DESCRIPTION OF H.R. 3799, THE "CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENT ACT"

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
on June 7, 2023

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

June 5, 2023
JCX-17-23

CONTENTS

Page

INTRODUCTION 1

A. Treatment of Health Reimbursement Arrangements Integrated with Individual Market Coverage 2

B. Estimated Revenue Effects of the Proposal 8

INTRODUCTION

The House Committee on Ways and Means has scheduled a committee markup of H.R. 3799, the "Custom Health Option and Individual Care Expense Arrangement Act." 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. 3799, the "Custom Health Option and Individual Care Expense Arrangement Act*" (JCX-17-23), June 5, 2023. This document can also be found on the Joint Committee on Taxation website at www.jct.gov. All section references in the document are to the Internal Revenue Code of 1986, as amended (the "Code"), unless otherwise stated.

A. Treatment of Health Reimbursement Arrangements Integrated with Individual Market Coverage

Present Law

Group health plan requirements

The Internal Revenue Code (the "Code") imposes various requirements with respect to employment-related health plans, referred to for this purpose as group health plans.[2] The Patient Protection and Affordable Care Act ("PPACA")[3] expanded the market reform requirements applicable to group health plans.[4]

Under the Code, an 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.[5] Generally, if the failure is due to reasonable cause and not to willful neglect, the maximum tax that can be imposed for failures during a taxable year is the lesser of 10 percent of the employer's group health plan expenses for the prior year or $500,000. 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.

Other health rules under the Code

Under the PPACA, "minimum essential coverage" includes employer-sponsored coverage under a group health plan and other than certain types of limited coverage, such as coverage only for vision or dental medical services.[6] 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.

---

[2] See, *e.g.*, sec. 4980B (relating to continuation coverage or "COBRA" 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). Code section 5000 also imposes Medicare secondary payor requirements on group health plans.

[3] Pub. L. No. 111-148, March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, March 30, 2010.

[4] See, *e.g.*, sections 2711 and 2713 of the PPACA. These provisions of the PPACA are incorporated into the Code through section 9815.

[5] Section 4980B(a) and (b) apply to a violation of the COBRA requirements, subject to an exception for plans of employers with fewer than 20 employees. Section 4980D(a) and (b) apply to a violation of the requirements under Chapter 100, subject to an exception for a plan of an employer with no more than 50 employees if coverage is provided solely through insurance. In some cases, a party other than the employer, such as a multiemployer plan, may be liable for the tax. For simplicity, this document refers to "employers" to indicate all such entities that may sponsor group health plans.

[6] Sec. 5000A.

An advanceable, refundable income tax credit, the premium tax credit ("PTC"), is available to certain individuals who purchase health insurance coverage in the individual market through an Exchange ("Exchange coverage").[7] However, an employee is generally not eligible for the PTC if his or her employer offers affordable minimum essential coverage under a group health plan and the coverage provides minimum value. 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 9.12 percent (for 2023)[8] of the employee's household income. To provide minimum value, the coverage offered under the group health plan must cover at least 60 percent of the total costs of benefits covered under the plan. An individual who applies for advance PTC with respect to Exchange coverage for a year must provide the Exchange with certain information, including information relating to employer-provided minimum essential coverage.[9]

If an applicable large employer fails to offer employees minimum essential coverage, or offers minimum essential coverage that either is not affordable (under the standard described above) or fails to provide minimum value, and any employee is allowed PTC, the employer may be subject to a tax penalty.[10] For this purpose, applicable large employer generally means, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalents) on business days during the preceding calendar year.[11]

Health reimbursement arrangements

In addition to offering health coverage, employers sometimes reimburse medical expenses of their employees (and their spouses and dependents). These arrangements are sometimes used by employers to pay or reimburse employees for medical expenses that are not

---

[7] Sec. 36B. An Exchange is established under section 1311 of the PPACA. Lower-income individuals who are eligible for PTCs and enrolled in health insurance coverage purchased on an Exchange may also be eligible for cost-sharing reductions under section 1402 of the PPACA.

[8] This percentage is updated as needed to reflect cost-of-living changes. Rev. Proc. 2022-34, 2022-33 I.R.B. 143.

