DESCRIPTION OF H.R. 954, A BILL TO AMEND THE INTERNAL REVENUE CODE OF 1986 TO EXEMPT FROM THE INDIVIDUAL MANDATE CERTAIN INDIVIDUALS WHO HAD COVERAGE UNDER A TERMINATED QUALIFIED HEALTH PLAN FUNDED THROUGH THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
on September 8, 2016

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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. 954, a bill to amend the Internal Revenue Code of 1986 to exempt from the individual mandate certain individuals who had coverage under a terminated qualified health plan funded through the Consumer Operated and Oriented Plan (CO-OP) program, on September 8, 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. 954, a Bill to Amend the Internal Revenue Code of 1986 to Exempt from the Individual Mandate Certain Individuals Who Had Coverage under a Terminated Qualified Health Plan Funded through the Consumer Operated and Oriented Plan (CO-OP) Program* (JCX-68-16), September 7, 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. Exemption from Individual Mandate for Certain Individuals Who Had Coverage Under a Terminated Qualified Health Plan Funded through the Consumer Operated and Oriented Plan (CO-OP) Program

Present Law

Requirement for individuals to have health coverage

In general

Individuals are required to be covered by a health plan that provides minimum essential coverage or pay a tax for failure to maintain coverage.[2] The tax is imposed for any month that an individual does not have minimum essential coverage unless the individual qualifies for an exemption for the month as described below.[3]

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, plans in the individual insurance market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of HHS in coordination with the Secretary of the Treasury.[4] Minimum essential coverage includes a health plan offered through an American Health Benefit Exchange, referred to as a qualified health plan.

Tax on failure to maintain minimum essential coverage

The tax for failure to maintain minimum essential coverage for any calendar month is one-twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of (1) a flat dollar amount and (2) an excess income amount, as described below, except that the total annual amount may not exceed the national average annual premium for bronze level qualified health plans offered through American Health Benefit Exchanges that year for the taxpayer's family size.

The flat dollar amount is the lesser of (1) the sum of the individual annual dollar amounts for the members of the taxpayer's family and (2) 300 percent of the adult individual dollar amount. The individual adult annual dollar amount is phased in over the first three years as

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[2] Section 5000A which was added to the Code by section 1501 of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No 111-148, enacted March 23, 2010, as amended by section 10106 of PPACA and 1002 of the Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, enacted March 30, 2010. PPACA and HCERA are collectively referred to as the Affordable Care Act ("ACA"). Section 5000A is effective for taxable years ending after December 31, 2013.

[3] In the case of a taxpayer's dependent under section 152, the taxpayer is liable for any tax for failure to maintain the required coverage with respect to the dependent.

[4] Minimum essential coverage does not include coverage that consists of certain excepted benefits as defined in section 2791(c)(1)-(4) of the Public Health Service Act (42 U.S.C. sec. 300gg-91(c)(1-4)). A parallel definition of excepted benefits is provided in section 9832(c)(1)-(4).

follows: $95 for 2014; $325 for 2015; and $695 for 2016.[5] For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount.

The excess income amount is a specified percentage of the excess of the taxpayer's household income for the taxable year over the threshold amount of income requiring the taxpayer to file an income tax return.[6] The specified percentage of income is phased in as follows: one percent for 2014; two percent for 2015; and 2.5 percent for 2016 and after.

Exemptions

Exemptions from the requirement to maintain minimum essential coverage are provided for the following: (1) an individual for whom coverage is unaffordable because the required contribution exceeds eight percent of household income, (2) an individual with household income below the income tax return filing threshold, (3) a member of an Indian tribe, (4) a member of one of certain recognized religious sects or a health sharing ministry, (5) an individual with a coverage gap for a continuous period of less than three months, and (6) an individual who is determined by the Secretary of Health and Human Services to have suffered a hardship with respect to the capability to obtain coverage.

Health plans under the CO-OP program

The CO-OP program was established to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.[7] A qualified nonprofit health insurance issuer is an organization--

- That is organized as a nonprofit, member corporation under State law,
- Substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans and in which health insurance market reforms have been implemented,
- That meets other applicable State law requirements for issuers of qualified health plans,
- That was not (nor was a related entity or a predecessor of either) a health insurance issuer as of July 16, 2009 and is not sponsored by a State or local government, any

[5] For years after 2016, the $695 amount is indexed to the consumer price index for all urban consumers, referred to as "CPI-U," rounded to the next lowest multiple of $50.

[6] Sec. 6012(a).

[7] Sec. 1322 of PPACA. Under section 501(c)(29), a health insurer that receives a grant or loan under the CO-OP program generally qualifies for exemption from Federal income tax for periods during which the organization is in compliance with the requirements of the CO-OP program and with the terms of any such grant or loan agreement to which the organization is a party.

political subdivision thereof, or any instrumentality of such government or political subdivision,

- That meets certain governance requirements, and
- That uses profits to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

In the last few years, some qualified nonprofit health insurance issuers under the CO-OP program have discontinued offering health plans providing minimum essential coverage, including qualified health plans.

Description of Proposal

The proposal provides an exemption from the requirement to maintain minimum essential coverage in the case of an individual who was enrolled in a qualified health plan offered by a qualified nonprofit health insurance issuer under the CO-OP program that was terminated or otherwise discontinued, during a month in a calendar year, in the area in which the individual resides. The exemption generally applies for that month and each subsequent month during that calendar year. If the discontinuance of the plan occurs during a month in the last quarter of the calendar year, the exemption applies through the end of the subsequent calendar year.

Effective Date

The proposal applies to October 2014 and subsequent months.