided plan, governmental programs (i.e., Medicare and Medicaid) and any plan offered in the individual market. There are virtually no specific benefit requirements for a plan's coverage to be considered minimum essential coverage, as long as the plan primarily covers medical benefits. Examples of plans that do not qualify include workers' compensation and long-term care insurance.

Individuals failing to maintain minimum essential coverage for themselves and their dependents in 2014 will be subject to a penalty equal to the greater of the amounts shown in columns (A) and (B) below:

<u>Year</u>	<u>Annual penalty equal to the greater of:</u>	
	(A)	(B)
2014	1% of household income over the income tax filing threshold	\$95 per adult
2015	2% of household income over the income tax filing threshold	\$325 per adult
2016	2.5% of household income over the income tax filing threshold	\$695 per adult

(After 2016, the penalty in column (B) will be increased by an annual cost of living adjustment.)

If a taxpayer files a joint return, the individual and his or her spouse would be jointly liable for any penalty payment. The penalty applies to any monthly period the individual does not maintain minimum essential coverage, and the monthly penalty is equal to 1/12 of the applicable annual penalty in column A or B above. The penalty will be assessed through the Internal Revenue Code.

A number of exemptions will be granted, including exemptions for financial hardship, religious objections, American Indians, those without coverage for less than three months, individuals residing outside the United States, unlawful aliens, incarcerated individuals, and certain low-income individuals.

Notwithstanding the foregoing, any individual or family who has coverage under an employer plan in existence as of March 23, 2010, and would like to retain that coverage, can do so under a "grandfather" provision. Grandfathered plans are exempt from many of the individual and group market reforms that take effect in 2014, and this coverage is deemed to meet the requirement to have health coverage. As long as the terms of the group plan or insurance coverage allow it, family members of an individual may enroll in a grandfathered plan in which that individual is enrolled, and a grandfathered group health plan also may provide for the enrollment of new employees and their families. Although the Act does not require individuals to terminate their existing coverage, the law also does not prevent a group health plan from dropping those grandfathered plans. Accordingly, whether an individual can maintain his or her existing coverage will depend in large part on whether the plan sponsor or insurer continues to provide that type of grandfathered plan. So far, there are no guidelines for maintaining a grandfathered plan or for determining what changes to the plan (such as cost, deductibles, coverage) would end the grandfathered status.

## **II. Large Employer Requirement to Offer Coverage**

As mentioned above, the Act provides a broad "grandfather" provision for plans in existence on the date of enactment (March 23, 2010), and employers that currently offer coverage are permitted to continue offering such coverage. However, for plans not in existence on March 23, 2010, the Act requires certain employers to offer and contribute to their workers' health insurance or pay a penalty (so-called "pay or play"). Effective for months beginning after December 31, 2013, a "large employer" (discussed below) that (1) does not offer coverage for all its full-time employees; (2) offers minimum essential coverage that is "unaffordable"; or (3) offers coverage that consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%, is required to pay a penalty if any full-time employee is certified to the employer as having purchased health insurance through a Health Benefit Exchange ("Exchange") with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to the employee. An Exchange is basically a state-based marketplace where consumers can shop for and purchase health insurance.

- A. Who is subject to the large employer mandate? Only an "applicable large employer," defined as an employer who employed an average of at least 50 full-time employees during the preceding calendar year, is subject to the requirement to offer coverage. Many small businesses are therefore exempt from the employer requirement since they have fewer than 50 employees. In counting the number of employees for purposes of

determining whether an employer is an applicable large employer, a full-time employee (an employee working 30 or more hours per week) is counted as one employee and all other employees are counted on a pro-rated basis.

However, even an employer with 50 or more employees is not subject to the penalty for not offering coverage if the employer does not have any full-time employees who are certified to the employer as having purchased health insurance through a state Exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to the employee, as discussed above. In other words, if an employer does not have a full-time employee who has a lower income that might allow him or her to receive a subsidy when purchasing a health plan in the health insurance state Exchange, the employer will not pay a "pay or play" penalty.

- B. Penalty for employers not offering coverage. As stated above, an applicable large employer who fails to offer its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an employer-sponsored plan for any month is subject to a penalty if at least one of its full-time employees is certified to the employer as having enrolled in health insurance coverage purchased through a state Exchange with respect to which a premium tax credit or cost-sharing reduction is allowed or paid to the employee. The penalty for any month is an excise tax equal to the number of all full-time employees over a 30-employee threshold during the applicable month (regardless of how many employees are actually receiving a premium tax credit or cost-sharing reduction) multiplied by \$166.67.

