DESCRIPTION OF H.R. 6311, A BILL TO AMEND THE INTERNAL REVENUE CODE OF 1986 AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT TO MODIFY THE DEFINITION OF QUALIFIED HEALTH PLAN FOR PURPOSES OF THE HEALTH INSURANCE PREMIUM TAX CREDIT AND TO ALLOW INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET TO PURCHASE A LOWER PREMIUM COPPER PLAN

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
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Prepared by the Staff
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INTRODUCTION

The House Committee on Ways and Means has scheduled on July 11, 2018, a markup of H.R. 6311, a bill to Amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to modify the definition of qualified health plan for purposes of the health insurance premium tax credit and to allow individuals purchasing health insurance in the individual market to purchase a lower premium copper plan. 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. 6311, A Bill to Amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to Modify the Definition of Qualified Health Plan for Purposes of the Health Insurance Premium Tax Credit and to Allow Individuals Purchasing Health Insurance in the Individual Market to Purchase a Lower Premium Copper Plan.* (JCX-57-18), July 10 2018. 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. Modification of Definition of Qualified Health Plan

Present Law

In general

A refundable tax credit (the "premium assistance credit") is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an American Health Benefit Exchange ("Exchange"), referred to as "qualified health plans."[2] The premium assistance credit is generally payable in advance directly to the insurer, as discussed below. However, eligible individuals may choose to pay their total health insurance premiums out-of-pocket and claim the credit at the end of the taxable year.

Qualified health plans generally must meet certain requirements.[3] Special rules apply to certain qualified health plans, referred to as "catastrophic-only" qualified health plans, which are available only to individuals who are under age 30 or meet other specified requirements.[4] The premium assistance credit is not available with respect to catastrophic-only qualified health plans.[5] In addition, in the case of a qualified health plan that provides coverage for abortions for which Federal funds may not be used, no part of the premium assistance credit may be used for the portion of premiums attributable to that coverage.[6]

The premium assistance credit is generally available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level ("FPL") for the family size involved. Household income is defined as the sum of: (1) the individual's modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining the individual's family size (but only if the other individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad),[7] (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the individual's social security benefits not included in

[2] Sec. 36B. Section 36B was enacted as part of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, and modified by the Healthcare and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152. PPACA and HCERA are referred to collectively as the Affordable Care Act ("ACA").

[3] Secs. 1301 and 1302 of PPACA.

[4] Sec. 1302(e) of PPACA.

[5] Under the Public Health Service Act ("PHSA") as amended by the ACA, health insurance must meet certain requirements. Section 1251 of PPACA excepts certain health plans sold at the time of enactment of PPACA from some of the PHSA requirements ("grandfathered" plans). The premium assistance credit is not available with respect to a grandfathered plan or plans that receive similar treatment under administrative guidance.

[6] Sec. 1303(b)(2) of PPACA.

[7] Sec. 911.

gross income.[8] To be eligible for the premium assistance credit, individuals who are married must file a joint return. Individuals who are listed as dependents on a return are not eligible for the premium assistance credit.

An individual who is eligible for minimum essential coverage from a source other than the individual insurance market generally is not eligible for the premium assistance credit.[9] However, an individual who is offered minimum essential coverage under an employer-sponsored health plan may be eligible for the premium assistance credit if an employee's share of the premium for self-only coverage exceeds 9.56 percent (for 2018) of the employee's household income, or the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent of such costs (called "minimum value"), and the individual declines the employer-offered coverage. An individual who enrolls in an employer-sponsored health plan generally is ineligible for the premium assistance credit, even if the coverage is considered unaffordable or does not provide minimum value.

As part of the process of enrollment in a qualified health plan through an Exchange, an individual may apply and be approved in advance for a premium assistance credit.[10] The individual must provide information on income, family size, changes in marital or family status or income, and citizenship or lawful presence status.[11] Initial eligibility for the premium assistance credit is generally based on the individual's income for the tax year ending two years prior to the enrollment period. The Exchange process includes a system through which information provided by the individual is verified with the Internal Revenue Service ("IRS"), the Social Security Administration ("SSA") and the Department of Homeland Security ("DHS").[12] If an individual is approved for advance premium assistance payments, the Treasury pays the advance amount directly to the issuer of the health plan in which the individual is enrolled. The

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[8] Under section 86, only a portion of an individual's social security benefits are included in gross income.

