

SMALL BUSINESS HEALTH CARE RELIEF ACT OF 2016

JUNE 21, 2016.—Committed to the Committee of the Whole House of the State of the Union and ordered to be printed

Mr. BRADY of Texas, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 5447]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5447) to provide an exception from certain group health plan requirements for qualified small employer health reimbursement arrangements, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Small Business Health Care Relief Act of 2016”.

SEC. 2. EXCEPTION FROM GROUP HEALTH PLAN REQUIREMENTS FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.

(a) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986 AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.—

(1) IN GENERAL.—Section 9831 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(d) EXCEPTION FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

“(1) IN GENERAL.—For purposes of this title (except as provided in section 4980I(f)(4) and notwithstanding any other provision of this title), the term ‘group health plan’ shall not include any qualified small employer health reimbursement arrangement.

“(2) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this subsection—

“(A) IN GENERAL.—The term ‘qualified small employer health reimbursement arrangement’ means an arrangement which—

“(i) is described in subparagraph (B), and

“(ii) is provided on the same terms to all eligible employees of the eligible employer.

“(B) ARRANGEMENT DESCRIBED.—An arrangement is described in this subparagraph if—

“(i) such arrangement is funded solely by an eligible employer and no salary reduction contributions may be made under such arrangement,

“(ii) such arrangement provides, after the employee provides proof of coverage, for the payment of, or reimbursement of, an eligible employee for expenses for medical care (as defined in section 213(d)) incurred by the eligible employee or the eligible employee’s family members (as determined under the terms of the arrangement), and

“(iii) the amount of payments and reimbursements described in clause (ii) for any year do not exceed \$5,130 (\$10,260 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee).

“(C) CERTAIN VARIATION PERMITTED.—For purposes of subparagraph (A)(ii), an arrangement shall not fail to be treated as provided on the same terms to each eligible employee merely because the employee’s permitted benefits under such arrangement vary in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on—

“(i) the age of the eligible employee (and, in the case of an arrangement which covers medical expenses of the eligible employee’s family members, the age of such family members), or

“(ii) the number of family members of the eligible employee the medical expenses of which are covered under such arrangement.

The variation permitted under the preceding sentence shall be determined by reference to the same insurance policy with respect to all eligible employees.

“(D) RULES RELATING TO MAXIMUM DOLLAR LIMITATION.—

“(i) AMOUNT PRORATED IN CERTAIN CASES.—In the case of an individual who is not covered by an arrangement for the entire year, the limitation under subparagraph (A)(iii) for such year shall be an amount which bears the same ratio to the amount which would (but for this clause) be in effect for such individual for such year under subparagraph (A)(iii) as the number of months for which such individual is covered by the arrangement for such year bears to 12.

“(ii) INFLATION ADJUSTMENT.—In the case of any year beginning after 2016, each of the dollar amounts in subparagraph (A)(iii) shall be increased by an amount equal to—

“(I) such dollar amount, multiplied by

“(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting ‘calendar year 2015’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any dollar amount increased under the preceding sentence is not a multiple of \$100, such dollar amount shall be rounded to the next lowest multiple of \$100.

“(3) OTHER DEFINITIONS.—For purposes of this subsection—

“(A) ELIGIBLE EMPLOYEE.—The term ‘eligible employee’ means any employee of an eligible employer, except that the terms of the arrangement may exclude from consideration employees described in any clause of section 105(h)(3)(B) (applied by substituting ‘90 days’ for ‘3 years’ in clause (i) thereof).

“(B) ELIGIBLE EMPLOYER.—The term ‘eligible employer’ means an employer that—

“(i) is not an applicable large employer as defined in section 4980H(c)(2), and

“(ii) does not offer a group health plan to any of its employees.

“(C) PERMITTED BENEFIT.—The term ‘permitted benefit’ means, with respect to any eligible employee, the maximum dollar amount of payments and reimbursements which may be made under the terms of the qualified small employer health reimbursement arrangement for the year with respect to such employee.

“(4) NOTICE.—

“(A) IN GENERAL.—An employer funding a qualified small employer health reimbursement arrangement for any year shall, not later than 90 days before the beginning of such year (or, in the case of an employee who is not eligible to participate in the arrangement as of the beginning of such year, the date on which such employee is first so eligible), provide a written notice to each eligible employee which includes the information described in subparagraph (B).

“(B) CONTENTS OF NOTICE.—The notice required under subparagraph (A) shall include each of the following:

“(i) A statement of the amount which would be such eligible employee’s permitted benefits under the arrangement for the year.

“(ii) A statement that the eligible employee should provide the information described in clause (i) to any health insurance exchange to which the employee applies for advance payment of the premium assistance tax credit.

“(iii) A statement that if the employee is not covered under minimum essential coverage for any month the employee may be subject to tax under section 5000A for such month and reimbursements under the arrangement may be includible in gross income.”.

(2) LIMITATION ON EXCLUSION FROM GROSS INCOME.—Section 106 of such Code is amended by adding at the end the following:

“(g) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).”.

(3) COORDINATION WITH HEALTH INSURANCE PREMIUM CREDIT.—Section 36B(c) of such Code is amended by adding at the end the following new paragraph:

“(4) SPECIAL RULES FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

“(A) IN GENERAL.—The term ‘coverage month’ shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health reimbursement arrangement which constitutes affordable coverage.

“(B) DENIAL OF DOUBLE BENEFIT.—In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the

credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.

“(C) AFFORDABLE COVERAGE.—For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if—

“(i) the excess of—

“(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market, over

“(II) $\frac{1}{12}$ of the employee’s permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

“(ii) $\frac{1}{12}$ of 9.5 percent of the employee’s household income.

“(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this paragraph, the term ‘qualified small employer health reimbursement arrangement’ has the meaning given such term by section 9831(d)(2).

“(E) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (C)(i)(II) shall be applied by substituting ‘the number of months during the year for which such arrangement was provided’ for ‘12’.

“(F) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).”

(4) APPLICATION OF EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.—

(A) IN GENERAL.—Section 4980I(f)(4) of such Code is amended by adding at the end the following: “Section 9831(d)(1) shall not apply for purposes of this section.”

(B) DETERMINATION OF COST OF COVERAGE.—Section 4980I(d)(2) of such Code is amended by redesignating subparagraph (D) as subparagraph (E) and by inserting after subparagraph (C) the following new subparagraph:

“(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of applicable employer-sponsored coverage consisting of coverage under any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)), the cost of coverage shall be equal to the amount described in section 6051(a)(15).”

(5) ENFORCEMENT OF NOTICE REQUIREMENT.—Section 6652 of such Code is amended by adding at the end the following new subsection:

“(o) FAILURE TO PROVIDE NOTICES WITH RESPECT TO QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of each failure to provide a written notice as required by section 9831(d)(4), unless it is shown that such failure is due to reasonable cause and not willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such written notice, an amount equal to \$50 per employee per incident of failure to provide such notice, but the total amount imposed on such person for all such failures during any calendar year shall not exceed \$2,500.”

(6) REPORTING.—

(A) W-2 REPORTING.—Section 6051(a) of such Code is amended by striking “and” at the end of paragraph (13), by striking the period at the end of paragraph (14) and inserting “, and”, and by inserting after paragraph (14) the following new paragraph:

“(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee.”

(B) INFORMATION REQUIRED TO BE PROVIDED BY EXCHANGE SUBSIDY APPLICANTS.—Section 1411(b)(3) of the Patient Protection and Affordable Care Act is amended by redesignating subparagraph (B) as subparagraph (C) and by inserting after subparagraph (A) the following new subparagraph:

“(B) CERTAIN INDIVIDUAL HEALTH INSURANCE POLICIES OBTAINED THROUGH SMALL EMPLOYERS.—The amount of the enrollee’s permitted benefit (as defined in section 9831(d)(3)(C) of the Internal Revenue Code of 1986) under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of such Code).”

(7) EFFECTIVE DATES.—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the amendments made by this subsection shall apply to years beginning after the earlier of—

- (i) the date that is 90 days after the date of the enactment of this Act, or
- (ii) December 31, 2016.

(B) TRANSITION RELIEF.—The relief under Treasury Notice 2015–17 shall be treated as applying to any plan year beginning on or before the date described in subparagraph (A).

(C) COORDINATION WITH HEALTH INSURANCE PREMIUM CREDIT.—The amendments made by paragraph (3) shall apply to taxable years beginning after the date described in subparagraph (A).

(D) EMPLOYEE NOTICE.—The amendments made by paragraph (5) shall apply to notices with respect to years beginning after the date described in subparagraph (A).

(E) W–2 REPORTING.—The amendments made by paragraph (6)(A) shall apply to calendar years beginning after December 31, 2016.

(F) INFORMATION PROVIDED BY EXCHANGE SUBSIDY APPLICANTS.—

(i) IN GENERAL.—The amendments made by paragraph (6)(B) shall apply to applications for enrollment made after the date described in subparagraph (A).

(ii) VERIFICATION.—Verification under section 1411 of the Patient Protection and Affordable Care Act of information provided under section 1411(b)(3)(B) of such Act shall apply with respect to months beginning after October 2016.

(8) SUBSTANTIATION REQUIREMENTS.—The Secretary of the Treasury (or his designee) may issue substantiation requirements as necessary to carry out this subsection.

(b) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Section 733(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(a)(1)) is amended by adding at the end the following: “Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).”

(2) EXCEPTION FROM CONTINUATION COVERAGE REQUIREMENTS, ETC.—Section 607(1) of such Act (29 U.S.C. 1167(1)) is amended by adding at the end the following: “Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).”

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after the date described in subsection (a)(7)(A).

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT.—

(1) IN GENERAL.—Section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)) is amended by adding at the end the following: “Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).”

(2) EXCEPTION FROM CONTINUATION COVERAGE REQUIREMENTS.—Section 2208(1) of the Public Health Service Act (42 U.S.C. 300bb–8(1)) is amended by adding at the end the following: “Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).”

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning after the date described in subsection (a)(7)(A).

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 5447, as reported by the Committee on Ways and Means, establishes new rules for Qualified Small Employer Health Reimbursement Arrangements (QSHERAs) that allow eligible employers to provide tax-preferred reimbursements to such arrangements and exempt those arrangements from current law group health plan associated penalties.

B. BACKGROUND AND NEED FOR LEGISLATION

The Committee believes that exempting QSHERAs from current law group health plan rules and associated penalties will relieve an unfair tax burden on small employers and their employees who use these arrangements.

The penalty currently facing those small businesses that are engaged in employer payment arrangements are different from the penalty that large employers are subject to through the employer mandate. Those large employers could face \$3,240 per year per employee penalties. In contrast, a small business that is not subject to the employer mandate that wishes to provide a small amount of money to help an employee purchase a plan in the individual market could face \$36,500 per year per employee penalties.

Many small businesses are not aware of this penalty and could face significant financial hardship absent legislative relief. Direct contributions to health care through health reimbursement arrangements should be encouraged as it increases coverage and leads to portability of health care benefits for American workers and their families. While these arrangements are not considered group health plans for purposes of the employer penalty, H.R. 5447 is not intended to change the extent to which these plans are employee welfare benefit plans under ERISA.

C. LEGISLATIVE HISTORY

Background

H.R. 5447 was introduced on June 10, 2016, and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up H.R. 5447, the Small Business Health Care Relief Act of 2016, on June 15, 2016, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

The policy issues associated with Health Reimbursement Arrangements (HRAs) and need for legislative response were discussed at three Ways and Means hearings during the 114th Congress:

- Ways and Means Committee Hearing on the Tax Treatment of Health Care (April 14, 2016);
- Subcommittee on Tax Policy Member Day Hearing on Tax Legislation (May 12, 2016); and
- Subcommittee on Health Member Day Hearing on Tax-Related Proposals to Improve Health Care (May 17, 2016).

II. EXPLANATION OF THE BILL

A. EXCEPTION FROM GROUP HEALTH PLAN REQUIREMENTS FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS (SEC. 2 OF THE BILL AND SECS. 36B, 106, 4980I, 6051 AND 9831 OF THE CODE)

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).¹ 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.²

The exclusion applies also to amounts paid or reimbursed from funds withheld from an employee's salary under a cafeteria plan (salary reduction amounts).³

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.⁴

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.⁵ 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.⁶ 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

¹Secs. 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.

²Treas. Reg. sec. 1.105-2.

³Sec. 125. An HRA cannot include salary reduction amounts.

⁴Sec. 6051(a)(14).

⁵Secs. 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.

⁶Secs. 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.

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.⁷ 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.⁸ 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).⁹ 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.¹⁰ 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 percent¹¹ of 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.¹²

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.¹³ For this purpose, applicable large employer generally means, with respect to a calendar year, an employer who em-

⁷Notice 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.

⁸Sec. 5000A.

⁹Sec. 36B.

¹⁰The 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.”

¹¹For years after 2014, this percentage is increased as needed to reflect cost-of-living increases. The percentage for 2016 is 9.66.

¹²Sec. 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.

¹³Sec. 4980H.

ployed an average of at least 50 full-time employees on business days during the preceding calendar year.¹⁴

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.¹⁵ 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.

REASONS FOR CHANGE

Small employers are not required to provide health insurance coverage to their employees and, for some small employers, doing so may not be feasible. Nonetheless, many small employers wish to provide pretax funds that employees may use to purchase their own health insurance or pay for expenses not covered by their insurance. However, under present law, providing such funds may expose a small employer to a substantial excise tax. The Committee wishes to enable small employers to provide such funds without incurring an excise tax.