[9] Sec. 1411(b) of the PPACA. This information is subject to verification during the Exchange process under section 1411(c) and (d) of the PPACA.

[10] Sec. 4980H.

[11] 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.

covered by health insurance and are commonly referred to as health reimbursement arrangements ("HRAs").[12]

The amounts in an HRA can be used only to reimburse medical expenses (including health insurance premiums) and not for other purposes, and HRAs cannot be funded on a salary reduction basis. HRAs must have a maximum dollar amount for each coverage period, and amounts remaining in an HRA at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[13]

An employee may exclude amounts provided through an HRA from gross income. For employer payments or reimbursements under an HRA to be excluded from gross income, expenses must be substantiated and an employee must be entitled to receive payments from the employer only if he or she incurs qualifying expenses.[14]

After the enactment of the PPACA and before the establishment of individual coverage HRAs (as described below), an HRA generally failed to meet the group health plan requirements imposed by the PPACA unless the HRA complied with IRS rules relating to HRAs provided in conjunction with (or "integrated" with) certain other employer-sponsored coverage that met the group health plan requirements.[15] 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 could be subject to an excise tax if it provided a stand-alone HRA covering medical expenses, with the exception of certain limited benefits, for example, coverage only for vision or dental medical services.[16]

---

[12] See secs. 105(b) and 106; Rev. Rul. 61-146, 1961-2 C.B. 25; Notice 2002-45, 2002-2 C.B. 93, July 15, 2002, and Rev. Rul. 2002-41, 2002-2 C.B. 75. Under section 105(h), a self-insured HRA 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 were 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. For simplicity, this document refers to "HRAs" to indicate all arrangements to which the individual coverage HRA final rules (described later in this document) apply.

[13] General guidance with respect to HRAs is provided in IRS Notice 2002-45.

[14] Treas. Reg. sec. 1.105-2.

[15] See, *e.g.*, Notice 2013-54, 2013-40 I.R.B. 287, September 30, 2013. The 21st Century Cures Act created a limited exception to this rule in the form qualified small employer health reimbursement arrangements (QSEHRAs). Unlike traditional HRAs, QSEHRAs are designed so that small employers may subsidize employees' purchase of individual coverage on an Exchange. Pug. Law. 114-255, sec. 18001, December 13, 2016.

[16] See Notice 2015-87, 2015-52 I.R.B. 889, December 28, 2015.

Individual coverage HRAs

In August 2019, final rules were issued permitting employers to contribute to HRAs used for the purpose of purchasing individual health insurance coverage, without violating the group health plan requirements (the "final rules").[17] The final rules provide that employers may offer employees an "individual coverage HRA," and, that if those individuals use the amounts contributed to that HRA to purchase health insurance coverage on the individual market, the group health plan meets the relevant group health plan requirements. An individual coverage HRA may also be used in conjunction with coverage under Medicare Part A and B or C.[18]

Individual coverage HRAs are subject to detailed regulations, including the following requirements: the terms of the individual coverage HRA must require that employees, spouses, and dependents enrolled in the HRA also be enrolled in individual health insurance coverage;[19] employers are not permitted to allow employees to choose between an individual coverage HRA and traditional employment-related health coverage;[20] employers are required to offer individual coverage HRAs on the same terms to all employees within enumerated classes of employees;[21] generally, employers are required to provide employees notice regarding the individual coverage HRA at least 90 calendar days before the beginning of the plan year;[22] and employers are required to adopt reasonable procedures for substantiation regarding individuals' enrollment in qualifying individual coverage.[23]

Because individual coverage HRAs are employer-sponsored group plans, individuals enrolled in individual coverage HRAs are not eligible for PTCs. Furthermore, the final rules include an affordability test, under which the value of the employer contribution to the individual coverage HRA is compared to the price of the lowest cost silver plan available to the employee. Similar to the rule for traditional group health plans, if the employee's share of the premium for self-only coverage under that plan is more than 9.12 percent (for 2023) of the employee's household income, the individual coverage HRA is not considered affordable and the employee may be entitled to PTCs for individual health coverage purchased on an Exchange.[24]

In addition to amounts contributed to an individual coverage HRA by the employer, employees may make contributions through a cafeteria plan to purchase individual coverage, if,

[17] T.D. 9867, 84 Fed. Reg. 28888, June 20, 2019.

