

CO-OP CONSUMER PROTECTION ACT OF 2016

SEPTEMBER 22, 2016.—Committed to the Committee of the Whole House on 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. 954]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 954) to amend the Internal Revenue Code of 1986 to exempt from the individual mandate certain individuals who had coverage under a terminated qualified health plan funded through the Consumer Operated and Oriented Plan (CO-OP) program, 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 “CO-OP Consumer Protection Act of 2016”.

**SEC. 2. EXEMPTION FROM INDIVIDUAL MANDATE FOR CERTAIN INDIVIDUALS WHO HAD COVERAGE UNDER A TERMINATED HEALTH PLAN FUNDED THROUGH THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM.**

(a) **IN GENERAL.**—Section 5000A(e) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(6) **CERTAIN INDIVIDUALS PREVIOUSLY ENROLLED IN HEALTH PLANS FUNDED THROUGH THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM.**—Any applicable individual for any month if—

“(A) such individual was enrolled in minimum essential coverage offered by a qualified nonprofit health insurance issuer (as defined in subsection (c) of section 1322 of the Patient Protection and Affordable Care Act (42 U.S.C. 18042)) receiving funds with respect to such coverage through the Consumer Operated and Oriented Plan program established under such section,

“(B) during the calendar year which includes such month, such issuer terminated such coverage in the area in which the individual resides, and

“(C) such month ends after the date on which such coverage was so terminated.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to months beginning after December 31, 2013.

## I. SUMMARY AND BACKGROUND

### A. PURPOSE AND SUMMARY

The bill, H.R. 954, as reported by the Committee on Ways and Means, temporarily exempts individuals, whose coverage under a plan offered by a qualified nonprofit health insurance issuer receiving funds through the Consumer Operated and Oriented Plan (CO-OP) program was terminated or otherwise discontinued, from the Patient Protection and Affordable Care Act (ACA)’s individual mandate.

### B. BACKGROUND AND NEED FOR LEGISLATION

Section 1332 of the ACA created the CO-OP program. The individual mandate was added to Section 5000(A) of the Internal Revenue Code (IRC) by Section 1501 of the ACA. According to the statute, beginning in 2014, all “applicable individuals” must have a “minimum essential coverage” for themselves and their dependents or pay a tax penalty. The law currently provides for several exemptions from the individual mandate, including for “hardship,” as determined by the Secretary of Health and Human Services (Section 5000A(e)(5) of the IRC) and short coverage gaps (Section 5000A(e)(4) of the IRC).

The CO-OP program was created in an attempt to artificially create competition in the health care market. In January 2015, 23

CO-OPs covered enrollees in 25 states. To date, most of these have failed and the Administration is attempting to prop up the six CO-OPs that remain.

Not only is the CO-OP program a significant financial drain, but its failure has had a negative effect on many Americans who were enrolled through one of these insurers. Cancelled plans can cause great disruptions—and extra, burdensome financial expenses—in people’s lives. For instance, many who might have fully paid their deductible for their terminated CO-OP plan could risk having to start over from a cost-sharing perspective with a new plan. The Committee believes that relief from the individual mandate is necessary for those Americans who tried to comply with the law only to watch the CO-OPs collapse around them during a coverage period.

### C. LEGISLATIVE HISTORY

#### *Background*

H.R. 954 was introduced on February 12, 2015, and was referred to the Committee on Ways and Means.

#### *Committee action*

The Committee on Ways and Means marked up H.R. 954, the CO-OP Consumer Protection Act of 2016, on September 8, 2016, and ordered the bill, as amended, favorably reported (with a quorum being present).

#### *Committee hearings*

The issues surrounding the termination or discontinuation of certain CO-OPs were discussed at a Ways and Means Subcommittee on Health hearing on November 3, 2015, and a Member Day Hearing on May 17, 2016.