EXPLANATION OF PROVISION

Qualified small employer health reimbursement arrangement

Under the provision, 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.¹⁶ 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 family members;¹⁷ and (4) the amount of payments and reimbursements under the arrangement for a year cannot exceed specified dollar limits.¹⁸ 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 em-

¹⁴In 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.

¹⁵Sec. 49801.

¹⁶A 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.

¹⁷The provision specifies that the Secretary of the Treasury or his designee may issue substantiation requirements as necessary to carry out the provision.

¹⁸For 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.

ployee 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 provision, "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 non-resident aliens with no earned income from sources within the United States.¹⁹ "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 provision, if an employee's medical care expenses are paid or reimbursed under a QSEHRA and the employee does not have minimum essential 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.²⁰ The provision is not intended to change the extent to which these plans are employee welfare benefit plans under ERISA.

Coordination with other Code rules

Under the provision, 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) $\frac{1}{12}$ of the employee's permitted benefit under the QSEHRA, does not exceed $\frac{1}{12}$ of 9.5 percent²¹ 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 cov-

¹⁹These 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.

²⁰The provision 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.

²¹For years after 2014, this percentage is increased as needed to reflect cost-of-living increases. The percentage for 2016 is 9.66.

erage), the credit amount is reduced (but not below zero) by the employee's permitted benefit.

Under the provision, 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 provision 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 provision generally applies to years beginning after the earlier of (1) the date that is 90 days after the date of enactment of the provision, or (2) December 31, 2016 (plan years beginning after the earlier of those two dates in the case of the ERISA and PHSA changes).²² The aspects of the provision 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.²³

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 5447, the "Small Business Health Care Relief Act of 2016," on June 15, 2016.

The bill, H.R. 5447, as amended, was ordered favorably reported to the House of Representatives by a voice vote (with a quorum being present).

²²The provision extends the excise tax relief under Notice 2015-17 to plan years beginning on or before the earlier of the two dates.

²³Verification of this information in the Exchange process applies with respect to months beginning after October 2016.

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 5447, as reported.

The bill, as reported, is estimated to have the following effect on Federal fiscal year budget receipts for the period 2016–2026^{1 2}.

FISCAL YEARS
[Millions of dollars]

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-21	2016-26
	-20	-225	-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:													
2016	—	27	30	32	34	36	38	40	40	42	44	159	363
2 Estimate includes the following off-budget effects:													
2016	-12	-47	-27	-29	6	16	24	32	49	61	83	-92	157

Pursuant to clause 8 of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the bill amending the Internal Revenue Code of 1986: The gross budgetary effect (before incorporating macroeconomic effects) in any fiscal year is less than 0.25 percent of the current projected gross domestic product of the United States for that fiscal year; therefore, the bill is not “major legislation” for purposes of requiring that the estimate include the budgetary effects of changes in economic output, employment, capital stock and other macroeconomic variables.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX
EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves increased budget authority with respect to outlays for refundable credits. The Committee further states that the revenue-reducing provisions of the bill involve increased tax expenditures. See amounts shown in the table in Part IV.A above.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET
OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 21, 2016.

Hon. KEVIN BRADY,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5447, the Small Business Health Care Relief Act of 2016.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Nathaniel Frentz.

Sincerely,

KEITH HALL.

Enclosure.

H.R. 5447—Small Business Health Care Relief Act of 2016

H.R. 5447 would amend the Internal Revenue Code to define a qualified small employer health reimbursement arrangement (QSEHRA) as an arrangement where an employer pays directly for or reimburses medical expenses of an employee and his or her dependents. In order to be eligible for this arrangement, an employer must generally have had fewer than 50 full-time employees during the prior year. An employee must provide proof of having minimum essential health insurance coverage, as defined for purposes of the individual mandate. The payments from an employer provided through a QSEHRA would not be counted in the employees' gross income and would therefore be exempt from income taxes. An employer that offered a QSEHRA would not be subject to penalties

under the Internal Revenue Code, the Employee Retirement Income Security Act of 1974, or the Public Health Service Act that typically apply to group health plans that fail to meet certain requirements.

The staff of the Joint Committee on Taxation (JCT) estimates that enacting H.R. 5447 would raise both revenues and outlays by \$363 million over the 2016–2026 period. JCT therefore estimates that enacting the bill would have no effect on federal budget deficits over the 2016–2026 period. The change in revenues includes an increase of \$157 million in off-budget revenues (from Social Security payroll taxes). As a result, on-budget deficits are expected to increase by \$157 million over the 2016–2026 period.

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting revenues or direct spending. The net changes in revenues and direct spending that are subject to those pay-as-you-go procedures are shown in the following table. Only on-budget changes to revenues and direct spending are subject to pay-as-you-go procedures.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 5447, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON JUNE 15, 2016

	By fiscal year, in millions of dollars—												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016-2021	2016-2026
NET INCREASE OR DECREASE (—) IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Effects	9	178	93	98	30	11	-2	-17	-51	-74	-116	418	157
Memorandum: ^a													
Change in Outlays	0	27	30	32	34	36	38	40	40	42	44	159	363
Change in On-Budget Revenues	-9	-151	-63	-66	4	25	39	57	91	116	160	-259	206
<i>Change in Off-Budget Revenues</i>	-13	-46	-27	-29	6	16	24	32	49	61	83	-92	157

Source: Staff of the Joint Committee on Taxation.

a. A positive sign for outlays indicates an increase in outlays. A positive sign for revenues indicates an increase in revenues.

Note: Components may not sum to total because of rounding.

CBO and JCT estimate that enacting the bill would not increase net direct spending or on-budget deficits by more than \$5 billion in any of the four 10-year periods beginning in 2027.

JCT has determined that the bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

The CBO staff contact for this estimate is Nathaniel Frentz. The estimate was approved by David Weiner, Assistant Director for Tax Analysis.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of H.R. 5447 that the Committee concluded that it is appropriate to report the bill, as amended, favorably to the House of Representatives with the recommendation that the bill do pass.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the bill and states that the bill does not involve any Federal income tax rate increases within the meaning of the rule.

E. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 ("IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all leg-

islation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code of 1986 and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Internal Revenue Code of 1986 and that have “widespread applicability” to individuals or small businesses, within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with Sec. 3(g)(2) of H. Res. 5 (114th Congress), the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to the Federal Program Information Act (Public Law 95–220, as amended by Public Law 98–169).

H. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (114th Congress), the following statement is made concerning directed rule makings: The Committee estimates that the bill requires no directed rule makings within the meaning of such section.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

A. TEXT OF EXISTING LAW AMENDED OR REPEALED BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(A) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the bill, as reported, is shown below:

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(A) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the bill, as reported, is shown below:

INTERNAL REVENUE CODE OF 1986

* * * * *

Subtitle A—Income Taxes

* * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

Subchapter A—Determination of Tax Liability

* * * * *

PART IV—CREDITS AGAINST TAX

* * * * *

Subpart C—Refundable Credits

* * * * *

SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) **IN GENERAL.**—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

(b) **PREMIUM ASSISTANCE CREDIT AMOUNT.**—For purposes of this section—

(1) **IN GENERAL.**—The term “premium assistance credit amount” means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(2) **PREMIUM ASSISTANCE AMOUNT.**—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer’s spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of—

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer’s household income for the taxable year.

(3) **OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.**—For purposes of paragraph (2)—

(A) **APPLICABLE PERCENTAGE.**—

(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is--	The final premium percentage is--
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

(ii) INDEXING.—

(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

(III) FAILSAFE.—Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides—

(I) self-only coverage in the case of an applicable taxpayer—

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) ADDITIONAL BENEFITS.—If—

(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii) (I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan de-

scribed in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

(1) APPLICABLE TAXPAYER.—

(A) IN GENERAL.—The term “applicable taxpayer” means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer’s spouse file a joint return for the taxable year.

(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

(2) COVERAGE MONTH.—For purposes of this subsection—

(A) IN GENERAL.—The term “coverage month” means, with respect to an applicable taxpayer, any month if—

(i) as of the first day of such month the taxpayer, the taxpayer’s spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

(i) IN GENERAL.—The term “coverage month” shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” has the meaning given such term by section 5000A(f).

(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(II) the employee’s required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer’s household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) DEFINITIONS AND OTHER RULES.—

(A) QUALIFIED HEALTH PLAN.—The term “qualified health plan” has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) GRANDFATHERED HEALTH PLAN.—The term “grandfathered health plan” has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) HOUSEHOLD INCOME.—

(A) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer’s family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) MODIFIED ADJUSTED GROSS INCOME.—The term “modified adjusted gross income” means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer’s social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) POVERTY LINE.—

(A) IN GENERAL.—The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer’s household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) **LAWFULLY PRESENT.**—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) **SECRETARIAL AUTHORITY.**—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) **RECONCILIATION OF CREDIT AND ADVANCE CREDIT.**—

(1) **IN GENERAL.**—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) **EXCESS ADVANCE PAYMENTS.**—

(A) **IN GENERAL.**—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) **LIMITATION ON INCREASE.**—

(i) **IN GENERAL.**—In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,500

(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2013” for “calendar year 1992” in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(3) INFORMATION REQUIREMENT.—Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

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Subchapter B—Computation of Taxable Income

* * * * *

PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

* * * * *

SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) CONTRIBUTIONS TO ARCHER MSAS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any Archer MSA of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

(3) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to an Archer MSA, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the Archer MSAs of such individual or such individual's spouse for such taxable year.

(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

(6) DEFINITIONS.—For purposes of this subsection, the terms "eligible individual" and "Archer MSA" have the respective meanings given to such terms by section 220.

(7) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the Archer MSAs of comparable employees, see section 4980E.

(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—Gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

(d) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account (as defined in section 223(d)) of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

(3) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.

(e) FSA AND HRA TERMINATIONS TO FUND HSAS.—

(1) IN GENERAL.—A plan shall not fail to be treated as a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because such plan provides for a qualified HSA distribution.

(2) QUALIFIED HSA DISTRIBUTION.—The term "qualified HSA distribution" means a distribution from a health flexible spending arrangement or health reimbursement arrangement to the extent that such distribution—

(A) does not exceed the lesser of the balance in such arrangement on September 21, 2006, or as of the date of such distribution, and

(B) is contributed by the employer directly to the health savings account of the employee before January 1, 2012.

Such term shall not include more than 1 distribution with respect to any arrangement.

(3) ADDITIONAL TAX FOR FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(A) IN GENERAL.—If, at any time during the testing period, the employee is not an eligible individual, then the amount of the qualified HSA distribution—

(i) shall be includible in the gross income of the employee for the taxable year in which occurs the first month in the testing period for which such employee is not an eligible individual, and

(ii) the tax imposed by this chapter for such taxable year on the employee shall be increased by 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Clauses (i) and (ii) of subparagraph (A) shall not apply if the em-

ployee ceases to be an eligible individual by reason of the death of the employee or the employee becoming disabled (within the meaning of section 72(m)(7)).

(4) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) TESTING PERIOD.—The term “testing period” means the period beginning with the month in which the qualified HSA distribution is contributed to the health savings account and ending on the last day of the 12th month following such month.

(B) ELIGIBLE INDIVIDUAL.—The term “eligible individual” has the meaning given such term by section 223(c)(1).

(C) TREATMENT AS ROLLOVER CONTRIBUTION.—A qualified HSA distribution shall be treated as a rollover contribution described in section 223(f)(5).

(5) TAX TREATMENT RELATING TO DISTRIBUTIONS.—For purposes of this title—

(A) IN GENERAL.—A qualified HSA distribution shall be treated as a payment described in subsection (d).

(B) COMPARABILITY EXCISE TAX.—

(i) IN GENERAL.—Except as provided in clause (ii), section 4980G shall not apply to qualified HSA distributions.

(ii) FAILURE TO OFFER TO ALL EMPLOYEES.—In the case of a qualified HSA distribution to any employee, the failure to offer such distribution to any eligible individual covered under a high deductible health plan of the employer shall (notwithstanding section 4980G(d)) be treated for purposes of section 4980G as a failure to meet the requirements of section 4980G(b).

(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

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Subtitle D—Miscellaneous Excise Taxes

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CHAPTER 43—QUALIFIED PENSION, ETC., PLANS

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SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IMPOSITION OF TAX.—If—

(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

(b) EXCESS BENEFIT.—For purposes of this section—

(1) IN GENERAL.—The term “excess benefit” means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

(B) an amount equal to $\frac{1}{12}$ of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

(3) ANNUAL LIMITATION.—For purposes of this subsection—

(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

(B) APPLICABLE ANNUAL LIMITATION.—

(i) IN GENERAL.—Except as provided in clause (ii), the annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

(ii) MULTIEMPLOYER PLAN COVERAGE.—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.

(C) APPLICABLE DOLLAR LIMIT.—

(i) 2018.—In the case of 2018, the dollar limit under this subparagraph is—

(I) in the case of an employee with self-only coverage, \$10,200 multiplied by the health cost adjustment percentage (determined by only taking into account self-only coverage), and

(II) in the case of an employee with coverage other than self-only coverage, \$27,500 multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage).

(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over

(II) 55 percent.

(iii) AGE AND GENDER ADJUSTMENT.—

(I) IN GENERAL.—The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

(II) AMOUNT DETERMINED.—The amount determined under this subclause is an amount equal to the excess (if any) of—

(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over

(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

(iv) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

(I) the dollar amount in clause (i)(I) shall be increased by \$1,650, and

(II) the dollar amount in clause (i)(II) shall be increased by \$3,450,

(v) SUBSEQUENT YEARS.—In the case of any calendar year after 2018, each of the dollar amounts under clauses (i) (after the application of clause (ii)) and (iv) shall be increased to the amount equal to such amount as determined for for the calendar year preceding such year, increased by an amount equal to the product of—

(I) such amount as so determined, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for “1992” in subparagraph (B) thereof), increased by 1 percentage point in the case of determinations for calendar years beginning before 2020.

