DESCRIPTION OF H.R. 2579, A BILL TO AMEND THE INTERNAL REVENUE CODE OF 1986 TO ALLOW THE PREMIUM TAX CREDIT WITH RESPECT TO UNSUBSIDIZED COBRA CONTINUATION COVERAGE

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INTRODUCTION

The House Committee on Ways and Means has scheduled a committee markup of H.R. 2579, a bill to amend the Internal Revenue Code of 1986 to allow the premium tax credit with respect to unsubsidized COBRA continuation coverage, on May 24, 2017. 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. 2579, A Bill to Amend the Internal Revenue Code of 1986 to Allow the Premium Tax Credit with Respect to Unsubsidized COBRA Continuation Coverage* (JCX-23-17), May 23, 2017. This document can be found also 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. Premium Tax Credit Allowed with Respect to Unsubsidized COBRA Continuation Coverage

Present Law

Premium assistance credit

A refundable tax credit ("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] In general, advance payments with respect to the premium assistance credit are made during the year directly to the insurer.[3] However, eligible individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

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.[4] 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,[5] (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 gross income.[6] 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.

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[2] Sec. 36B, effective for taxable years ending after December 31, 2013. Under the Affordable Care Act, an American Health Benefit Exchange is a source through which individuals can purchase health insurance coverage. As used herein, the Affordable Care Act (or "ACA") refers to the combination of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, and the Healthcare and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152. Qualified health plan is defined in PPACA section 1301.

[3] PPACA sections 1411-1412 provide rules relating to eligibility for and receipt of advance payments.

[4] Federal poverty level refers to the most recently published poverty guidelines determined by the Secretary of Health and Human Services. Levels for 2017 and previous years are available at https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references.

[5] Sec. 911.

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

COBRA continuation coverage requirements

Employer-sponsored health plans (referred to as "group health plans"[7]) generally are required to offer an employee, spouse or dependent child covered by the plan the opportunity to continue coverage under the plan for a specified period of time after the occurrence of certain events that otherwise would have terminated the coverage ("qualifying events").[8] These continuation coverage requirements are often referred to as "COBRA continuation coverage" or "COBRA" requirements.[9] The premium charged an individual for COBRA continuation coverage cannot exceed 102 percent of the "applicable premium," that is, it cannot exceed 102 percent of the cost to the plan of providing coverage to a similarly situated individual who has not experienced a qualifying event. In the case of a failure to comply with the COBRA continuation coverage requirements under the Code, an excise tax may apply to the employer maintaining the group health plan or, in the case of a multiemployer group health plan, to the plan.

COBRA continuation requirements generally apply also under the Employee Retirement Income Security Act of 1974 ("ERISA") to group health plans covering employees of private employers, other than church plans, and under the Public Health Service Act ("PHSA") to group health plans covering State or local government employees. Similar requirements (referred to as "temporary continuation coverage" or "TCC") apply with respect to coverage under the Federal Employees Health Benefit Program ("FEHBP").[10] In addition, some State laws apply similar continuation coverage requirements with respect to employer-sponsored health plans. In some cases, church plans provide for similar continuation coverage, regardless of whether legally required.

Responsibility for the administration of an employee benefit plan, including a group health plan, generally lies with the plan administrator. Plan administrator is defined as the person specifically designated as plan administrator by the terms of the plan, or, in the absence of a designation, (1) in the case of a plan maintained by a single employer, the employer, (2) in the case of a plan maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other

[7] A group health plan may include a health flexible spending arrangement, under which medical care expenses of an employee (and family members, if applicable) that are not covered by insurance may be paid or reimbursed.

[8] Sec. 4980B. Section 4980B(d) provides exceptions for plans maintained by employers with fewer than 20 employees, plans of governmental employers, and church plans.

[9] The COBRA requirements were originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272.

[10] 5 U.S.C. sec. 8905a.

similar group of representatives of the parties who maintained the plan, or (3) in any other case, the person prescribed by regulations.[11]

The American Health Care Act of 2017

The American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017 (the "AHCA"), amends various health-related provisions of the Code.[12] Effective for months beginning after December 31, 2019, in taxable years ending after that date, the AHCA replaces the present-law premium assistance credit with a new credit and provides a new definition of "qualified health plan" to which the new credit applies.[13] Under the AHCA, qualified health plan means health insurance coverage[14] that is offered in the individual health insurance market within a State and that meets certain other requirements.[15] In order for an individual to be eligible for the new credit, the health insurance coverage must be certified by the State in which the insurance is offered as meeting the qualified health plan requirements.[16] A State certification will not be taken into account for this purpose unless the certification is made available to the public and meets such other requirements as the Secretary of the Treasury ("Secretary") may provide.[17]

Description of Proposal

The proposal amends the definition of qualified health plan under the provision of the AHCA relating to the new premium assistance credit to include unsubsidized COBRA continuation coverage. For this purpose, COBRA continuation coverage generally means continuation coverage provided under the Code, ERISA, the PHSA, or the FEHBP. It also includes coverage under a State law or program that provides comparable continuation coverage and continuation coverage under a church plan that is comparable to COBRA coverage. It does not include coverage under a health flexible spending arrangement. Unsubsidized COBRA

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[11] Sec. 414(g). In some cases, a plan sponsor or plan administrator may contract for administrative services by a separate service provider, often referred to as a third-party administrator or "TPA." However, a TPA does not necessarily assume the legal status of plan administrator.

[12] H.R. 1628, as passed by the House of Representatives on May 4, 2017.

[13] AHCA section 214. AHCA sections 201 and 202 amend the present-law premium assistance credit for periods before the new credit becomes effective.

[14] Health insurance coverage is defined in section 9832(b) and means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. Health insurance issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a State and which is subject to State law regulating insurance. A group health plan is not a health insurance issuer.

[15] Section 36B(f) as amended by AHCA section 214.

[16] Section 36B(d)(1) as amended by AHCA section 214.

[17] Section 36B(g)(8) as amended by AHCA section 214.

continuation coverage means COBRA continuation coverage, the payment of the applicable premiums for which is solely the obligation of the taxpayer. In the case of COBRA continuation coverage, the plan administrator of the group health plan must certify that the coverage meets the qualified health plan requirements, and the certification must meet requirements provided by the Secretary.

Effective Date

The proposal is contingent on enactment of the AHCA and will apply (if at all) to months beginning after December 31, 2019, in taxable years ending after that date.

B. Estimated Revenue Effect

The bill is estimated to have no effect on Federal revenues.