Example: If an employer fails to offer minimum essential coverage and has 60 full-time employees, 10 of whom receive a tax credit for the month for enrolling in a state Exchange-offered plan, the employer will owe \$166.67 for each employee over the 30-employee threshold, for a total penalty of \$5,000 (\$166.67 multiplied by 30 (60 minus 30)). The number of employees who actually receive a tax credit does not effect the calculation.

- C. Penalty for employers that offer coverage but have at least one employee receiving a premium tax credit. An applicable large employer who offers coverage but has at least one full-time employee receiving a premium tax credit or cost-sharing reduction is also subject to a penalty. The penalty is an excise tax that is imposed for each employee who receives a premium tax credit or cost-sharing reduction for health insurance purchased through a state Exchange. For each full-time employee actually receiving a premium tax credit or cost-sharing subsidy through a state Exchange for any month, the employer is required to pay a penalty equal to \$250. Nevertheless, the monthly penalty for the employer is capped at the penalty amount that would be imposed under paragraph B

above (i.e., \$166.67 multiplied by the number of all full-time employees during the month in excess of 30).

Example: If an employer offers health coverage and has 60 full-time employees, 15 of whom receive a tax credit for the month for enrolling in a state Exchange-offered plan, the employer will owe a penalty of \$250 per month for each employee receiving a tax credit, for a total monthly penalty of \$3,750 (\$250 multiplied by 15). The maximum penalty for this employer is capped at the amount of the penalty that it would have been assessed for a failure to provide coverage, which is \$5,000 (\$166.67 multiplied by 30 (60 minus 30)). Since the calculated penalty of \$3,750 is less than the maximum amount, the employer must pay the \$3,750 calculated penalty.

- D. Requirement to offer free choice vouchers. After 2013, employers offering minimum essential coverage through an eligible employer-sponsored plan and paying a portion of that coverage will have to provide "qualified employees" with a voucher whose value could be applied to the purchase of a health plan through the state Exchange. Qualified employees are employees (1) who do not participate in the employer's health plan; (2) whose required contribution for employer sponsored minimum essential coverage exceeds 8%, but does not exceed 9.8% of household income; and (3) whose total household income does not exceed 400% of the poverty line for the family. The value of the voucher would be equal to the dollar value of the employer contribution to the employer offered health plan. Employers providing free choice vouchers will not be subject to penalties for employees that receive a voucher.

### III. Tax Changes Affecting Small Businesses

The health reform legislation has some key provisions for owners of small businesses and their workers. The major provisions include tax credits, excise taxes and penalties. Whether a business will be affected by these new rules depends on a variety of factors, such as the number of employees the business has.

- A. Tax credits to certain small employers that provide insurance. The new law provides small employers with a tax credit (i.e., a dollar-for-dollar reduction in tax) for nonelective contributions to purchase health insurance for their employees. The credit can offset an employer's regular tax or its Alternative Minimum Tax (AMT) liability.
1. *Small business employers eligible for the credit.* To qualify, a business must offer health insurance to its employees as part of their benefits and contribute at least half the total premium cost. The business must have no more than 25 full-time equivalent employees ("FTEs"), and the employees must have annual full-time

equivalent wages that average no more than \$50,000. However, the full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of less than \$25,000. For purposes of the credit, the number of FTEs is calculated by dividing the total hours worked by all employees (full time and part time) during the employer's tax year by 2080, with no single employee treated as working more than 2080 hours.

2. *Years the credit is available.* The credit is initially available for tax years beginning in 2010, 2011, 2012 and 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage purchased from an insurance company licensed under state law. For tax years beginning after 2013, the credit is only available to an eligible small employer that purchases health insurance coverage for its employees through a state Exchange and is only available for two years. The maximum two-year coverage period does not take into account any tax years beginning in years before 2014. Thus, an eligible small employer could potentially qualify for this credit for six tax years (four years under the first phase and two years under the second phase).
3. *Calculating the amount of the credit.* For tax years beginning in 2010, 2011, 2012 and 2013, the credit is generally 35% (50% in 2014 and 2015) of the employer's nonelective contributions toward the employees' health insurance premiums. The credit phases out as the number of employees and average wages increase. Tax-exempt small businesses meeting these requirements are eligible for payroll tax credits of up to 25% for tax years beginning in 2010, 2011, 2012 and 2013 (35% in 2014 and 2015) of the employer's nonelective contributions toward the employees' health insurance premiums.
4. *Special rules.* Self-employed individuals, including partners and sole proprietors, 2% shareholders of an S corporation and 5% owners of the employer are not treated as employees for purposes of this credit. Any employee unrelated to a self-employed individual's trade or business is not an employee of an "employer" for purposes of this credit. Thus, the credit is not available for a domestic employee of a sole proprietor of a business. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Accordingly, no credit is available for any contribution to the purchase of health insurance for these individuals, and the individual is not taken into account in determining the number of full-time equivalent employees or average full-time equivalent wages.