If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

(c) LIABILITY TO PAY TAX.—

(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

(2) COVERAGE PROVIDER.—For purposes of this subsection, the term “coverage provider” means each of the following:

(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a

group health plan which provides health insurance coverage, the health insurance issuer.

(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

(A) IN GENERAL.—Each employer shall—

(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

(A) IN GENERAL.—The term “applicable employer-sponsored coverage” means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

(B) EXCEPTIONS.—The term “applicable employer-sponsored coverage” shall not include—

(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care, or

(ii) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth

(including any organ or structure within the mouth) or for treatment of the eye, or

(iii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

(2) DETERMINATION OF COST.—

(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

- (i) the amount of employer contributions under any salary reduction election under the arrangement, plus
- (ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be al-

located to months in a taxable period on such basis as the Secretary may prescribe.

(3) EMPLOYEE.—The term “employee” includes any former employee, surviving spouse, or other primary insured individual.

(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

(2) LIMITATIONS ON PENALTY.—

(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

(i) such failure was due to reasonable cause and not to willful neglect, and

(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) COVERAGE DETERMINATIONS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage

only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

(2) **QUALIFIED RETIREE.**—The term “qualified retiree” means any individual who—

(A) is receiving coverage by reason of being a retiree,

(B) has attained age 55, and

(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

(3) **EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.**—The term “employees engaged in a high-risk profession” means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee’s employment.

(4) **GROUP HEALTH PLAN.**—The term “group health plan” has the meaning given such term by section 5000(b)(1).

(5) **HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.**—

(A) **HEALTH INSURANCE COVERAGE.**—The term “health insurance coverage” has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

(B) **HEALTH INSURANCE ISSUER.**—The term “health insurance issuer” has the meaning given such term by section 9832(b)(2).

(6) **PERSON THAT ADMINISTERS THE PLAN BENEFITS.**—The term “person that administers the plan benefits” shall include the plan sponsor if the plan sponsor administers benefits under the plan.

(7) **PLAN SPONSOR.**—The term “plan sponsor” has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(8) **TAXABLE PERIOD.**—The term “taxable period” means the calendar year or such shorter period as the Secretary may pre-

scribe. The Secretary may have different taxable periods for employers of varying sizes.

(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

(10) DEDUCTIBILITY OF TAX.—Section 275(a)(6) shall not apply to the tax imposed by subsection (a).

(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart C—Information Regarding Wages Paid Employees

SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

- (1) the name of such person,
- (2) the name of the employee (and an identifying number for the employee if wages as defined in section 3121(a) have been paid),
- (3) the total amount of wages as defined in section 3401(a),
- (4) the total amount deducted and withheld as tax under section 3402,
- (5) the total amount of wages as defined in section 3121(a),
- (6) the total amount deducted and withheld as tax under section 3101,

(8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),

(9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),

(10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned income as determined for purposes of section 32 (relating to earned income credit),

(11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,

(12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse,

(13) the total amount of deferrals for the year under a non-qualified deferred compensation plan (within the meaning of section 409A(d)),

(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

(A) coverage to which paragraphs (11) and (12) apply, or

(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by

paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) **ADDITIONAL REQUIREMENTS.**—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) **STATEMENTS TO CONSTITUTE INFORMATION RETURNS.**—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) **RAILROAD EMPLOYEES.**—

(1) **ADDITIONAL REQUIREMENT.**—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) **INFORMATION TO BE SUPPLIED TO EMPLOYEES.**—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) **STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.**—

(1) **STATEMENTS REQUIRED FROM PAYOR.**—

(A) **IN GENERAL.**—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

(i) the name and, if there is withholding under section 3402(o), the social security number of such employee,

(ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and

(iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term “third-party sick pay” means any sick pay (as defined in section 3402(o)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(o)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

(A) the information shown on the statement furnished under paragraph (1)(A), and

(B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable.

To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

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CHAPTER 68—ADDITIONS TO THE TAX, ADDITIONAL AMOUNTS, AND ASSESSABLE PENALTIES

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Subchapter A—Additions to the Tax and Additional Amounts

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PART I—GENERAL PROVISIONS

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SEC. 6652. FAILURE TO FILE CERTAIN INFORMATION RETURNS, REGISTRATION STATEMENTS, ETC.

(a) RETURNS WITH RESPECT TO CERTAIN PAYMENTS AGGREGATING LESS THAN \$10.—In the case of each failure to file a statement of a payment to another person required under the authority of—

(1) section 6042(a)(2) (relating to payments of dividends aggregating less than \$10), or

(2) section 6044(a)(2) (relating to payments of patronage dividends aggregating less than \$10),

on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid (upon notice and demand by the Secretary and in the same manner as tax) by the person failing to so file the statement, \$1 for each such statement not so filed, but the total amount imposed on the delinquent person for all such failures during the calendar year shall not exceed \$1,000.

(b) FAILURE TO REPORT TIPS.—In the case of failure by an employee to report to his employer on the date and in the manner prescribed therefor any amount of tips required to be so reported by section 6053(a) which are wages (as defined in section 3121(a)) or which are compensation (as defined in section 3231(e)), unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be paid by the employee, in addition to the tax imposed by section 3101 or section 3201 (as the case may be) with respect to the amount of tips which he so failed to report, an amount equal to 50 percent of such tax.

(c) RETURNS BY EXEMPT ORGANIZATIONS AND BY CERTAIN TRUSTS.—

(1) ANNUAL RETURNS UNDER SECTION 6033(A)(1) OR 6012(A)(6).—

(A) PENALTY ON ORGANIZATION.—In the case of—

(i) a failure to file a return required under section 6033(a)(1) (relating to returns by exempt organizations) or section 6012(a)(6) (relating to returns by political organizations) on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing), or

(ii) a failure to include any of the information required to be shown on a return filed under section 6033(a)(1) or section 6012(a)(6) or to show the correct information,

there shall be paid by the exempt organization \$20 for each day during which such failure continues. The maximum penalty under this subparagraph on failures with respect to any 1 return shall not exceed the lesser of \$10,000 or 5 percent of the gross receipts of the organization for the year. In the case of an organization having gross receipts exceeding \$1,000,000 for any year, with respect to the return required under section 6033(a)(1) or section 6012(a)(6) for such year, in applying the first sentence of this subparagraph, the amount of the penalty for each day during which a failure continues shall be \$100 in lieu of the amount otherwise specified, and, in lieu of applying the second sentence of this subparagraph, the maximum penalty under this subparagraph shall not exceed \$50,000.

(B) MANAGERS.—

(i) IN GENERAL.—The Secretary may make a written demand on any organization subject to penalty under subparagraph (A) specifying therein a reasonable fu-

ture date by which the return shall be filed (or the information furnished) for purposes of this subparagraph.

(ii) FAILURE TO COMPLY WITH DEMAND.—If any person fails to comply with any demand under clause (i) on or before the date specified in such demand, there shall be paid by the person failing to so comply \$10 for each day after the expiration of the time specified in such demand during which such failure continues. The maximum penalty imposed under this subparagraph on all persons for failures with respect to any 1 return shall not exceed \$5,000.

(C) PUBLIC INSPECTION OF ANNUAL RETURNS AND REPORTS.—In the case of a failure to comply with the requirements of section 6104(d) with respect to any annual return on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing) or report required under section 527(j), there shall be paid by the person failing to meet such requirements \$20 for each day during which such failure continues. The maximum penalty imposed under this subparagraph on all persons for failures with respect to any 1 return or report shall not exceed \$10,000.

(D) PUBLIC INSPECTION OF APPLICATIONS FOR EXEMPTION AND NOTICE OF STATUS.—In the case of a failure to comply with the requirements of section 6104(d) with respect to any exempt status application materials (as defined in such section) or notice materials (as defined in such section) on the date and in the manner prescribed therefor, there shall be paid by the person failing to meet such requirements \$20 for each day during which such failure continues.

(E) NO PENALTY FOR CERTAIN ANNUAL NOTICES.—This paragraph shall not apply with respect to any notice required under section 6033(i).

(2) RETURNS UNDER SECTION 6034 OR 6043(B).—

(A) PENALTY ON ORGANIZATION OR TRUST.—In the case of a failure to file a return required under section 6034 (relating to returns by certain trusts) or section 6043(b) (relating to terminations, etc., of exempt organizations), on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing), there shall be paid by the exempt organization or trust failing so to file \$10 for each day during which such failure continues, but the total amount imposed under this subparagraph on any organization or trust for failure to file any 1 return shall not exceed \$5,000.

(B) MANAGERS.—The Secretary may make written demand on an organization or trust failing to file under subparagraph (A) specifying therein a reasonable future date by which such filing shall be made for purposes of this subparagraph. If such filing is not made on or before such date, there shall be paid by the person failing so to file \$10 for each day after the expiration of the time specified in the written demand during which such failure continues,

but the total amount imposed under this subparagraph on all persons for failure to file any 1 return shall not exceed \$5,000.

(C) SPLIT-INTEREST TRUSTS.—In the case of a trust which is required to file a return under section 6034(a), subparagraphs (A) and (B) of this paragraph shall not apply and paragraph (1) shall apply in the same manner as if such return were required under section 6033, except that—

(i) the 5 percent limitation in the second sentence of paragraph (1)(A) shall not apply,

(ii) in the case of any trust with gross income in excess of \$250,000, in applying the first sentence of paragraph (1)(A), the amount of the penalty for each day during which a failure continues shall be \$100 in lieu of the amount otherwise specified, and in lieu of applying the second sentence of paragraph (1)(A), the maximum penalty under paragraph (1)(A) shall not exceed \$50,000, and

(iii) the third sentence of paragraph (1)(A) shall be disregarded.

In addition to any penalty imposed on the trust pursuant to this subparagraph, if the person required to file such return knowingly fails to file the return, such penalty shall also be imposed on such person who shall be personally liable for such penalty.

(3) DISCLOSURE UNDER SECTION 6033(A)(2).—

(A) PENALTY ON ENTITIES.—In the case of a failure to file a disclosure required under section 6033(a)(2), there shall be paid by the tax-exempt entity (the entity manager in the case of a tax-exempt entity described in paragraph (4), (5), (6), or (7) of section 4965(c)) \$100 for each day during which such failure continues. The maximum penalty under this subparagraph on failures with respect to any 1 disclosure shall not exceed \$50,000.

(B) WRITTEN DEMAND.—

(i) IN GENERAL.—The Secretary may make a written demand on any entity or manager subject to penalty under subparagraph (A) specifying therein a reasonable future date by which the disclosure shall be filed for purposes of this subparagraph.

(ii) FAILURE TO COMPLY WITH DEMAND.—If any entity or manager fails to comply with any demand under clause (i) on or before the date specified in such demand, there shall be paid by such entity or manager failing to so comply \$100 for each day after the expiration of the time specified in such demand during which such failure continues. The maximum penalty imposed under this subparagraph on all entities and managers for failures with respect to any 1 disclosure shall not exceed \$10,000.

(C) DEFINITIONS.—Any term used in this section which is also used in section 4965 shall have the meaning given such term under section 4965.

(4) NOTICES UNDER SECTION 506.—

(A) PENALTY ON ORGANIZATION.—In the case of a failure to submit a notice required under section 506(a) (relating to organizations required to notify Secretary of intent to operate as 501(c)(4)) on the date and in the manner prescribed therefor, there shall be paid by the organization failing to so submit \$20 for each day during which such failure continues, but the total amount imposed under this subparagraph on any organization for failure to submit any one notice shall not exceed \$5,000.

(B) MANAGERS.—The Secretary may make written demand on an organization subject to penalty under subparagraph (A) specifying in such demand a reasonable future date by which the notice shall be submitted for purposes of this subparagraph. If such notice is not submitted on or before such date, there shall be paid by the person failing to so submit \$20 for each day after the expiration of the time specified in the written demand during which such failure continues, but the total amount imposed under this subparagraph on all persons for failure to submit any one notice shall not exceed \$5,000.

(5) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under this subsection with respect to any failure if it is shown that such failure is due to reasonable cause.

(6) OTHER SPECIAL RULES.—

(A) TREATMENT AS TAX.—Any penalty imposed under this subsection shall be paid on notice and demand of the Secretary and in the same manner as tax.

(B) JOINT AND SEVERAL LIABILITY.—If more than 1 person is liable under this subsection for any penalty with respect to any failure, all such persons shall be jointly and severally liable with respect to such failure.

(C) PERSON.—For purposes of this subsection, the term “person” means any officer, director, trustee, employee, or other individual who is under a duty to perform the act in respect of which the violation occurs.

(7) ADJUSTMENT FOR INFLATION.—

(A) IN GENERAL.—In the case of any failure relating to a return required to be filed in a calendar year beginning after 2014, each of the dollar amounts under paragraphs (1), (2), and (3) shall be increased by such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) determined by substituting “calendar year 2013” for “calendar year 1992” in subparagraph (B) thereof.

(B) ROUNDING.—If any amount adjusted under subparagraph (A)—

(i) is not less than \$5,000 and is not a multiple of \$500, such amount shall be rounded to the next lowest multiple of \$500, and

(ii) is not described in clause (i) and is not a multiple of \$5, such amount shall be rounded to the next lowest multiple of \$5.

