

**DESCRIPTION OF H.R. 5447,
THE “SMALL BUSINESS HEALTH CARE RELIEF ACT”**

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
on June 15, 2016

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION



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INTRODUCTION

The House Committee on Ways and Means has scheduled a committee markup of H.R. 5447, the “Small Business Health Care Relief Act,” on June 15, 2016. This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a description of the bill.

¹ This document may be cited as follows: Joint Committee on Taxation, *Description of H.R. 5447, the Small Business Health Care Relief Act* (JCX-47-16), June 14, 2016. This document can also be found on the Joint Committee on Taxation website at www.jct.gov. All section references herein are to the Internal Revenue Code of 1986, as amended, unless otherwise stated.

A. Exception from Group Health Plan Requirements for Qualified Small Employer Health Reimbursement Arrangements

Present Law

Exclusion for employer-provided health benefits

An employee may exclude from gross income amounts provided through an arrangement under which (1) an employer pays or reimburses premiums for health insurance for the employee and family members purchased in the individual insurance market (referred to as an employer payment plan) or (2) an employer reimburses the employee for medical expenses generally of the employee and family members (referred to as a health reimbursement arrangement or HRA).² In order for employer payments or reimbursements under these arrangements to be excluded from gross income, premiums and other expenses must be substantiated and an employee must be entitled to receive payments from the employer only if he or she incurs qualifying expenses.³

The exclusion applies also to amounts paid or reimbursed from funds withheld from an employee's salary under a cafeteria plan (salary reduction amounts).⁴

The value of employer-provided health benefits for a year is generally required to be reported by the employer on an employee's Form W-2, Wage and Tax Statement, for the year.⁵

Group health plan requirements

The Code, the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHSA) impose various requirements with respect to employer-sponsored health plans, referred to for this purpose as group health plans.⁶ Under the Code, an

² Secs. 105(b) and 106; Rev. Rul. 61-146, 1961-2 C.B. 25; Notice 2002-45, 2002-2 C.B. 93, and Rev. Rul. 2002-41, 2002-2 C.B. 75. Under section 105(h), a self-insured medical reimbursement plan must meet certain nondiscrimination requirements in order for the benefits provided to a highly compensated individual to be excluded from income. For this purpose, the following groups of employees may be excluded: employees who have not completed three years of service with the employer, employees under age 25, part-time or seasonal employees, employees covered by a collective bargaining agreement if health benefits was the subject of good faith bargaining, and nonresident aliens with no earned income from sources within the United States. Employer payments and reimbursements for health insurance and medical expenses are also excluded from wages for employment tax purposes. Secs. 3121(a)(2), 3231(e)(1), 3306(b)(2), 3401(a)(20), Rev. Rul. 56-632, 1956-2 C.B. 101.

³ Treas. Reg. sec. 1.105-2.

⁴ Sec. 125. An HRA cannot include salary reduction amounts.

⁵ Sec. 6051(a)(14).

⁶ Secs. 4980B (relating to continuation coverage or "COBRA" requirements) and 5000 (relating to Medicare secondary payor requirements) and Chapter 100 (secs. 9801-9834, relating to various additional requirements, such as prohibitions on preexisting condition exclusions and discrimination based on health status); Title I, Parts 6 and 7, of ERISA; Title XVII of PHSA.

employer is generally subject to an excise tax of \$100 a day per employee if it sponsors a group health plan that fails to meet any of these requirements.⁷ In some cases, the excise tax does not apply if the failure is due to reasonable cause and not to willful neglect and the failure is corrected within a certain period. In addition, in some cases in which failure is due to reasonable cause and not to willful neglect, some or all of the excise tax may be waived to the extent payment of the tax would be excessive relative to the failure involved.

IRS guidance holds that employer payment plans generally fail to meet certain group health plan requirements.⁸ In addition, an HRA fails to meet those requirements unless the HRA is provided in conjunction with (or “integrated” with) employer-sponsored coverage that meets the requirements. An HRA that is integrated with such employer-sponsored coverage is often referred to as an “integrated” HRA, and an HRA that is not integrated with such employer-sponsored coverage is often referred to as a “stand-alone” HRA. Thus, an employer may be subject to an excise tax if it provides an employer payment plan or a stand-alone HRA.

Other health rules under the Code

Individuals are generally required to have health coverage, referred to as minimum essential coverage.⁹ Unless an exception applies, an individual who fails to have minimum essential coverage may be subject to a tax penalty. Minimum essential coverage includes employer-sponsored coverage under a group health plan, other than certain types of limited coverage, such as coverage only for vision or dental medical services. Minimum essential coverage also includes coverage purchased in the individual insurance market, other than certain types of limited coverage, such as coverage only for vision or dental medical services.