It should also be noted that the employer is entitled to an ordinary and necessary business expense deduction equal to the amount of the employer contribution minus the dollar amount of the credit. For example, if an eligible small employer pays 100% of the cost of its employees' health insurance coverage and the amount of the tax credit is 50% of that cost (in tax years beginning after 2013), the employer can claim a deduction for the other 50% of the premium cost.

- B. Most small businesses exempted from penalties for not offering coverage to their employees. Although the new law imposes penalties on certain businesses for not providing coverage to their employees, most small businesses will not have to worry about this provision because employers with fewer than 50 full-time employees are not subject to the "pay or play" penalty. As discussed above, for businesses with at least 50 full-time employees, the possible penalties vary depending on whether or not the employer offers health insurance to its employees.
- C. Small employers can provide simple cafeteria plans. In tax years beginning after December 31, 2010, the cafeteria plans of certain "small" employers (generally those with 100 or fewer employees for this purpose) may qualify as "simple" cafeteria plans to which the applicable nondiscrimination requirements of a classic cafeteria plan do not apply, provided that these simple cafeteria plans satisfy minimum participation and contribution requirements.

#### **IV. Premium Assistance Tax Credits for Purchasing Health Insurance**

A major component of the health care legislation is its provision of tax credits to low and middle income individuals and families for the purchase of health insurance. For tax years ending after 2013, the new law creates a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an Exchange. The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of certain health insurance plans through an Exchange. Under the provision, an eligible individual enrolls in a plan offered through an Exchange and reports his or her income to the Exchange. Based on the information provided to the Exchange, the individual is entitled to a premium assistance credit based on income, and the IRS pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium assistance credit amount and the total premium charged for the plan. For employed individuals who purchase health insurance through an Exchange, the premium payments are made through payroll deductions.

The premium assistance credit will be available for individuals and families with incomes up to 400% of the federal poverty level. 400% of the poverty level is \$43,320 for an individual

or \$88,200 for a family of four, using 2009 poverty level figures. Such individuals also must not be eligible for Medicaid, employer sponsored insurance, or other acceptable coverage. The credits will be available on a sliding scale basis. The amount of the credit will be based on the percentage of income the cost of premiums represents, rising from 2% of income for those at 100% of the federal poverty level for the family size involved to 9.5% of income for those at 400% of the federal poverty level for the family size involved.

**V. Higher Medicare Taxes on High-Income Taxpayers**

High-income taxpayers will be hit with a double whammy: a tax increase on wages and a new levy on investments. To help offset the cost of providing health insurance to millions of Americans, the new law imposes an additional 0.9% Medicare tax on wages above \$200,000 for individuals and \$250,000 for married couples filing jointly. In addition, for higher-income households, the new law adds a 3.8% tax on unearned income, including interest, dividends, capital gains and other investment income.

- A. Higher Medicare payroll tax on wages. The Medicare payroll tax is the primary source of financing for Medicare's hospital insurance trust fund, which pays hospital bills for beneficiaries who are 65 and older or disabled. Under current law, wages are subject to a 2.9% Medicare payroll tax. Workers and employers pay 1.45% each. Self-employed people pay both halves of the tax (but are allowed to deduct half of this amount for income tax purposes). Unlike the payroll tax for Social Security, which applies to earnings up to an annual ceiling (\$106,800 for 2010), the Medicare tax is levied on all of a worker's wages without limit.