(d) ANNUAL REGISTRATION AND OTHER NOTIFICATION BY PENSION PLAN.—

(1) REGISTRATION.—In the case of any failure to file a registration statement required under section 6057(a) (relating to annual registration of certain plans) which includes all participants required to be included in such statement, on the date prescribed therefor (determined without regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing so to file, an amount equal to \$1 for each participant with respect to whom there is a failure to file, multiplied by the number of days during which such failure continues, but the total amount imposed under this paragraph on any person for any failure to file with respect to any plan year shall not exceed \$5,000.

(2) NOTIFICATION OF CHANGE OF STATUS.—In the case of failure to file a notification required under section 6057(b) (relating to notification of change of status) on the date prescribed therefor (determined without regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing so to file, \$1 for each day during which such failure continues, but the total amounts imposed under this paragraph on any person for failure to file any notification shall not exceed \$1,000.

(e) INFORMATION REQUIRED IN CONNECTION WITH CERTAIN PLANS OF DEFERRED COMPENSATION, ETC.—In the case of failure to file a return or statement required under section 6058 (relating to information required in connection with certain plans of deferred compensation), 6047 (relating to information relating to certain trusts and annuity and bond purchase plans), or 6039D (relating to returns and records with respect to certain fringe benefit plans) on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing so to file, \$25 for each day during which such failure continues, but the total amount imposed under this subsection on any person for failure to file any return shall not exceed \$15,000. This subsection shall not apply to any return or statement which is an information return described in section 6724(d)(1)(C)(ii) or a payee statement described in section 6724(d)(2)(Y).

(f) RETURNS REQUIRED UNDER SECTION 6039C.—

(1) IN GENERAL.—In the case of each failure to make a return required by section 6039C which contains the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause and not to willful neglect, the amount determined under paragraph (2) shall be paid (upon notice and demand by the Secretary and in the same manner as tax) by the person failing to make such return.

(2) AMOUNT OF PENALTY.—For purposes of paragraph (1), the amount determined under this paragraph with respect to any

failure shall be \$25 for each day during which such failure continues.

(3) LIMITATION.—The amount determined under paragraph (2) with respect to any person for failing to meet the requirements of section 6039C for any calendar year shall not exceed the lesser of—

(A) \$25,000, or

(B) 5 percent of the aggregate of the fair market value of the United States real property interests owned by such person at any time during such year.

For purposes of the preceding sentence, fair market value shall be determined as of the end of the calendar year (or, in the case of any property disposed of during the calendar year, as of the date of such disposition).

(h) FAILURE TO GIVE NOTICE TO RECIPIENTS OF CERTAIN PENSION, ETC., DISTRIBUTIONS.—In the case of each failure to provide notice as required by section 3405(e)(10)(B), at the time prescribed therefor, unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such notice, an amount equal to \$10 for each such failure, but the total amount imposed on such person for all such failures during any calendar year shall not exceed \$5,000.

(i) FAILURE TO GIVE WRITTEN EXPLANATION TO RECIPIENTS OF CERTAIN QUALIFYING ROLLOVER DISTRIBUTIONS.—In the case of each failure to provide a written explanation as required by section 402(f), at the time prescribed therefor, unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such written explanation, an amount equal to \$100 for each such failure, but the total amount imposed on such person for all such failures during any calendar year shall not exceed \$50,000.

(j) FAILURE TO FILE CERTIFICATION WITH RESPECT TO CERTAIN RESIDENTIAL RENTAL PROJECTS.—In the case of each failure to provide a certification as required by section 142(d)(7) at the time prescribed therefor, unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such certification, an amount equal to \$100 for each such failure.

(k) FAILURE TO MAKE REPORTS REQUIRED UNDER SECTION 1202.—

In the case of a failure to make a report required under section 1202(d)(1)(C) which contains the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing to make such report, an amount equal to \$50 for each report with respect to which there was such a failure. In the case of any failure due to negligence or intentional disregard, the preceding sentence shall be applied by substituting “\$100” for “\$50”. In the case of a report covering periods in 2 or more years, the penalty determined under preceding provisions of this subsection shall be multiplied by the number of such years. No penalty shall be im-

posed under this subsection on any failure which is shown to be due to reasonable cause and not willful neglect.

(l) FAILURE TO FILE RETURN WITH RESPECT TO CERTAIN CORPORATE TRANSACTIONS.—In the case of any failure to make a return required under section 6043(c) containing the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing to file such return, an amount equal to \$500 for each day during which such failure continues, but the total amount imposed under this subsection with respect to any return shall not exceed \$100,000.

(m) ALCOHOL AND TOBACCO TAXES FOR PENALTIES FOR FAILURE TO FILE CERTAIN INFORMATION RETURNS.—with respect to alcohol and tobacco taxes, see, generally, subtitle E.

(n) FAILURE TO MAKE REPORTS REQUIRED UNDER SECTIONS 3511, 6053(C)(8), AND 7705.—In the case of a failure to make a report required under section 3511, 6053(c)(8), or 7705 which contains the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing to make such report, an amount equal to \$50 for each report with respect to which there was such a failure. In the case of any failure due to negligence or intentional disregard the preceding sentence shall be applied by substituting “\$100” for “\$50”.

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter C—General Provisions

SEC. 9831. GENERAL EXCEPTIONS.

(a) EXCEPTION FOR CERTAIN PLANS.—The requirements of this chapter shall not apply to—

- (1) any governmental plan, and
- (2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(1).

(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(2) if the benefits—

(A) are provided under a separate policy, certificate, or contract of insurance; or

(B) are otherwise not an integral part of the plan.

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(3) if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

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TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

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Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST- SHARING REDUCTIONS

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Subpart B—Eligibility Determinations

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) **ESTABLISHMENT OF PROGRAM.**—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) **INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.**—

(1) **IN GENERAL.**—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an “enrollee”); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) **CITIZENSHIP OR IMMIGRATION STATUS.**—The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) **ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.**—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under sec-

tion 36B of such Code or section 1402 is being claimed, the following information:

(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(1)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status

as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) CITIZENSHIP OR IMMIGRATION STATUS.—

(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) INFORMATION.—The information described in clause (i) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) METHODS.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall

provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary

shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) SPECIFIC ACTIONS NOT INVOLVING CITIZENSHIP OR LAWFUL PRESENCE.—

(i) IN GENERAL.—Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) ELIGIBILITY OR AMOUNT OF CREDIT OR REDUCTION.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) EMPLOYER AFFORDABILITY.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of such Code.

(iv) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(C) APPEALS PROCESS.—The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) APPEALS AND REDETERMINATIONS.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) EMPLOYER LIABILITY.—

(A) IN GENERAL.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) CONFIDENTIALITY.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information

with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—

(1) IN GENERAL.—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) RECEIPT OF INFORMATION.—Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) PENALTIES.—

(1) FALSE OR FRAUDULENT INFORMATION.—

(A) CIVIL PENALTY.—

(i) IN GENERAL.—If—

(I) any person fails to provide correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms "negligence" and "disregard" shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) KNOWING AND WILLFUL VIOLATIONS.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$250,000.

(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000.

(3) LIMITATIONS ON LIENS AND LEVIES.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) REPORT.—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

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EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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SUBTITLE B—REGULATORY PROVISIONS

* * * * *

PART 6—CONTINUATION COVERAGE AND ADDITIONAL STANDARDS
FOR GROUP HEALTH PLANS

* * * * *

SEC. 607. DEFINITIONS AND SPECIAL RULES.

For purposes of this part—

(1) **GROUP HEALTH PLAN.**—The term “group health plan” means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code).

(2) **COVERED EMPLOYEE.**—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986).

(3) **QUALIFIED BENEFICIARY.**—

(A) **IN GENERAL.**—The term “qualified beneficiary” means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

- (i) as the spouse of the covered employee, or
- (ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this part.

(B) **SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.**—In the case of a qualifying event described in section 603(2), the term “qualified beneficiary” includes the covered employee.

(C) **SPECIAL RULE FOR RETIREES AND WIDOWS.**—In the case of a qualifying event described in section 603(6), the term “qualified beneficiary” includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

- (i) as the spouse of the covered employee,
- (ii) as the dependent child of the employee, or
- (iii) as the surviving spouse of the covered employee.

(4) **EMPLOYER.**—Subsection (n) (relating to leased employees) and subsection (t) (relating to application of controlled group rules to certain employee benefits) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of this part in the same manner and to the same extent as such subsections apply for purposes of section 106 of such Code. Any regulations prescribed by the Secretary pursuant to the preceding sentence shall be consistent and coextensive with any regulations prescribed for similar purposes by the Secretary of

the Treasury (or such Secretary's delegate) under such subsections.

(5) OPTIONAL EXTENSION OF REQUIRED PERIODS.—A group health plan shall not be treated as failing to meet the requirements of this part solely because the plan provides both—

(A) that the period of extended coverage referred to in section 602(2) commences with the date of the loss of coverage, and

(B) that the applicable notice period provided under section 606(a)(2) commences with the date of the loss of coverage.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART C—GENERAL PROVISIONS

* * * * *

SEC. 733. DEFINITIONS.

(a) GROUP HEALTH PLAN.—For purposes of this part—

(1) IN GENERAL.—The term “group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) MEDICAL CARE.—The term “medical care” means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this part—

(1) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) 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.

(2) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term “health maintenance organization” means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term “group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(c) EXCEPTED BENEFITS.—For purposes of this part, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers’ compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—For purposes of this part—

(1) COBRA CONTINUATION PROVISION.—The term “COBRA continuation provision” means any of the following:

(A) Part 6 of this subtitle.

(B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(C) Title XXII of the Public Health Service Act.

(2) HEALTH STATUS-RELATED FACTOR.—The term “health status-related factor” means any of the factors described in section 702(a)(1).

(3) NETWORK PLAN.—The term “network plan” means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(4) PLACED FOR ADOPTION.—The term “placement”, or being “placed”, for adoption, has the meaning given such term in section 609(c)(3)(B).

(5) FAMILY MEMBER.—The term “family member” means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 701(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) GENETIC INFORMATION.—

(A) IN GENERAL.—The term “genetic information” means, with respect to any individual, information about—

(i) such individual’s genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term “genetic information” shall not include information about the sex or age of any individual.

(7) GENETIC TEST.—

(A) IN GENERAL.—The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term “genetic test” does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate

training and expertise in the field of medicine involved.

- (8) GENETIC SERVICES.—The term “genetic services” means—
 - (A) a genetic test;
 - (B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or
 - (C) genetic education.

- (9) UNDERWRITING PURPOSES.—The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

- (A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;
- (B) the computation of premium or contribution amounts under the plan or coverage;
- (C) the application of any pre-existing condition exclusion under the plan or coverage; and
- (D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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PUBLIC HEALTH SERVICE ACT

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TITLE XXII—REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES

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SEC. 2208. DEFINITIONS.

For purposes of this title—

- (1) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term in 5000(b) of the Internal Revenue Code of 1986. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code).

- (2) COVERED EMPLOYEE.—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986).

- (3) QUALIFIED BENEFICIARY.—

- (A) IN GENERAL.—The term “qualified beneficiary” means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

- (i) as the spouse of the covered employee, or
- (ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this title.

(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 2203(2), the term “qualified beneficiary” includes the covered employee.

(4) PLAN ADMINISTRATOR.—The term “plan administrator” has the meaning given the term “administrator” by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

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TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

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PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 2791. DEFINITIONS.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—The term “group health plan” means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) MEDICAL CARE.—The term “medical care” means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) 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.

(2) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organi-

zation, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term “health maintenance organization” means—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term “group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) EXCEPTED BENEFITS.—For purposes of this title, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers’ compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Se-

curity Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—

(1) APPLICABLE STATE AUTHORITY.—The term “applicable State authority” means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) BENEFICIARY.—The term “beneficiary” has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

(3) BONA FIDE ASSOCIATION.—The term “bona fide association” means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA CONTINUATION PROVISION.—The term “COBRA continuation provision” means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of such Act.

(C) Title XXII of this Act.

(5) EMPLOYEE.—The term “employee” has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(6) EMPLOYER.—The term “employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

(7) CHURCH PLAN.—The term “church plan” has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(8) GOVERNMENTAL PLAN.—(A) The term “governmental plan” has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

(B) FEDERAL GOVERNMENTAL PLAN.—The term “Federal governmental plan” means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) NON-FEDERAL GOVERNMENTAL PLAN.—The term “non-Federal governmental plan” means a governmental plan that is not a Federal governmental plan.

(9) HEALTH STATUS-RELATED FACTOR.—The term “health status-related factor” means any of the factors described in section 2702(a)(1).

(10) NETWORK PLAN.—The term “network plan” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) PARTICIPANT.—The term “participant” has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(12) PLACED FOR ADOPTION DEFINED.—The term “placement”, or being “placed”, for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement with such person terminates upon the termination of such legal obligation.