An advanceable, refundable income tax credit (premium assistance credit) is available to certain individuals who purchase health insurance coverage in the individual market through an American Health Benefit Exchange (Exchange coverage).¹⁰ However, an individual is generally not eligible for the credit if his or her employer offers affordable minimum essential coverage under a group health plan.¹¹ For this purpose, coverage is affordable if the employee’s share of the premium for self-only coverage under the group health plan is not more than 9.5 percent¹² of

⁷ Secs. 4980B(a) and (b), 4980D(a) and (b), 5000(a). Sec. 4980B(d)(1) provides an exception for plans of employers with fewer than 20 employees. Sec. 4980D(d)(1) provides an exception for a plan of an employer with no more than 50 employees if coverage is provided solely through insurance.

⁸ Notice 2015-17, 2015-14 I.R.B. 845, and Notice 2013-54, 2013-2 C.B. 287. Notice 2015-17 provides relief from the excise tax under section 4980D for periods before July 1, 2015, for certain small employers.

⁹ Sec. 5000A.

¹⁰ Sec. 36B.

¹¹ The coverage offered under the group health plan must also cover at least 60 percent of the total costs of benefits covered under the plan, referred to as “minimum value.”

¹² For years after 2014, this percentage is increased as needed to reflect cost-of-living increases. The percentage for 2016 is 9.66.

the employee's household income. An individual who applies for advance premium assistance with respect to Exchange coverage for a year must provide the Exchange with certain information, including information relating to employer-provided minimum essential coverage.¹³

If an applicable large employer fails to offer employees minimum essential coverage, or offers minimum essential coverage that is not affordable (under the standard described above), and any employee receives a premium assistance credit, the employer may be subject to a tax penalty.¹⁴ For this purpose, applicable large employer generally means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.¹⁵

Effective 2020, an excise tax (the high-cost coverage excise tax, commonly also referred to as the "Cadillac" tax) applies if the aggregate cost of employer-provided coverage provided to an employee under an employer's group health plans exceeds a specified amount.¹⁶ The aggregate cost of coverage for this purpose generally includes the cost of all types of coverage provided by the employer's group health plans, other than certain types of limited coverage, such as coverage only for vision or dental medical services.

Description of Proposal

Qualified small employer health reimbursement arrangement

Under the proposal, a "qualified small employer health reimbursement arrangement" (referred to herein as a QSEHRA) is generally not a group health plan under the Code, ERISA or PHSa and thus is not subject to the group health plan requirements.¹⁷ A QSEHRA is defined as an arrangement that (1) is provided on the same terms to all eligible employees of an eligible employer; (2) is funded solely by the eligible employer and no salary reduction contributions may be made under the arrangement; (3) provides, after an employee provides proof of minimum essential coverage, for the payment or reimbursement of medical expenses of the employee and

¹³ Sec. 1411(b) of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 110-148. This information is subject to verification during the Exchange process under section 1411(c) and (d) of PPACA.

¹⁴ Sec. 4980H.

¹⁵ In determining whether an employer is an applicable large employer (that is, whether the employer has at least 50 full-time employees), besides the number of full-time employees, the employer must include the number of its full time equivalent employees for a month, determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. In addition, in determining applicable large employer status, members of the same controlled group, group under common control, and affiliated service group under section 414(b), (c), (m) and (o) are treated as a single employer.

¹⁶ Sec. 4980I.

¹⁷ A QSEHRA continues to be treated as a group health plan as defined under PHSa, for purposes of applying that definition to the privacy requirements applicable to medical information under the Health Insurance Portability and Accountability Act of 1996 (referred to as HIPAA), Part C of Title XI of the Social Security Act.

family members;¹⁸ and (4) the amount of payments and reimbursements under the arrangement for a year cannot exceed specified dollar limits.¹⁹ In the case of an individual not covered by the arrangement for all 12 months of a year, the dollar amounts are prorated to reflect the number of months of coverage.

The maximum dollar amount of payments or reimbursements that may be made under a QSEHRA with respect to an eligible employee for a year is the employee's "permitted benefit." An arrangement does not fail to be provided on the same terms to all eligible employees merely because employees' permitted benefits vary with the price of a health insurance policy in the individual insurance market based on the ages of the employee and family members or the number of family members covered by the arrangement, provided that the variation is determined by reference to the same insurance policy for all eligible employees.

Under the proposal, "eligible employee" means any employee of an eligible employer, except that the terms of the QSEHRA may exclude employees who have not completed 90 days of service with the employer, employees under age 25, part-time or seasonal employees, employees covered by a collective bargaining agreement if health benefits were the subject of good faith bargaining, and nonresident aliens with no earned income from sources within the United States.²⁰ "Eligible employer" means an employer that (1) is not an applicable large employer as defined for purposes of the requirement that an applicable large employer offer its employees minimum essential coverage (that is, generally, an employer with fewer than 50 full-time employees during the preceding year), and (2) does not offer a group health plan to any of its employees.