[18] Treas. Reg. sec. 54.9802-4(e).

[19] Treas. Reg. sec. 54.9802-4(c)(1).

[20] Treas. reg. sec. 54.9802-4(c)(2).

[21] Treas. Reg. sec. 54.9802-4(c)(3).

[22] Treas. Reg. sec. 54.9802-4(c)(6).

[23] Treas. Reg. sec. 54.9802-4(c)(5).

[24] Treas. Reg. sec. 1.36B-2(c)(3). An individual coverage HRA that is affordable is also treated as providing minimum value.

for example, the employer's contribution to the individual coverage HRA is less than the premium for the individual coverage selected by the employee. However, amounts available through a cafeteria plan may not be used to purchase individual health coverage on an Exchange, so, in these circumstances, employees must use the individual coverage HRA to purchase off-Exchange coverage.[25]

Description of Proposal

The proposal codifies the final rules permitting employers to offer individual coverage HRAs – renamed as Custom Health Option and Individual Care Expense, or "CHOICE," arrangements – without violating the group health plan requirements. Specifically, the proposal specifies that a CHOICE arrangement that otherwise satisfies the requirements prescribed in the proposal complies with sections 2711 and 2713 of the PPACA.

The proposal defines a CHOICE arrangement as an HRA under which payments or reimbursements may only be made for medical care during periods during which a covered individual is also covered by a health plan offered in the individual market (other than coverage that consists solely of excepted benefits) or under Medicare parts A and B or C. In addition, a CHOICE arrangement must meet the following requirements:

- The CHOICE arrangement must be offered to all employees in the same class of employees on the same terms.
- The employer may not offer any other group health plan to any employees in such a class.
- The CHOICE arrangement must have reasonable procedures to substantiate that the covered individual is, or will be, enrolled in qualifying individual market coverage as of the beginning date of coverage under the arrangement; and that the covered individual remains so enrolled when requests are made for payment or reimbursement of medical care.
- A CHOICE arrangement generally must provide each employee eligible to participate in the in the CHOICE arrangement with written notice of the employee's rights and obligations under the arrangement not later than 90 days before the beginning of the plan year. The notice must be sufficiently accurate and comprehensive to appraise the employee of such rights and obligations be written in a manner calculated to be understood by the average employee eligible to participate.

The proposal includes the following classes of employees:

- Full-time employees;
- Part-time employees;

[25] Sec. 125(f)(3), providing that an employer generally may not provide a qualified health plan offered through an Exchange as a cafeteria plan benefit.

- Salaried employees;
- Non-salaried employees;
- Employees whose primary site of employment is in the same rating area;
- Employees who are included in a collective bargaining unit;
- Employees who have not met a waiting period requirement;
- Seasonal employees;
- Employees who are non-resident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States;[26] and
- Such other classes as designated by the Secretary.

Under the proposal, an employer may designate two or more of the classes as specified classes to which the arrangement is offered, and distinctions regarding full-time, part-time, and seasonal employees must be made under rules similar to those that apply under sections 105(h) or 4980H, at the election of the employer for the plan year. An arrangement does not fail to qualify as a CHOICE arrangement if the maximum dollar amount varies within a class because the amount increases with the number of additional individuals covered under the arrangement or increases as the age of the employee increases, as long as the increase is not in excess of 300 percent of the lowest maximum dollar amount available. Finally, an employer that currently offers a traditional group health plan to a class of employees is permitted to prospectively offer newly-hired employees in that class a CHOICE arrangement while continuing to offer previously-hired employees a traditional health plan without violating the rule prohibiting differing offers within a class of employees.

The proposal provides that, to the extent not inconsistent with the proposal, no inference is intended with respect to the individual coverage HRA final rules. The proposal also specifies that all references in the proposal to CHOICE arrangements must be treated as including references to individual coverage HRAs.

Effective Date

The proposal is effective for plans years beginning after December 31, 2023.

[26] Under the section 861(a)(3) rules for the source of income from personal services.

B. Estimated Revenue Effects of the Proposal

The proposal is estimated to have no effect on Federal fiscal year budget receipts for the period 2023-2033.