(13) PLAN SPONSOR.—The term “plan sponsor” has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(14) STATE.—The term “State” means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) FAMILY MEMBER.—The term “family member” means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 2701(f)(2)) of such individual; and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(16) GENETIC INFORMATION.—

(A) IN GENERAL.—The term “genetic information” means, with respect to any individual, information about—

(i) such individual’s genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

- (C) EXCLUSIONS.—The term “genetic information” shall not include information about the sex or age of any individual.
- (17) GENETIC TEST.—
- (A) IN GENERAL.—The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.
- (B) EXCEPTIONS.—The term “genetic test” does not mean—
- (i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
 - (ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
- (18) GENETIC SERVICES.—The term “genetic services” means—
- (A) a genetic test;
 - (B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or
 - (C) genetic education.
- (19) UNDERWRITING PURPOSES.—The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—
- (A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;
 - (B) the computation of premium or contribution amounts under the plan or coverage;
 - (C) the application of any pre-existing condition exclusion under the plan or coverage; and
 - (D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.
- (20) QUALIFIED HEALTH PLAN.—The term “qualified health plan” has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.
- (21) EXCHANGE.—The term “Exchange” means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.
- (e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—For purposes of this title:
- (1) INDIVIDUAL MARKET.—
- (A) IN GENERAL.—The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.
- (B) TREATMENT OF VERY SMALL GROUPS.—
- (i) IN GENERAL.—Subject to clause (ii), such terms includes coverage offered in connection with a group

health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) LARGE EMPLOYER.—The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) LARGE GROUP MARKET.—The term “large group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) SMALL EMPLOYER.—The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(5) SMALL GROUP MARKET.—The term “small group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(7) STATE OPTION TO EXTEND DEFINITION OF SMALL EMPLOYER.—Notwithstanding paragraphs (2) and (4), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

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B. CHANGES IN EXISTING LAW PROPOSED BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter A—Determination of Tax Liability

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PART IV—CREDITS AGAINST TAX

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Subpart C—Refundable Credits

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SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) **IN GENERAL.**—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

(b) **PREMIUM ASSISTANCE CREDIT AMOUNT.**—For purposes of this section—

(1) **IN GENERAL.**—The term “premium assistance credit amount” means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(2) **PREMIUM ASSISTANCE AMOUNT.**—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of—

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

(A) APPLICABLE PERCENTAGE.—

(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

In the case of household income (expressed as a percent of poverty line) within the following income tier.	The initial premium percentage is--	The final premium percentage is--
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

(ii) INDEXING.—

(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

(III) FAILSAFE.—Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides—

(I) self-only coverage in the case of an applicable taxpayer—

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) ADDITIONAL BENEFITS.—If—

(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers

benefits in addition to the essential health benefits required to be provided by the plan, or

(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii) (I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

(1) APPLICABLE TAXPAYER.—

(A) IN GENERAL.—The term “applicable taxpayer” means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer’s spouse file a joint return for the taxable year.

(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable

to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(2) **COVERAGE MONTH.**—For purposes of this subsection—

(A) **IN GENERAL.**—The term “coverage month” means, with respect to an applicable taxpayer, any month if—

(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

(B) **EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.**—

(i) **IN GENERAL.**—The term “coverage month” shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) **MINIMUM ESSENTIAL COVERAGE.**—The term “minimum essential coverage” has the meaning given such term by section 5000A(f).

(C) **SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.**—For purposes of subparagraph (B)—

(i) **COVERAGE MUST BE AFFORDABLE.**—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) **COVERAGE MUST PROVIDE MINIMUM VALUE.**—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

(iii) **EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.**—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eli-

gible employer-sponsored plan or the grandfathered health plan.

(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) DEFINITIONS AND OTHER RULES.—

(A) QUALIFIED HEALTH PLAN.—The term “qualified health plan” has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) GRANDFATHERED HEALTH PLAN.—The term “grandfathered health plan” has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(4) SPECIAL RULES FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

(A) IN GENERAL.—*The term “coverage month” shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health reimbursement arrangement which constitutes affordable coverage.*

(B) DENIAL OF DOUBLE BENEFIT.—*In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.*

(C) AFFORDABLE COVERAGE.—*For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if—*

(i) the excess of—

(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market, over

(II) $\frac{1}{12}$ of the employee’s permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

(ii) $\frac{1}{12}$ of 9.5 percent of the employee’s household income.

(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—*For purposes of this paragraph, the term “qualified small employer health reimbursement arrangement” has the meaning given such term by section 9831(d)(2).*

(E) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (C)(i)(II) shall be applied by substituting “the number of months during the year for which such arrangement was provided” for “12”.

(F) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) HOUSEHOLD INCOME.—

(A) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer’s family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) MODIFIED ADJUSTED GROSS INCOME.—The term “modified adjusted gross income” means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer’s social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) POVERTY LINE.—

(A) IN GENERAL.—The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to al-

lowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) **LAWFULLY PRESENT.**—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) **SECRETARIAL AUTHORITY.**—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) **RECONCILIATION OF CREDIT AND ADVANCE CREDIT.**—

(1) **IN GENERAL.**—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) **EXCESS ADVANCE PAYMENTS.**—

(A) **IN GENERAL.**—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) **LIMITATION ON INCREASE.**—

(i) **IN GENERAL.**—In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,500

(ii) **INDEXING OF AMOUNT.**—In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2013” for “calendar year 1992” in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(3) **INFORMATION REQUIREMENT.**—Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

(g) **REGULATIONS.**—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

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Subchapter B—Computation of Taxable Income

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PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

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SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

(a) **GENERAL RULE.**—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) **CONTRIBUTIONS TO ARCHER MSAS.**—

(1) **IN GENERAL.**—In the case of an employee who is an eligible individual, amounts contributed by such employee’s employer to any Archer MSA of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) **NO CONSTRUCTIVE RECEIPT.**—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

(3) **SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.**—Any employer contribution to an Archer MSA, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(4) **EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.**—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the Archer MSAs of such individual or such individual’s spouse for such taxable year.

(5) **MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.**—Paragraph (1) shall not apply for purposes of section 4980B.

(6) **DEFINITIONS.**—For purposes of this subsection, the terms “eligible individual” and “Archer MSA” have the respective meanings given to such terms by section 220.

(7) **CROSS REFERENCE.**—For penalty on failure by employer to make comparable contributions to the Archer MSAs of comparable employees, see section 4980E.

(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—Gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

(d) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account (as defined in section 223(d)) of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

(3) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.

(e) FSA AND HRA TERMINATIONS TO FUND HSAS.—

(1) IN GENERAL.—A plan shall not fail to be treated as a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because such plan provides for a qualified HSA distribution.

(2) QUALIFIED HSA DISTRIBUTION.—The term "qualified HSA distribution" means a distribution from a health flexible spending arrangement or health reimbursement arrangement to the extent that such distribution—

(A) does not exceed the lesser of the balance in such arrangement on September 21, 2006, or as of the date of such distribution, and

(B) is contributed by the employer directly to the health savings account of the employee before January 1, 2012.

Such term shall not include more than 1 distribution with respect to any arrangement.

(3) ADDITIONAL TAX FOR FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(A) IN GENERAL.—If, at any time during the testing period, the employee is not an eligible individual, then the amount of the qualified HSA distribution—

(i) shall be includible in the gross income of the employee for the taxable year in which occurs the first month in the testing period for which such employee is not an eligible individual, and

(ii) the tax imposed by this chapter for such taxable year on the employee shall be increased by 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Clauses (i) and (ii) of subparagraph (A) shall not apply if the employee ceases to be an eligible individual by reason of the death of the employee or the employee becoming disabled (within the meaning of section 72(m)(7)).

(4) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) TESTING PERIOD.—The term “testing period” means the period beginning with the month in which the qualified HSA distribution is contributed to the health savings account and ending on the last day of the 12th month following such month.

(B) ELIGIBLE INDIVIDUAL.—The term “eligible individual” has the meaning given such term by section 223(c)(1).

(C) TREATMENT AS ROLLOVER CONTRIBUTION.—A qualified HSA distribution shall be treated as a rollover contribution described in section 223(f)(5).

(5) TAX TREATMENT RELATING TO DISTRIBUTIONS.—For purposes of this title—

(A) IN GENERAL.—A qualified HSA distribution shall be treated as a payment described in subsection (d).

(B) COMPARABILITY EXCISE TAX.—

(i) IN GENERAL.—Except as provided in clause (ii), section 4980G shall not apply to qualified HSA distributions.

(ii) FAILURE TO OFFER TO ALL EMPLOYEES.—In the case of a qualified HSA distribution to any employee, the failure to offer such distribution to any eligible individual covered under a high deductible health plan of the employer shall (notwithstanding section 4980G(d)) be treated for purposes of section 4980G as a failure to meet the requirements of section 4980G(b).

(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(g) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for

medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).

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Subtitle D—Miscellaneous Excise Taxes

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CHAPTER 43—QUALIFIED PENSION, ETC., PLANS

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SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) **IMPOSITION OF TAX.**—If—

(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

(b) **EXCESS BENEFIT.**—For purposes of this section—

(1) **IN GENERAL.**—The term “excess benefit” means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

(2) **MONTHLY EXCESS AMOUNT.**—The excess amount determined under this paragraph for any month is the excess (if any) of—

(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

(B) an amount equal to $\frac{1}{12}$ of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

(3) **ANNUAL LIMITATION.**—For purposes of this subsection—

(A) **IN GENERAL.**—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

(B) **APPLICABLE ANNUAL LIMITATION.**—

(i) **IN GENERAL.**—Except as provided in clause (ii), the annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

(ii) **MULTIEMPLOYER PLAN COVERAGE.**—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.

(C) **APPLICABLE DOLLAR LIMIT.**—

(i) 2018.—In the case of 2018, the dollar limit under this subparagraph is—

(I) in the case of an employee with self-only coverage, \$10,200 multiplied by the health cost adjustment percentage (determined by only taking into account self-only coverage), and

(II) in the case of an employee with coverage other than self-only coverage, \$27,500 multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage).

(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over

(II) 55 percent.

(iii) AGE AND GENDER ADJUSTMENT.—

(I) IN GENERAL.—The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

(II) AMOUNT DETERMINED.—The amount determined under this subclause is an amount equal to the excess (if any) of—

(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over

(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

(iv) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

(I) the dollar amount in clause (i)(I) shall be increased by \$1,650, and

(II) the dollar amount in clause (i)(II) shall be increased by \$3,450,

(v) SUBSEQUENT YEARS.—In the case of any calendar year after 2018, each of the dollar amounts under clauses (i) (after the application of clause (ii)) and (iv)

shall be increased to the amount equal to such amount as determined for for the calendar year preceding such year, increased by an amount equal to the product of—

- (I) such amount as so determined, multiplied by
- (II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for “1992” in subparagraph (B) thereof), increased by 1 percentage point in the case of determinations for calendar years beginning before 2020.

If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

(c) LIABILITY TO PAY TAX.—

(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

(2) COVERAGE PROVIDER.—For purposes of this subsection, the term “coverage provider” means each of the following:

(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider’s applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

(A) IN GENERAL.—Each employer shall—

(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made

available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

(d) **APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.**—For purposes of this section—

(1) **APPLICABLE EMPLOYER-SPONSORED COVERAGE.**—

(A) **IN GENERAL.**—The term “applicable employer-sponsored coverage” means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

(B) **EXCEPTIONS.**—The term “applicable employer-sponsored coverage” shall not include—

(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care, or

(ii) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, or

(iii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

(C) **COVERAGE INCLUDES EMPLOYEE PAID PORTION.**—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

(D) **SELF-EMPLOYED INDIVIDUAL.**—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

(E) **GOVERNMENTAL PLANS INCLUDED.**—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

(2) **DETERMINATION OF COST.**—

(A) **IN GENERAL.**—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-spon-

sored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

- (i) the amount of employer contributions under any salary reduction election under the arrangement, plus
- (ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—*In the case of applicable employer-sponsored coverage consisting of coverage under any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)), the cost of coverage shall be equal to the amount described in section 6051(a)(15).*

[(D)] (E) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

(3) EMPLOYEE.—The term “employee” includes any former employee, surviving spouse, or other primary insured individual.

(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

(2) LIMITATIONS ON PENALTY.—

(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for

which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

(i) such failure was due to reasonable cause and not to willful neglect, and

(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) COVERAGE DETERMINATIONS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

(2) QUALIFIED RETIREE.—The term “qualified retiree” means any individual who—

(A) is receiving coverage by reason of being a retiree,

(B) has attained age 55, and

(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term “employees engaged in a high-risk profession” means law enforcement officers (as such term is defined in section 1204 of the Omnibus Crime Control and Safe Streets Act of 1968), employees in fire protection activities (as such term is defined in section 3(y) of the Fair Labor Standards Act of 1938), individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders), individuals whose primary work is longshore work (as defined in section 258(b) of the Immigration and Nationality Act (8 U.S.C. 1288(b)), determined without regard to paragraph (2) thereof), and individuals engaged in the con-

struction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession described in the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee's employment.

(4) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term by section 5000(b)(1). *Section 9831(d)(1) shall not apply for purposes of this section.*

(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

(A) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” has the meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

(B) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” has the meaning given such term by section 9832(b)(2).

(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term “person that administers the plan benefits” shall include the plan sponsor if the plan sponsor administers benefits under the plan.

(7) PLAN SPONSOR.—The term “plan sponsor” has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(8) TAXABLE PERIOD.—The term “taxable period” means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

(9) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

(10) DEDUCTIBILITY OF TAX.—Section 275(a)(6) shall not apply to the tax imposed by subsection (a).

(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart C—Information Regarding Wages Paid Employees

SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

- (1) the name of such person,
- (2) the name of the employee (and an identifying number for the employee if wages as defined in section 3121(a) have been paid),
- (3) the total amount of wages as defined in section 3401(a),
- (4) the total amount deducted and withheld as tax under section 3402,
- (5) the total amount of wages as defined in section 3121(a),
- (6) the total amount deducted and withheld as tax under section 3101,
- (8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),
- (9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),
- (10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned income as determined for purposes of section 32 (relating to earned income credit),
- (11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,
- (12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse,
- (13) the total amount of deferrals for the year under a non-qualified deferred compensation plan (within the meaning of section 409A(d)), **[and]**
- (14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—
 - (A) coverage to which paragraphs (11) and (12) apply, or
 - (B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125) **[.]**, and

(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee.