Income tax treatment of QSEHRA benefits

Coverage and payments or reimbursements under a QSEHRA are generally excluded from gross income.

Because a QSEHRA is not a group health plan, coverage under a QSEHRA is not minimum essential coverage and does not satisfy the requirement that an individual have minimum essential coverage. Under the proposal, if an employee's medical care expenses are paid or reimbursed under a QSEHRA and the employee does not have minimum essential

¹⁸ The proposal specifies that the Secretary of the Treasury or his designee may issue substantiation requirements as necessary to carry out the proposal.

¹⁹ For 2016, the dollar limits are \$5,130 (\$10,260 in the case of expenses of an employee and family members). For years after 2016, the dollar limits are increased as needed to reflect cost-of-living increases.

²⁰ These groups are based on the groups that can be excluded in applying the nondiscrimination requirements under section 105(h) to a self-insured plan with 90 days of service substituted for three years of service.

coverage for the month in which the medical care was provided, the amount of the payment or reimbursement for those expenses is includible in the employee's income.²¹

Coordination with other Code rules

Under the proposal, an eligible employee under a QSEHRA is not eligible for the premium assistance credit for a month if the QSEHRA constitutes affordable coverage for the month. For this purpose, a QSEHRA constitutes affordable coverage for a month if the excess of (1) the employee's premium for self-only coverage under the second lowest cost silver plan offered in the Exchange, over (2) 1/12 of the employee's permitted benefit under the QSEHRA, does not exceed 1/12 of 9.5 percent²² of the employee's household income for the year. In the case of an eligible employee under a QSEHRA who is eligible for a premium assistance credit for a year (that is, the QSEHRA does not constitute affordable coverage), the credit amount is reduced (but not below zero) by the employee's permitted benefit.

Under the proposal, a QSEHRA continues to be treated as a group health plan for purposes of the excise tax on high-cost coverage. For that purpose, an employee's permitted benefit is treated as the cost of coverage under the QSEHRA.

Notice and reporting requirements

The proposal includes several requirements relating to notices and reporting.

Not later than 90 days before the beginning of a year in which an employer will fund a QSEHRA (or, if later, the date on which an employee becomes eligible for the QSEHRA), the employer must provide eligible employees with a written notice containing the amount of the employee's permitted benefit and certain other information. An employer that fails to provide the notice may be subject to a tax penalty of \$50 per employee, subject to a maximum of \$2,500 for the year.

In addition, the employer must report an employee's permitted benefit for a year on the employee's Form W-2 for the year. An eligible employee who applies for advance premium assistance with respect to Exchange coverage for a year must provide the Exchange with the amount of his or her permitted benefit for the year.

Effective Date

The proposal generally applies to years beginning after the earlier of (1) the date that is 90 days after the date of enactment of the proposal, or (2) December 31, 2016 (plan years

²¹ The proposal does not change the treatment of such payments or reimbursements for employment tax purposes. Thus, they continue to be excluded from wages for employment tax purposes.

²² For years after 2014, this percentage is increased as needed to reflect cost-of-living increases. The percentage for 2016 is 9.66.

beginning after the earlier of those two dates in the case of the ERISA and PHSAs changes).²³ The aspects of the proposal relating to the premium assistance credit apply to taxable years beginning after the earlier of those two dates. The requirement that an employer report an employee's permitted benefit on the employee's Form W-2 applies to calendar years beginning after December 31, 2016. The requirement that an eligible employee applying for advance premium assistance provide the Exchange with the amount of his or her permitted benefit applies to applications for enrollment made after the earlier of the two dates described above.²⁴

²³ The proposal extends the excise tax relief under Notice 2015-17 to plan years beginning on or before the earlier of the two dates.

²⁴ Verification of this information in the Exchange process applies with respect to months beginning after October 2016.

B. Estimated Revenue Effect of the Proposal [1] [2]

Fiscal Years												
[Millions of Dollars]												
<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2016-21</u>	<u>2016-26</u>
-110	-135	-120	-127	-24	6	25	49	100	136	199	-510	---

NOTE: Details do not add to totals due to rounding.

[1] Estimate includes the following outlay effects:

<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2016-21</u>	<u>2016-26</u>
26	27	30	32	34	36	38	40	40	42	44	185	389

[2] Estimate includes the following off-budget effects:

<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2016-21</u>	<u>2016-26</u>
-25	-33	-27	-29	6	16	24	32	49	61	83	-92	157