Beginning in 2013, most taxpayers will continue to pay the 1.45% Medicare hospital insurance tax, but single people earning more than \$200,000 and joint filers earning more than \$250,000 will be taxed at an additional 0.9% (2.35% in total) on the excess over those base amounts. Employers will collect the extra 0.9% on wages exceeding \$200,000 for a single person and \$250,000 for married couples just as they would withhold Medicare taxes and remit them to the IRS. The Act does not change the employer's portion of Medicare taxes (1.45%). Companies will not be responsible for determining whether a worker's combined income with his or her spouse makes them subject to the tax. Instead, some employees will have to remit additional Medicare taxes when they file income tax returns, and some will get a tax credit for amounts overpaid. Self-employed persons will pay 3.8% on earnings over the threshold. Married couples with combined incomes approaching \$250,000 will have to keep tabs on both spouses' pay to avoid an unexpected tax bill. It should also be noted that the \$200,000/\$250,000 thresholds are not indexed for inflation, so it is likely that more and more people will be subject to the higher taxes in coming years.

B. **Medicare payroll tax extended to investments.** Under current law, the Medicare payroll tax only applies to wages and self-employment income. Beginning in 2013, a Medicare tax will, for the first time, be applied to investment income. A new 3.8% tax will be imposed on net investment income of single taxpayers with adjusted gross income ("AGI") above \$200,000 and joint filers with AGI over \$250,000 (unindexed). Net investment income is interest, dividends, royalties, rents, gross income from a trade or business involving passive activities and net gain from disposition of property (other than property held in a trade or business). Net investment income is reduced by properly allocable deductions to such income. However, the new tax will not apply to income in retirement accounts, such as 401(k) plans, 403(b) plans, IRAs and Roth IRAs. Also, the new tax will apply only to income in excess of the \$200,000/\$250,000 thresholds. So if a couple earns \$200,000 in wages and \$100,000 in capital gains, \$50,000 will be subject to the new tax.

**VI. Floor on Medical Expenses Deduction Raised from 7.5% of AGI to 10%**

Under current law, taxpayers can take an itemized deduction for unreimbursed medical expenses for regular income tax purposes only to the extent that those expenses exceed 7.5% of the taxpayer's AGI. The new law raises the floor on itemized medical expense deductions from 7.5% of AGI to 10%, effective for tax years beginning after December 31, 2012. The AGI floor for individuals age 65 and older (and their spouses) will remain unchanged at 7.5% through 2016.

**VII. Limit on Reimbursement of Over-The-Counter Medications**

The new law excludes the costs of over-the-counter drugs not prescribed by a doctor from being reimbursed through a health reimbursement account (HRA) or health flexible savings accounts (FSAs) and from being reimbursed on a tax-free basis through a health savings account (HSA) or Archer Medical Savings Account (MSA), effective for tax years beginning after December 31, 2010.

**VIII. Increased Penalties on Nonqualified Distributions from HSAs and Archer MSAs**

Effective for distributions made after December 31, 2010, the new law increases the tax on distributions from an HSA or an Archer MSA that are not used for qualified medical expenses to 20% (up from 10% for HSAs and from 15% for Archer MSAs) of the disbursed amount.

**IX. Health Flexible Spending Arrangements (FSAs) are Limited to \$2,500**

An FSA is one of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan of an employer. An FSA allows an employee to set aside a portion of his

or her earnings to pay for qualified expenses, usually for medical expenses and/or dependent care. There is currently no limit on the amount of contributions to a health FSA. Under the new law, however, allowable contributions to health FSAs will be capped at \$2,500 per year, effective for tax years beginning after December 31, 2012. The dollar amount will be indexed for inflation after 2013.

**X. Dependent Coverage in Employer Health Plans**

Effective for plan years beginning on or after September 23, 2010, plans offered in the group or individual market that include dependent coverage must extend dependent coverage to adult children under the age of 26, regardless of the adult child's marital or student status. Under current law, this applies to children under age 19, or under age 24, if a student. It should be noted that for plan years beginning before 2014, the new dependent coverage provision applies in the case of an adult child with respect to a grandfathered health plan only if the adult child is not eligible to enroll in another employer-sponsored health plan.

Since dependents under the age of 26 can now be covered under their parent's employer-provided health plan, the Act also extends the exclusion from gross income for employer-provided health coverage for adult children who have not reached age 27. Similarly, the Act allows self-employed individuals to deduct the cost of coverage for adult children who have not reached age 27.

**XI. Excise Tax on Indoor Tanning Services**

The new law imposes a 10% excise tax on indoor tanning services. The tax, which will be paid by the individual on whom the tanning services are performed, but collected and remitted by the person receiving payment for the tanning services, will take effect July 1, 2010.