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) ADDITIONAL REQUIREMENTS.—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) STATEMENTS TO CONSTITUTE INFORMATION RETURNS.—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) RAILROAD EMPLOYEES.—

(1) ADDITIONAL REQUIREMENT.—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit

or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) INFORMATION TO BE SUPPLIED TO EMPLOYEES.—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.—

(1) STATEMENTS REQUIRED FROM PAYOR.—

(A) IN GENERAL.—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

(i) the name and, if there is withholding under section 3402(o), the social security number of such employee,

(ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and

(iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term “third-party sick pay” means any sick pay (as defined in section 3402(o)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(o)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

(A) the information shown on the statement furnished under paragraph (1)(A), and
 (B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable.
 To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

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CHAPTER 68—ADDITIONS TO THE TAX, ADDITIONAL AMOUNTS, AND ASSESSABLE PENALTIES

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Subchapter A—Additions to the Tax and Additional Amounts

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PART I—GENERAL PROVISIONS

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SEC. 6652. FAILURE TO FILE CERTAIN INFORMATION RETURNS, REGISTRATION STATEMENTS, ETC.

(a) RETURNS WITH RESPECT TO CERTAIN PAYMENTS AGGREGATING LESS THAN \$10.—In the case of each failure to file a statement of a payment to another person required under the authority of—

- (1) section 6042(a)(2) (relating to payments of dividends aggregating less than \$10), or
- (2) section 6044(a)(2) (relating to payments of patronage dividends aggregating less than \$10),

on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid (upon notice and demand by the Secretary and in the same manner as tax) by the person failing to so file the statement, \$1 for each such statement not so filed, but the total amount imposed on the delinquent person for all such failures during the calendar year shall not exceed \$1,000.

(b) FAILURE TO REPORT TIPS.—In the case of failure by an employee to report to his employer on the date and in the manner prescribed therefor any amount of tips required to be so reported by section 6053(a) which are wages (as defined in section 3121(a)) or which are compensation (as defined in section 3231(e)), unless it is shown that such failure is due to reasonable cause and not due to willful neglect, there shall be paid by the employee, in addition to the tax imposed by section 3101 or section 3201 (as the case may be) with respect to the amount of tips which he so failed to report, an amount equal to 50 percent of such tax.

(c) RETURNS BY EXEMPT ORGANIZATIONS AND BY CERTAIN TRUSTS.—

- (1) ANNUAL RETURNS UNDER SECTION 6033(A)(1) OR 6012(A)(6).—

(A) PENALTY ON ORGANIZATION.—In the case of—

(i) a failure to file a return required under section 6033(a)(1) (relating to returns by exempt organizations) or section 6012(a)(6) (relating to returns by political organizations) on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing), or

(ii) a failure to include any of the information required to be shown on a return filed under section 6033(a)(1) or section 6012(a)(6) or to show the correct information,

there shall be paid by the exempt organization \$20 for each day during which such failure continues. The maximum penalty under this subparagraph on failures with respect to any 1 return shall not exceed the lesser of \$10,000 or 5 percent of the gross receipts of the organization for the year. In the case of an organization having gross receipts exceeding \$1,000,000 for any year, with respect to the return required under section 6033(a)(1) or section 6012(a)(6) for such year, in applying the first sentence of this subparagraph, the amount of the penalty for each day during which a failure continues shall be \$100 in lieu of the amount otherwise specified, and, in lieu of applying the second sentence of this subparagraph, the maximum penalty under this subparagraph shall not exceed \$50,000.

(B) MANAGERS.—

(i) IN GENERAL.—The Secretary may make a written demand on any organization subject to penalty under subparagraph (A) specifying therein a reasonable future date by which the return shall be filed (or the information furnished) for purposes of this subparagraph.

(ii) FAILURE TO COMPLY WITH DEMAND.—If any person fails to comply with any demand under clause (i) on or before the date specified in such demand, there shall be paid by the person failing to so comply \$10 for each day after the expiration of the time specified in such demand during which such failure continues. The maximum penalty imposed under this subparagraph on all persons for failures with respect to any 1 return shall not exceed \$5,000.

(C) PUBLIC INSPECTION OF ANNUAL RETURNS AND REPORTS.—In the case of a failure to comply with the requirements of section 6104(d) with respect to any annual return on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing) or report required under section 527(j), there shall be paid by the person failing to meet such requirements \$20 for each day during which such failure continues. The maximum penalty imposed under this subparagraph on all persons for failures with respect to any 1 return or report shall not exceed \$10,000.

(D) PUBLIC INSPECTION OF APPLICATIONS FOR EXEMPTION AND NOTICE OF STATUS.—In the case of a failure to comply

with the requirements of section 6104(d) with respect to any exempt status application materials (as defined in such section) or notice materials (as defined in such section) on the date and in the manner prescribed therefor, there shall be paid by the person failing to meet such requirements \$20 for each day during which such failure continues.

(E) NO PENALTY FOR CERTAIN ANNUAL NOTICES.—This paragraph shall not apply with respect to any notice required under section 6033(i).

(2) RETURNS UNDER SECTION 6034 OR 6043(B).—

(A) PENALTY ON ORGANIZATION OR TRUST.—In the case of a failure to file a return required under section 6034 (relating to returns by certain trusts) or section 6043(b) (relating to terminations, etc., of exempt organizations), on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing), there shall be paid by the exempt organization or trust failing so to file \$10 for each day during which such failure continues, but the total amount imposed under this subparagraph on any organization or trust for failure to file any 1 return shall not exceed \$5,000.

(B) MANAGERS.—The Secretary may make written demand on an organization or trust failing to file under subparagraph (A) specifying therein a reasonable future date by which such filing shall be made for purposes of this subparagraph. If such filing is not made on or before such date, there shall be paid by the person failing so to file \$10 for each day after the expiration of the time specified in the written demand during which such failure continues, but the total amount imposed under this subparagraph on all persons for failure to file any 1 return shall not exceed \$5,000.

(C) SPLIT-INTEREST TRUSTS.—In the case of a trust which is required to file a return under section 6034(a), subparagraphs (A) and (B) of this paragraph shall not apply and paragraph (1) shall apply in the same manner as if such return were required under section 6033, except that—

(i) the 5 percent limitation in the second sentence of paragraph (1)(A) shall not apply,

(ii) in the case of any trust with gross income in excess of \$250,000, in applying the first sentence of paragraph (1)(A), the amount of the penalty for each day during which a failure continues shall be \$100 in lieu of the amount otherwise specified, and in lieu of applying the second sentence of paragraph (1)(A), the maximum penalty under paragraph (1)(A) shall not exceed \$50,000, and

(iii) the third sentence of paragraph (1)(A) shall be disregarded.

In addition to any penalty imposed on the trust pursuant to this subparagraph, if the person required to file such return knowingly fails to file the return, such penalty shall also be imposed on such person who shall be personally liable for such penalty.

(3) DISCLOSURE UNDER SECTION 6033(A)(2).—

(A) PENALTY ON ENTITIES.—In the case of a failure to file a disclosure required under section 6033(a)(2), there shall be paid by the tax-exempt entity (the entity manager in the case of a tax-exempt entity described in paragraph (4), (5), (6), or (7) of section 4965(c)) \$100 for each day during which such failure continues. The maximum penalty under this subparagraph on failures with respect to any 1 disclosure shall not exceed \$50,000.

(B) WRITTEN DEMAND.—

(i) IN GENERAL.—The Secretary may make a written demand on any entity or manager subject to penalty under subparagraph (A) specifying therein a reasonable future date by which the disclosure shall be filed for purposes of this subparagraph.

(ii) FAILURE TO COMPLY WITH DEMAND.—If any entity or manager fails to comply with any demand under clause (i) on or before the date specified in such demand, there shall be paid by such entity or manager failing to so comply \$100 for each day after the expiration of the time specified in such demand during which such failure continues. The maximum penalty imposed under this subparagraph on all entities and managers for failures with respect to any 1 disclosure shall not exceed \$10,000.

(C) DEFINITIONS.—Any term used in this section which is also used in section 4965 shall have the meaning given such term under section 4965.

(4) NOTICES UNDER SECTION 506.—

(A) PENALTY ON ORGANIZATION.—In the case of a failure to submit a notice required under section 506(a) (relating to organizations required to notify Secretary of intent to operate as 501(c)(4)) on the date and in the manner prescribed therefor, there shall be paid by the organization failing to so submit \$20 for each day during which such failure continues, but the total amount imposed under this subparagraph on any organization for failure to submit any one notice shall not exceed \$5,000.

(B) MANAGERS.—The Secretary may make written demand on an organization subject to penalty under subparagraph (A) specifying in such demand a reasonable future date by which the notice shall be submitted for purposes of this subparagraph. If such notice is not submitted on or before such date, there shall be paid by the person failing to so submit \$20 for each day after the expiration of the time specified in the written demand during which such failure continues, but the total amount imposed under this subparagraph on all persons for failure to submit any one notice shall not exceed \$5,000.

(5) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under this subsection with respect to any failure if it is shown that such failure is due to reasonable cause.

(6) OTHER SPECIAL RULES.—

(A) TREATMENT AS TAX.—Any penalty imposed under this subsection shall be paid on notice and demand of the Secretary and in the same manner as tax.

(B) JOINT AND SEVERAL LIABILITY.—If more than 1 person is liable under this subsection for any penalty with respect to any failure, all such persons shall be jointly and severally liable with respect to such failure.

(C) PERSON.—For purposes of this subsection, the term “person” means any officer, director, trustee, employee, or other individual who is under a duty to perform the act in respect of which the violation occurs.

(7) ADJUSTMENT FOR INFLATION.—

(A) IN GENERAL.—In the case of any failure relating to a return required to be filed in a calendar year beginning after 2014, each of the dollar amounts under paragraphs (1), (2), and (3) shall be increased by such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) determined by substituting “calendar year 2013” for “calendar year 1992” in subparagraph (B) thereof.

(B) ROUNDING.—If any amount adjusted under subparagraph (A)—

(i) is not less than \$5,000 and is not a multiple of \$500, such amount shall be rounded to the next lowest multiple of \$500, and

(ii) is not described in clause (i) and is not a multiple of \$5, such amount shall be rounded to the next lowest multiple of \$5.

(d) ANNUAL REGISTRATION AND OTHER NOTIFICATION BY PENSION PLAN.—

(1) REGISTRATION.—In the case of any failure to file a registration statement required under section 6057(a) (relating to annual registration of certain plans) which includes all participants required to be included in such statement, on the date prescribed therefor (determined without regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing so to file, an amount equal to \$1 for each participant with respect to whom there is a failure to file, multiplied by the number of days during which such failure continues, but the total amount imposed under this paragraph on any person for any failure to file with respect to any plan year shall not exceed \$5,000.

(2) NOTIFICATION OF CHANGE OF STATUS.—In the case of failure to file a notification required under section 6057(b) (relating to notification of change of status) on the date prescribed therefor (determined without regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing so to file, \$1 for each day during which such failure continues, but the total amounts imposed under this paragraph on any person for failure to file any notification shall not exceed \$1,000.

(e) INFORMATION REQUIRED IN CONNECTION WITH CERTAIN PLANS OF DEFERRED COMPENSATION, ETC.—In the case of failure to file a return or statement required under section 6058 (relating to information required in connection with certain plans of deferred compensation), 6047 (relating to information relating to certain trusts and annuity and bond purchase plans), or 6039D (relating to returns and records with respect to certain fringe benefit plans) on the date and in the manner prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing so to file, \$25 for each day during which such failure continues, but the total amount imposed under this subsection on any person for failure to file any return shall not exceed \$15,000. This subsection shall not apply to any return or statement which is an information return described in section 6724(d)(1)(C)(ii) or a payee statement described in section 6724(d)(2)(Y).

(f) RETURNS REQUIRED UNDER SECTION 6039C.—

(1) IN GENERAL.—In the case of each failure to make a return required by section 6039C which contains the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause and not to willful neglect, the amount determined under paragraph (2) shall be paid (upon notice and demand by the Secretary and in the same manner as tax) by the person failing to make such return.

(2) AMOUNT OF PENALTY.—For purposes of paragraph (1), the amount determined under this paragraph with respect to any failure shall be \$25 for each day during which such failure continues.

(3) LIMITATION.—The amount determined under paragraph (2) with respect to any person for failing to meet the requirements of section 6039C for any calendar year shall not exceed the lesser of—

(A) \$25,000, or

(B) 5 percent of the aggregate of the fair market value of the United States real property interests owned by such person at any time during such year.

For purposes of the preceding sentence, fair market value shall be determined as of the end of the calendar year (or, in the case of any property disposed of during the calendar year, as of the date of such disposition).

(h) FAILURE TO GIVE NOTICE TO RECIPIENTS OF CERTAIN PENSION, ETC., DISTRIBUTIONS.—In the case of each failure to provide notice as required by section 3405(e)(10)(B), at the time prescribed therefor, unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such notice, an amount equal to \$10 for each such failure, but the total amount imposed on such person for all such failures during any calendar year shall not exceed \$5,000.

(i) FAILURE TO GIVE WRITTEN EXPLANATION TO RECIPIENTS OF CERTAIN QUALIFYING ROLLOVER DISTRIBUTIONS.—In the case of

each failure to provide a written explanation as required by section 402(f), at the time prescribed therefor, unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such written explanation, an amount equal to \$100 for each such failure, but the total amount imposed on such person for all such failures during any calendar year shall not exceed \$50,000.