[9] Minimum essential coverage is defined in section 5000A(f).

[10] Secs. 1411-1412 of PPACA. Under section 1402 of PPACA, certain individuals eligible for advance premium assistance payments are eligible also for a reduction in their share of medical costs, such as deductibles and copays, under the plan, referred to as reduced cost-sharing. Eligibility for reduced cost-sharing is also determined as part of the Exchange enrollment process. The Department of Health and Human Services ("HHS") is responsible for rules relating to Exchanges and the eligibility determination process.

[11] Under section 1312(f)(3) of PPACA, an individual may not enroll in a qualified health plan through an Exchange if the individual is not a citizen or national of United States or an alien lawfully present in the United States. Thus, such an individual is not eligible for the premium assistance credit.

[12] Under section 6103, except as provided in the Code, 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. Under section 6103(l)(21), upon written request of the Secretary of HHS, the IRS is permitted to disclose certain return information in connection with a determination through the Exchange process of an individual's eligibility for advance premium assistance payments, reduced cost-sharing, or certain other government-sponsored health programs.

individual then pays to the issuer of the plan the difference between the advance payment amount and the total premium charged for the plan.

Description of Proposal

Application of credit to additional coverage

Qualified health plans generally must meet certain requirements.[13] Under the proposal, the premium assistance credit is available with respect to catastrophic plans[14] that meet the requirements relating to qualified health plans. Under the proposal, the premium assistance credit is also available with respect to health plans that meet the requirements relating to qualified health plans except that they are not offered through an Exchange. Thus, an individual who purchases a qualified health plan in the individual market, but not through an Exchange, may be eligible for the premium assistance credit if the requirements for eligibility are otherwise met. However, advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange. An individual who purchases such a plan must claim the premium assistance credit on his or her income tax return.

Under present law, any person that provides minimum essential coverage to an individual during a calendar year must report certain information to the IRS.[15] The proposal requires additional information reporting for minimum essential coverage provided to an individual that is not enrolled through an Exchange.

As under present law, the credit is not available with respect to grandfathered plans or plans that receive similar treatment under administrative guidance. In addition, the proposal specifies that the credit is not available with respect to grandmothered plans. Under the proposal, a grandmothered health plan is defined to be health insurance coverage which is offered in the individual health insurance market as of October 1, 2013, and is permitted to be offered in such market after January 1, 2014, as a result of CCIIO guidance.[16]

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[13] Section 2 of the proposal amends section 1302(e) of PPACA to allow all individuals purchasing health insurance in the individual market the option to purchase a lower premium plan that does not offer a bronze, silver, gold, or platinum level of coverage.

[14] As described in sec. 1302(e) of PPACA.

[15] Sec. 6055(b).

[16] CCIIO guidance refers to the letters issued by the Centers for Medicare and Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified. Subsequent modifications include a communication entitled, "Insurance Standards Bulletin Series- INFORMATION- Extension of Transitional Policy through Calendar Year 2017," issued on February 29, 2016 by the Director of the Center for Consumer Information and Insurance Oversight of such Centers.

Ineligibility of qualified health plans covering abortion

Under the proposal, the premium assistance credit is not available with respect to a qualified health plan that provides coverage for abortions for which Federal funds may not be used.[17] However, nothing in the proposal prohibits an individual from purchasing, or a health insurance issuer from offering separate coverage for abortions, or a health plan that includes abortions, as long as no premium assistance credit is allowed with respect to the premiums for such coverage and premiums are not paid for with any amount attributable to the premium assistance credit (or the amount of any advance payment of the credit).

Effective Date

The modifications to the premium assistance credit are generally effective for taxable years beginning after December 31, 2018. The proposal specifying that advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange is effective on January 1, 2019. The proposal amending the present-law reporting requirements under section 6055 is effective for coverage provided for months beginning after December 31, 2018.

[17] This includes coverage for abortions other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest. The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of determining eligibility for the premium assistance credit.