**XII. The "Cadillac Tax" on High-Cost Health Plans**

The new law places an excise tax on high-cost employer-sponsored health coverage (often referred to as "Cadillac" health plans). This is a 40% excise tax on insurance companies, based on premiums that exceed certain amounts. The tax is not on employers themselves unless they have self-funded health care plans (this typically occurs at larger employers). However, it is expected that employers and workers will ultimately bear this tax in the form of higher premiums passed on by insurers.

The new tax, which applies for tax years beginning after December 31, 2017, places a 40% nondeductible excise tax on insurance companies and plan administrators for any health coverage plan to the extent that the annual premium exceeds \$10,200 for single coverage and \$27,500 for family coverage. An additional threshold amount of \$1,650 for single coverage and

\$3,450 for family coverage will apply for retired individuals age 55 and older and for plans that cover employees engaged in high risk professions. The tax will apply to self-insured plans and plans sold in the group market, but not to plans sold in the individual market (except for coverage eligible for the deduction for self-employed individuals). Stand-alone dental and vision plans will be disregarded in applying the tax. The dollar amount thresholds can potentially be increased for inflation. Employers with age and gender demographics that result in higher premiums can value the coverage provided to employees using the rates that would apply using a national risk pool. Employers will be required to aggregate the coverage subject to the limit and issue information returns for insurers indicating the amount subject to the excise tax.

### **XIII. Nondiscrimination Rules for Insured Plans**

Under current law, if a self-insured employer health plan discriminates in favor of highly compensated employees, then the excess benefits are taxable to those employees. On the other hand, most employers use outside insurance companies (such as BlueCross BlueShield), and these insured plans are not subject to any nondiscrimination requirements. As a result, many employers currently provide top executives with generous nontaxable health insurance coverage that is unavailable to other employees. Under the Act, the nondiscrimination rules for self-insured plans do not change, but effective for plan years beginning on or after September 23, 2010, outside insured plans are prohibited from discriminating in favor of highly compensated employees. This includes rules for eligibility, benefits and controlled groups. Accordingly, excess benefits provided to highly compensated employees are permissible but taxable to highly compensated employees if offered through a self-insured plan, and they are prohibited under an outside insured plan. It is likely that an outside insured plan that does not comply with this requirement may be treated as failing to provide minimum essential coverage, thus giving rise to possible penalties. As such, additional guidance is needed to determine proper application of this rule. It should be noted, however, that outside insured plans that are grandfathered are exempt from compliance with the nondiscrimination rules.

### **XIV. Subsidies for Employers Providing Coverage to Retirees**

The Act provides for the creation of a program effective June 23, 2010, that provides government reimbursement to employers whose group health plans cover early retirees who do not currently qualify for Medicare and are between the age of 55 and the age of Medicare eligibility. This program also applies to plans that cover an early retiree's spouse, surviving spouse and/or dependents. Employers providing such coverage may qualify for reimbursement of up to 80% of the costs of providing the coverage to such individuals, for costs that exceed \$15,000, but do not exceed \$90,000. These limits apply and claims are filed for an individual's costs, and employers cannot add two or more individuals together to meet the threshold. The reimbursement payments are to be used to lower plan costs or to reduce premiums, copayments, deductibles, coinsurance, or other out-of-pocket expenses of participants. Payments made under

the reinsurance program are excluded from gross income. \$5 billion in funding is provided for the temporary program, which expires on the earlier of January 1, 2014, or when the \$5 billion program allotment is exhausted.

**XV. Conclusion**

This is just a brief summary of highlights of the healthcare legislation. The details of the new provisions including definitions, calculations, procedures and exceptions are too numerous to include in this letter. We can expect many refinements and "clarifications" since many of the various sections of the Act come into effect after 2013. Over the course of the next few months, the IRS and other federal agencies will begin filling in the details on how to comply with all the provisions under the massive health care reform package. The IRS is expected to issue guidance soon on the provisions with effective dates in 2010 and 2011. We are prepared to answer client questions that undoubtedly will arise regarding tax-related compliance rules and opportunities under the Act. In the meantime, if you have any questions about the new law, please do not hesitate to call us.

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*Pursuant to federal regulations imposed on practitioners who render tax advice ("Circular 230"), we are required to advise you that any tax advice contained herein is not intended or written to be used for the purpose of avoiding tax penalties that may be imposed by the IRS.*