(j) FAILURE TO FILE CERTIFICATION WITH RESPECT TO CERTAIN RESIDENTIAL RENTAL PROJECTS.—In the case of each failure to provide a certification as required by section 142(d)(7) at the time prescribed therefor, unless it is shown that such failure is due to reasonable cause and not to willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such certification, an amount equal to \$100 for each such failure.

(k) FAILURE TO MAKE REPORTS REQUIRED UNDER SECTION 1202.—

In the case of a failure to make a report required under section 1202(d)(1)(C) which contains the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing to make such report, an amount equal to \$50 for each report with respect to which there was such a failure. In the case of any failure due to negligence or intentional disregard, the preceding sentence shall be applied by substituting “\$100” for “\$50”. In the case of a report covering periods in 2 or more years, the penalty determined under preceding provisions of this subsection shall be multiplied by the number of such years. No penalty shall be imposed under this subsection on any failure which is shown to be due to reasonable cause and not willful neglect.

(l) FAILURE TO FILE RETURN WITH RESPECT TO CERTAIN CORPORATE TRANSACTIONS.—In the case of any failure to make a return required under section 6043(c) containing the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing to file such return, an amount equal to \$500 for each day during which such failure continues, but the total amount imposed under this subsection with respect to any return shall not exceed \$100,000.

(m) ALCOHOL AND TOBACCO TAXES FOR PENALTIES FOR FAILURE TO FILE CERTAIN INFORMATION RETURNS.—with respect to alcohol and tobacco taxes, see, generally, subtitle E.

(n) FAILURE TO MAKE REPORTS REQUIRED UNDER SECTIONS 3511, 6053(C)(8), AND 7705.—In the case of a failure to make a report required under section 3511, 6053(c)(8), or 7705 which contains the information required by such section on the date prescribed therefor (determined with regard to any extension of time for filing), there shall be paid (on notice and demand by the Secretary and in the same manner as tax) by the person failing to make such report, an amount equal to \$50 for each report with respect to which there was such a failure. In the case of any failure due to negligence or

intentional disregard the preceding sentence shall be applied by substituting “\$100” for “\$50”.

(o) FAILURE TO PROVIDE NOTICES WITH RESPECT TO QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—In the case of each failure to provide a written notice as required by section 9831(d)(4), unless it is shown that such failure is due to reasonable cause and not willful neglect, there shall be paid, on notice and demand of the Secretary and in the same manner as tax, by the person failing to provide such written notice, an amount equal to \$50 per employee per incident of failure to provide such notice, but the total amount imposed on such person for all such failures during any calendar year shall not exceed \$2,500.

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Subtitle K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

* * * * *

Subchapter C—General Provisions

SEC. 9831. GENERAL EXCEPTIONS.

(a) EXCEPTION FOR CERTAIN PLANS.—The requirements of this chapter shall not apply to—

- (1) any governmental plan, and
- (2) any group health plan for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees.

(b) EXCEPTION FOR CERTAIN BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(1).

(c) EXCEPTION FOR CERTAIN BENEFITS IF CERTAIN CONDITIONS MET.—

(1) LIMITED, EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(2) if the benefits—

- (A) are provided under a separate policy, certificate, or contract of insurance; or
- (B) are otherwise not an integral part of the plan.

(2) NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(3) if all of the following conditions are met:

- (A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

(3) SUPPLEMENTAL EXCEPTED BENEFITS.—The requirements of this chapter shall not apply to any group health plan in relation to its provision of excepted benefits described in section 9832(c)(4) if the benefits are provided under a separate policy, certificate, or contract of insurance.

(d) EXCEPTION FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

(1) IN GENERAL.—For purposes of this title (except as provided in section 4980I(f)(4) and notwithstanding any other provision of this title), the term “group health plan” shall not include any qualified small employer health reimbursement arrangement.

(2) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this subsection—

(A) IN GENERAL.—The term “qualified small employer health reimbursement arrangement” means an arrangement which—

(i) is described in subparagraph (B), and

(ii) is provided on the same terms to all eligible employees of the eligible employer.

(B) ARRANGEMENT DESCRIBED.—An arrangement is described in this subparagraph if—

(i) such arrangement is funded solely by an eligible employer and no salary reduction contributions may be made under such arrangement,

(ii) such arrangement provides, after the employee provides proof of coverage, for the payment of, or reimbursement of, an eligible employee for expenses for medical care (as defined in section 213(d)) incurred by the eligible employee or the eligible employee’s family members (as determined under the terms of the arrangement), and

(iii) the amount of payments and reimbursements described in clause (ii) for any year do not exceed \$5,130 (\$10,260 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee).

(C) CERTAIN VARIATION PERMITTED.—For purposes of subparagraph (A)(ii), an arrangement shall not fail to be treated as provided on the same terms to each eligible employee merely because the employee’s permitted benefits under such arrangement vary in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on—

(i) the age of the eligible employee (and, in the case of an arrangement which covers medical expenses of the eligible employee’s family members, the age of such family members), or

(ii) the number of family members of the eligible employee the medical expenses of which are covered under such arrangement.

The variation permitted under the preceding sentence shall be determined by reference to the same insurance policy with respect to all eligible employees.

(D) RULES RELATING TO MAXIMUM DOLLAR LIMITATION.—

(i) AMOUNT PRORATED IN CERTAIN CASES.—In the case of an individual who is not covered by an arrangement for the entire year, the limitation under subparagraph (A)(iii) for such year shall be an amount which bears the same ratio to the amount which would (but for this clause) be in effect for such individual for such year under subparagraph (A)(iii) as the number of months for which such individual is covered by the arrangement for such year bears to 12.

(ii) INFLATION ADJUSTMENT.—In the case of any year beginning after 2016, each of the dollar amounts in subparagraph (A)(iii) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting “calendar year 2015” for “calendar year 1992” in subparagraph (B) thereof.

If any dollar amount increased under the preceding sentence is not a multiple of \$100, such dollar amount shall be rounded to the next lowest multiple of \$100.

(3) OTHER DEFINITIONS.—For purposes of this subsection—

(A) ELIGIBLE EMPLOYEE.—The term “eligible employee” means any employee of an eligible employer, except that the terms of the arrangement may exclude from consideration employees described in any clause of section 105(h)(3)(B) (applied by substituting “90 days” for “3 years” in clause (i) thereof).

(B) ELIGIBLE EMPLOYER.—The term “eligible employer” means an employer that—

(i) is not an applicable large employer as defined in section 4980H(c)(2), and

(ii) does not offer a group health plan to any of its employees.

(C) PERMITTED BENEFIT.—The term “permitted benefit” means, with respect to any eligible employee, the maximum dollar amount of payments and reimbursements which may be made under the terms of the qualified small employer health reimbursement arrangement for the year with respect to such employee.

(4) NOTICE.—

(A) IN GENERAL.—An employer funding a qualified small employer health reimbursement arrangement for any year shall, not later than 90 days before the beginning of such year (or, in the case of an employee who is not eligible to participate in the arrangement as of the beginning of such year, the date on which such employee is first so eligible),

provide a written notice to each eligible employee which includes the information described in subparagraph (B).

(B) CONTENTS OF NOTICE.—The notice required under subparagraph (A) shall include each of the following:

(i) A statement of the amount which would be such eligible employee’s permitted benefits under the arrangement for the year.

(ii) A statement that the eligible employee should provide the information described in clause (i) to any health insurance exchange to which the employee applies for advance payment of the premium assistance tax credit.

(iii) A statement that if the employee is not covered under minimum essential coverage for any month the employee may be subject to tax under section 5000A for such month and reimbursements under the arrangement may be includible in gross income.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

* * * * *

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

* * * * *

Subpart B—Eligibility Determinations

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen

or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an “enrollee”); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:

(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) CERTAIN INDIVIDUAL HEALTH INSURANCE POLICIES OBTAINED THROUGH SMALL EMPLOYERS.—*The amount of the enrollee's permitted benefit (as defined in section 9831(d)(3)(C) of the Internal Revenue Code of 1986) under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of such Code).*

[(B)] (C) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with

respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accord-

ance with the requirements of this subsection and subsection (d).

(2) CITIZENSHIP OR IMMIGRATION STATUS.—

(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) INFORMATION.—The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) METHODS.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary

of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility will be determined in the same manner as an individual's eligibility under the medicaid pro-

gram is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) SPECIFIC ACTIONS NOT INVOLVING CITIZENSHIP OR LAWFUL PRESENCE.—

(i) IN GENERAL.—Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) ELIGIBILITY OR AMOUNT OF CREDIT OR REDUCTION.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) EMPLOYER AFFORDABILITY.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact

and that the employer may be liable for the payment assessed under section 4980H of such Code.

(iv) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(C) APPEALS PROCESS.—The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(f) APPEALS AND REDETERMINATIONS.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) EMPLOYER LIABILITY.—

(A) IN GENERAL.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) CONFIDENTIALITY.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's income is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—

(1) IN GENERAL.—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) RECEIPT OF INFORMATION.—Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) PENALTIES.—

(1) FALSE OR FRAUDULENT INFORMATION.—

(A) CIVIL PENALTY.—

(i) IN GENERAL.—If—

(I) any person fails to provide correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms “negligence” and “disregard” shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) KNOWING AND WILLFUL VIOLATIONS.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$250,000.

(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000.

(3) LIMITATIONS ON LIENS AND LEVIES.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) REPORT.—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

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EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

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SUBTITLE B—REGULATORY PROVISIONS

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PART 6—CONTINUATION COVERAGE AND ADDITIONAL STANDARDS FOR GROUP HEALTH PLANS

* * * * *

SEC. 607. DEFINITIONS AND SPECIAL RULES.

For purposes of this part—

(1) GROUP HEALTH PLAN.—The term “group health plan” means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Internal Revenue Code of 1986) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include

any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code). *Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).*

(2) COVERED EMPLOYEE.—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986).

(3) QUALIFIED BENEFICIARY.—

(A) IN GENERAL.—The term “qualified beneficiary” means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

- (i) as the spouse of the covered employee, or
- (ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this part.

(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 603(2), the term “qualified beneficiary” includes the covered employee.

(C) SPECIAL RULE FOR RETIREES AND WIDOWS.—In the case of a qualifying event described in section 603(6), the term “qualified beneficiary” includes a covered employee who had retired on or before the date of substantial elimination of coverage and any other individual who, on the day before such qualifying event, is a beneficiary under the plan—

- (i) as the spouse of the covered employee,
- (ii) as the dependent child of the employee, or
- (iii) as the surviving spouse of the covered employee.

(4) EMPLOYER.—Subsection (n) (relating to leased employees) and subsection (t) (relating to application of controlled group rules to certain employee benefits) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of this part in the same manner and to the same extent as such subsections apply for purposes of section 106 of such Code. Any regulations prescribed by the Secretary pursuant to the preceding sentence shall be consistent and coextensive with any regulations prescribed for similar purposes by the Secretary of the Treasury (or such Secretary’s delegate) under such subsections.

(5) OPTIONAL EXTENSION OF REQUIRED PERIODS.—A group health plan shall not be treated as failing to meet the requirements of this part solely because the plan provides both—

- (A) that the period of extended coverage referred to in section 602(2) commences with the date of the loss of coverage, and

(B) that the applicable notice period provided under section 606(a)(2) commences with the date of the loss of coverage.

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PART 7—GROUP HEALTH PLAN REQUIREMENTS

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SUBPART C—GENERAL PROVISIONS

* * * * *

SEC. 733. DEFINITIONS.

(a) GROUP HEALTH PLAN.—For purposes of this part—

(1) IN GENERAL.—The term “group health plan” means an employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. *Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).*

(2) MEDICAL CARE.—The term “medical care” means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—For purposes of this part—

(1) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) 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.

(2) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2)). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term “health maintenance organization” means—

(A) a federally qualified health maintenance organization (as defined in section 1301(a) of the Public Health Service Act (42 U.S.C. 300e(a))),

- (B) an organization recognized under State law as a health maintenance organization, or
- (C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.
- (4) GROUP HEALTH INSURANCE COVERAGE.—The term “group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.
- (c) EXCEPTED BENEFITS.—For purposes of this part, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following:
- (1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—
- (A) Coverage only for accident, or disability income insurance, or any combination thereof.
- (B) Coverage issued as a supplement to liability insurance.
- (C) Liability insurance, including general liability insurance and automobile liability insurance.
- (D) Workers’ compensation or similar insurance.
- (E) Automobile medical payment insurance.
- (F) Credit-only insurance.
- (G) Coverage for on-site medical clinics.
- (H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—
- (A) Limited scope dental or vision benefits.
- (B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
- (C) Such other similar, limited benefits as are specified in regulations.
- (3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—
- (A) Coverage only for a specified disease or illness.
- (B) Hospital indemnity or other fixed indemnity insurance.
- (4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.
- (d) OTHER DEFINITIONS.—For purposes of this part—
- (1) COBRA CONTINUATION PROVISION.—The term “COBRA continuation provision” means any of the following:
- (A) Part 6 of this subtitle.
- (B) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.
- (C) Title XXII of the Public Health Service Act.

(2) HEALTH STATUS-RELATED FACTOR.—The term “health status-related factor” means any of the factors described in section 702(a)(1).

(3) NETWORK PLAN.—The term “network plan” means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(4) PLACED FOR ADOPTION.—The term “placement”, or being “placed”, for adoption, has the meaning given such term in section 609(c)(3)(B).