## II. EXPLANATION OF THE BILL

### A. EXEMPTION FROM INDIVIDUAL MANDATE FOR CERTAIN INDIVIDUALS WHO HAD COVERAGE UNDER A TERMINATED QUALIFIED HEALTH PLAN FUNDED THROUGH THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM (SEC. 2 OF THE BILL AND SEC. 5000A OF THE CODE)

#### PRESENT LAW

#### *Requirement for individuals to have health coverage*

##### *In general*

Individuals are required to be covered by a health plan that provides minimum essential coverage or pay a tax for failure to maintain coverage.<sup>1</sup> The tax is imposed for any month that an individual does not have minimum essential coverage unless the indi-

<sup>1</sup> Section 5000A which was added to the Code by section 1501 of the Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111–148, enacted March 23, 2010, as amended by section 10106 of PPACA and 1002 of the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111–152, enacted March 30, 2010. PPACA and HCERA are collectively referred to as the Affordable Care Act (“ACA”). Section 5000A is effective for taxable years ending after December 31, 2013.

vidual qualifies for an exemption for the month as described below.<sup>2</sup>

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, plans in the individual insurance market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of Health and Human Services (“HHS”) in coordination with the Secretary of the Treasury.<sup>3</sup> Minimum essential coverage includes a health plan offered through an American Health Benefit Exchange, referred to as a qualified health plan.

*Tax on failure to maintain minimum essential coverage*

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

The flat dollar amount is the lesser of (1) the sum of the individual annual dollar amounts for the members of the taxpayer’s family and (2) 300 percent of the adult individual dollar amount. The individual adult annual dollar amount is phased in over the first three years as follows: \$95 for 2014; \$325 for 2015; and \$695 for 2016.<sup>4</sup> For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount.

The excess income amount is a specified percentage of the excess of the taxpayer’s household income for the taxable year over the threshold amount of income requiring the taxpayer to file an income tax return.<sup>5</sup> The specified percentage of income is phased in as follows: one percent for 2014; two percent for 2015; and 2.5 percent for 2016 and after.

*Exemptions*

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

<sup>2</sup>In the case of a taxpayer’s dependent under section 152, the taxpayer is liable for any tax for failure to maintain the required coverage with respect to the dependent.

<sup>3</sup>Minimum essential coverage does not include coverage that consists of certain excepted benefits as defined in section 2791(c)(1)–(4) of the Public Health Service Act (42 U.S.C. sec. 300gg–91(c)(1)–(4)). A parallel definition of excepted benefits is provided in section 9832(c)(1)–(4).

<sup>4</sup>For years after 2016, the \$695 amount is indexed to the consumer price index for all urban consumers, referred to as “CPI-U,” rounded to the next lowest multiple of \$50.

<sup>5</sup>Sec. 6012(a).

*Health plans under the CO-OP program*

The CO-OP program was established to foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans.<sup>6</sup> A qualified nonprofit health insurance issuer is an organization—

- That is organized as a nonprofit, member corporation under State law,
- Substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in each State in which it is licensed to issue such plans and in which health insurance market reforms have been implemented,
- That meets other applicable State law requirements for issuers of qualified health plans,
- That was not (nor was a related entity or a predecessor of either) a health insurance issuer as of July 16, 2009 and is not sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision,
- That meets certain governance requirements, and
- That uses profits to lower premiums, improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

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

## REASONS FOR CHANGE

The midyear cancellation of health plans under the CO-OP program causes individuals enrolled in those plans to lose their health insurance coverage. In some circumstances, obtaining new coverage for the remainder of the year may present difficulties not addressed by the present-law exemptions from the requirement to maintain minimum essential coverage. The Committee wishes to ensure that individuals in those circumstances do not face a tax penalty in addition to losing their health coverage. The bill therefore provides an exemption from the coverage requirement for the remainder of the year for individuals in those circumstances.

## EXPLANATION OF PROVISION

Under the provision, in the case of an individual who was enrolled in minimum essential coverage that was offered by a qualified nonprofit health insurance issuer under the CO-OP program and that was terminated during a calendar year in the area in which the individual resides, an exemption from the requirement to maintain minimum essential coverage applies for any month that is included in that calendar year and that ends after the date on which the coverage was terminated. Thus, the exemption ap-

<sup>6</sup>Sec. 1322 of PPACA. Under section 501(c)(29), a health insurer that receives a grant or loan under the CO-OP program generally qualifies for exemption from Federal income tax for periods during which the organization is in compliance with the requirements of the CO-OP program and with the terms of any such grant or loan agreement to which the organization is a party.

plies as of the first month for which the coverage was terminated and the remaining months in the calendar year.

#### EFFECTIVE DATE

The provision applies to months beginning after December 31, 2013.

### 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. 954, the “CO-OP Consumer Protection Act of 2016,” on September 8, 2016.