(5) FAMILY MEMBER.—The term “family member” means, with respect to an individual—

(A) a dependent (as such term is used for purposes of section 701(f)(2)) of such individual, and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(6) GENETIC INFORMATION.—

(A) IN GENERAL.—The term “genetic information” means, with respect to any individual, information about—

(i) such individual’s genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term “genetic information” shall not include information about the sex or age of any individual.

(7) GENETIC TEST.—

(A) IN GENERAL.—The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term “genetic test” does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(8) GENETIC SERVICES.—The term “genetic services” means—

(A) a genetic test;

- (B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or
 - (C) genetic education.
- (9) UNDERWRITING PURPOSES.—The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

- (A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;
- (B) the computation of premium or contribution amounts under the plan or coverage;
- (C) the application of any pre-existing condition exclusion under the plan or coverage; and
- (D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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PUBLIC HEALTH SERVICE ACT

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TITLE XXII—REQUIREMENTS FOR CERTAIN GROUP HEALTH PLANS FOR CERTAIN STATE AND LOCAL EMPLOYEES

* * * * *

SEC. 2208. DEFINITIONS.

For purposes of this title—

(1) **GROUP HEALTH PLAN.**—The term “group health plan” has the meaning given such term in 5000(b) of the Internal Revenue Code of 1986. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code). *Such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).*

(2) **COVERED EMPLOYEE.**—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for 1 or more persons maintaining the plan (including as an employee defined in section 401(c)(1) of the Internal Revenue Code of 1986).

(3) **QUALIFIED BENEFICIARY.**—

(A) **IN GENERAL.**—The term “qualified beneficiary” means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the plan—

- (i) as the spouse of the covered employee, or
- (ii) as the dependent child of the employee.

Such term shall also include a child who is born to or placed for adoption with the covered employee during the period of continuation coverage under this title.

(B) SPECIAL RULE FOR TERMINATIONS AND REDUCED EMPLOYMENT.—In the case of a qualifying event described in section 2203(2), the term “qualified beneficiary” includes the covered employee.

(4) PLAN ADMINISTRATOR.—The term “plan administrator” has the meaning given the term “administrator” by section 3(16)(A) of the Employee Retirement Income Security Act of 1974.

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TITLE XXVII—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

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PART C—DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 2791. DEFINITIONS.

(a) GROUP HEALTH PLAN.—

(1) DEFINITION.—The term “group health plan” means an employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2)) and including items and services paid for as medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. *Except for purposes of part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), such term shall not include any qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code of 1986).*

(2) MEDICAL CARE.—The term “medical care” means amounts paid for—

(A) the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,

(B) amounts paid for transportation primarily for and essential to medical care referred to in subparagraph (A), and

(C) amounts paid for insurance covering medical care referred to in subparagraphs (A) and (B).

(3) TREATMENT OF CERTAIN PLANS AS GROUP HEALTH PLAN FOR NOTICE PROVISION.—A program under which creditable coverage described in subparagraph (C), (D), (E), or (F) of section 2701(c)(1) is provided shall be treated as a group health plan for purposes of applying section 2701(e).

(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hos-

pital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

(2) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” means an insurance company, insurance service, or insurance organization (including a health maintenance organization, as defined in paragraph (3)) which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.

(3) HEALTH MAINTENANCE ORGANIZATION.—The term “health maintenance organization” means—

(A) a Federally qualified health maintenance organization (as defined in section 1301(a)),

(B) an organization recognized under State law as a health maintenance organization, or

(C) a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(4) GROUP HEALTH INSURANCE COVERAGE.—The term “group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.

(5) INDIVIDUAL HEALTH INSURANCE COVERAGE.—The term “individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(c) EXCEPTED BENEFITS.—For purposes of this title, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following:

(1) BENEFITS NOT SUBJECT TO REQUIREMENTS.—

(A) Coverage only for accident, or disability income insurance, or any combination thereof.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers’ compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for on-site medical clinics.

(H) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(2) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED SEPARATELY.—

(A) Limited scope dental or vision benefits.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Such other similar, limited benefits as are specified in regulations.

(3) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS INDEPENDENT, NONCOORDINATED BENEFITS.—

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) BENEFITS NOT SUBJECT TO REQUIREMENTS IF OFFERED AS SEPARATE INSURANCE POLICY.—Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, and similar supplemental coverage provided to coverage under a group health plan.

(d) OTHER DEFINITIONS.—

(1) APPLICABLE STATE AUTHORITY.—The term “applicable State authority” means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved with respect to such issuer.

(2) BENEFICIARY.—The term “beneficiary” has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974.

(3) BONA FIDE ASSOCIATION.—The term “bona fide association” means, with respect to health insurance coverage offered in a State, an association which—

(A) has been actively in existence for at least 5 years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

(D) makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

(E) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

(F) meets such additional requirements as may be imposed under State law.

(4) COBRA CONTINUATION PROVISION.—The term “COBRA continuation provision” means any of the following:

(A) Section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines.

(B) Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of such Act.

(C) Title XXII of this Act.

(5) EMPLOYEE.—The term “employee” has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974.

(6) EMPLOYER.—The term “employer” has the meaning given such term under section 3(5) of the Employee Retirement Income Security Act of 1974, except that such term shall include only employers of two or more employees.

(7) CHURCH PLAN.—The term “church plan” has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

(8) GOVERNMENTAL PLAN.—(A) The term “governmental plan” has the meaning given such term under section 3(32) of the Employee Retirement Income Security Act of 1974 and any Federal governmental plan.

(B) FEDERAL GOVERNMENTAL PLAN.—The term “Federal governmental plan” means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

(C) NON-FEDERAL GOVERNMENTAL PLAN.—The term “non-Federal governmental plan” means a governmental plan that is not a Federal governmental plan.

(9) HEALTH STATUS-RELATED FACTOR.—The term “health status-related factor” means any of the factors described in section 2702(a)(1).

(10) NETWORK PLAN.—The term “network plan” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(11) PARTICIPANT.—The term “participant” has the meaning given such term under section 3(7) of the Employee Retirement Income Security Act of 1974.

(12) PLACED FOR ADOPTION DEFINED.—The term “placement”, or being “placed”, for adoption, in connection with any placement for adoption of a child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child’s placement with such person terminates upon the termination of such legal obligation.

(13) PLAN SPONSOR.—The term “plan sponsor” has the meaning given such term under section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(14) STATE.—The term “State” means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(15) FAMILY MEMBER.—The term “family member” means, with respect to any individual—

(A) a dependent (as such term is used for purposes of section 2701(f)(2)) of such individual; and

(B) any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual or of an individual described in subparagraph (A).

(16) GENETIC INFORMATION.—

(A) IN GENERAL.—The term “genetic information” means, with respect to any individual, information about—

(i) such individual’s genetic tests,

(ii) the genetic tests of family members of such individual, and

(iii) the manifestation of a disease or disorder in family members of such individual.

(B) INCLUSION OF GENETIC SERVICES AND PARTICIPATION IN GENETIC RESEARCH.—Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual.

(C) EXCLUSIONS.—The term “genetic information” shall not include information about the sex or age of any individual.

(17) GENETIC TEST.—

(A) IN GENERAL.—The term “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes.

(B) EXCEPTIONS.—The term “genetic test” does not mean—

(i) an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or

(ii) an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(18) GENETIC SERVICES.—The term “genetic services” means—

(A) a genetic test;

(B) genetic counseling (including obtaining, interpreting, or assessing genetic information); or

(C) genetic education.

(19) UNDERWRITING PURPOSES.—The term “underwriting purposes” means, with respect to any group health plan, or health insurance coverage offered in connection with a group health plan—

(A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the plan or coverage;

(B) the computation of premium or contribution amounts under the plan or coverage;

(C) the application of any pre-existing condition exclusion under the plan or coverage; and

(D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(20) QUALIFIED HEALTH PLAN.—The term “qualified health plan” has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) EXCHANGE.—The term “Exchange” means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

(e) DEFINITIONS RELATING TO MARKETS AND SMALL EMPLOYERS.—For purposes of this title:

(1) INDIVIDUAL MARKET.—

(A) IN GENERAL.—The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) TREATMENT OF VERY SMALL GROUPS.—

(i) IN GENERAL.—Subject to clause (ii), such terms includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of a State that elects to regulate the coverage described in such clause as coverage in the small group market.

(2) LARGE EMPLOYER.—The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(3) LARGE GROUP MARKET.—The term “large group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer.

(4) SMALL EMPLOYER.—The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employees on the first day of the plan year.

(5) SMALL GROUP MARKET.—The term “small group market” means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

(6) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection—

(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(7) STATE OPTION TO EXTEND DEFINITION OF SMALL EMPLOYER.—Notwithstanding paragraphs (2) and (4), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar

year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

* * * * *

VII. EXCHANGE OF LETTERS WITH ADDITIONAL COMMITTEES OF REFERRAL

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DAVID STEWART,
STAFF DIRECTOR

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-0548
<http://waysandmeans.house.gov>

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JANICE MAYES,
MINORITY CHIEF COUNSEL

June 13, 2016

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

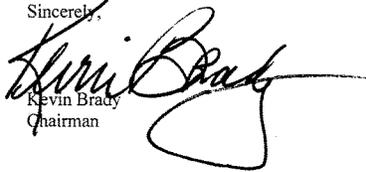
Dear Chairman Upton,

Thank you for your letter regarding H.R. 5447, to provide an exception from certain group health plan requirements for qualified small employer health reimbursement arrangements. As you noted, the Committee on Energy and Commerce was granted an additional referral of the bill.

I am most appreciative of your decision to waive formal consideration of H.R. 5447 so that it may proceed expeditiously to the House floor. I acknowledge that although you waived formal consideration of the bill, the Committee on Energy and Commerce is in no way waiving its jurisdiction over the subject matter contained in those provisions of the bill that fall within your Rule X jurisdiction. I would support your effort to seek appointment of an appropriate number of conferees on any House-Senate conference involving this legislation.

I will include a copy of our letters in the Congressional Record during consideration of this legislation on the House floor.

Sincerely,


Kevin Brady
Chairman

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225 2927
Minority (202) 225 3641

June 13, 2016

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady:

I write in regard to H.R. 5447, to provide an exception from certain group health plan requirements for qualified small employer health reimbursement arrangements, which was referred in addition to the Committee on Energy and Commerce. I wanted to notify you that the Committee will forgo action on H.R. 5447 so that it may proceed expeditiously to the House floor for consideration.

This is done with the understanding that the Committee on Energy and Commerce's jurisdictional interests over this and similar legislation are in no way diminished or altered. In addition, the Committee reserves the right to seek conferees on H.R. 5447 and requests your support when such a request is made.

I would appreciate your response confirming this understanding with respect to H.R. 5447 and ask that a copy of our exchange of letters on this matter be included in the Congressional Record during consideration of the bill on the House floor.

Sincerely,



Fred Upton
Chairman



COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2176 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

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June 21, 2016

The Honorable Kevin Brady
Chairman, Committee on Ways and Means
U. S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to confirm our mutual understanding with respect to H.R. 5447, the *Small Business Health Care Relief Act*. Thank you for consulting with the Committee on Education and the Workforce with regard to H.R. 5447 on those matters within the Committee's jurisdiction.

In the interest of expediting the House's consideration of H.R. 5447, the Committee on Education and the Workforce will forgo further consideration of this bill. However, I do so only with the understanding this procedural route will not be construed to prejudice my Committee's jurisdictional interest and prerogatives on this bill or any other similar legislation and will not be considered as precedent for consideration of matters of jurisdictional interest to my Committee in the future. Additionally, I appreciate your committee's assistance with any additional improvements to the bill within the jurisdiction of the Education and the Workforce Committee.

I respectfully request your support for the appointment of outside conferees from the Committee on Education and the Workforce should this bill or a similar bill be considered in a conference with the Senate. I also request you include our exchange of letters on this matter in the Committee Report on H.R. 5447 and in the Congressional Record during consideration of this bill on the House Floor. Thank you for your attention to these matters.

Sincerely,


JOHN KLINE
Chairman

Congress of the United States
U.S. House of Representatives
COMMITTEE ON WAYS AND MEANS
1102 LONGWORTH HOUSE OFFICE BUILDING
(202) 225-3625
Washington, DC 20515-0518
<http://waysandmeans.house.gov>

KEVIN BRADY, TEXAS,
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SAM JOHNSON, TEXAS
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LINDA SANCHEZ, CALIFORNIA

JANICE MAYES
MINORITY CHIEF COUNSEL

DAVID STEWART
STAFF DIRECTOR

June 21, 2016

The Honorable John Kline
Chairman
Committee on Education and the Workforce
2176 Rayburn House Office Building
Washington, D.C. 20515

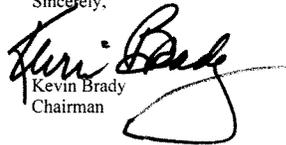
Dear Chairman Kline,

Thank you for your letter regarding H.R. 5447, the "Small Business Health Care Relief Act." As you noted, the Committee on Education and the Workforce was granted an additional referral of the bill.

I am most appreciative of your decision to waive formal consideration of H.R. 5447 so that it may proceed expeditiously to the House floor. I acknowledge that although you waived formal consideration of the bill, the Committee on Education and the Workforce is in no way waiving its jurisdiction over the subject matter contained in those provisions of the bill that fall within your Rule X jurisdiction. I would support your effort to seek appointment of an appropriate number of conferees on any House-Senate conference involving this legislation.

I will include a copy of our letters in the Congressional Record during consideration of this legislation on the House floor.

Sincerely,


Kevin Brady
Chairman