The bill, H.R. 954, as amended, was ordered favorably reported to the House of Representatives by a voice vote (with a quorum being present).

### 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. 954, as reported.

The bill, as reported, is estimated to have the following effect on Federal fiscal year budget receipts for the period 2017–2026:

FISCAL YEARS											
[Millions of dollars] [1]											
2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
–3	–1	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	–4	–4

NOTE: Details do not add to totals due to rounding.  
 [1] Estimate includes a reduction of less than \$500,000 in outlays.  
 [2] Loss of less than \$500,000.

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 no new or increased budget authority. The Committee further states that the revenue-reducing provisions of the bill do not involve increased tax expenditures.

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, September 15, 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. 954, the CO-OP Consumer Protection Act of 2016.

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

Sincerely,

MARK P. HADLEY  
(For Keith Hall, *Director*).

Enclosure.

*H.R. 954—CO-OP Consumer Protection Act of 2016*

H.R. 954 would provide an exemption from the individual health insurance mandate for certain individuals who had coverage under a health plan that was issued under the Consumer Operated and Oriented Plan (CO-OP) program and later terminated. The CO-OP program was established by the Affordable Care Act and included federal loans to foster the creation of nonprofit plans that would offer health insurance to individuals and small employers. Under current law, individuals are required to maintain minimum essential coverage under a health insurance plan or pay a penalty for any month that they do not maintain such coverage, unless they qualify for one of the existing exemptions.

H.R. 954 would exempt individuals from the mandate and from resulting penalties (which are recorded as revenues in the federal budget) under certain circumstances. Individuals enrolled in a health plan issued through the CO-OP program would be exempt from the individual mandate for the remaining months in a calendar year if that plan was terminated partway through the year. The changes from enacting H.R. 954 would be effective retroactively, starting on January 1, 2014.

The staff of the Joint Committee on Taxation (JCT) estimates that the legislation would reduce revenues by \$4 million over the 2016–2026 period. JCT also estimates that H.R. 954 would reduce direct spending by less than \$500,000 over the 2016–2026 period, reflecting very small changes in subsidies for insurance purchased through health insurance marketplaces established by the Affordable Care Act. JCT therefore estimates that the legislation would increase federal budget deficits by \$4 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 and direct spending. The net changes in revenues and outlays

that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 954, AS ORDERED REPORTED BY THE  
HOUSE COMMITTEE ON WAYS AND MEANS ON SEPTEMBER 8, 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 IN THE DEFICIT												
Statutory Pay-As-You-Go Effects	0	3	1	0	0	0	0	0	0	0	0	4	4

Source: Staff of the Joint Committee on Taxation.

Note: The net increase in the deficit includes insignificant reductions in outlays.

JCT and CBO estimate that enacting the bill would not increase net direct spending in any of the four consecutive 10-year periods beginning in 2027, and would increase on-budget deficits over those periods by very small amounts.

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 Peter Huether. The estimate was approved by John McClelland, 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. 954 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 legislation 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 D—Miscellaneous Excise Taxes**

\* \* \* \* \*

**CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE**

\* \* \* \* \*

**SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**

(a) **REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) **SHARED RESPONSIBILITY PAYMENT.**—

(1) **IN GENERAL.**—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) **INCLUSION WITH RETURN.**—Any penalty imposed by this section with respect to any month shall be included with a taxpayer’s return under chapter 1 for the taxable year which includes such month.

(3) **PAYMENT OF PENALTY.**—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer’s taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) AMOUNT OF PENALTY.—

(1) IN GENERAL.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to  $\frac{1}{12}$  of the greater of the following amounts:

(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is \$695.

(B) PHASE IN.—The applicable dollar amount is \$95 for 2014 and \$325 for 2015.

(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$695, increased by an amount equal to—

- (i) \$695, multiplied by
- (ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2015” 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.

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

(A) 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.

(B) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer for any taxable year, 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.

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

(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term “applicable individual” means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) RELIGIOUS EXEMPTIONS.—

(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

- (i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and
- (ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) HEALTH CARE SHARING MINISTRY.—

- (i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) **HEALTH CARE SHARING MINISTRY.**—The term “health care sharing ministry” means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) **INDIVIDUALS NOT LAWFULLY PRESENT.**—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) **INCARCERATED INDIVIDUALS.**—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) **EXEMPTIONS.**—No penalty shall be imposed under subsection (a) with respect to—

(1) **INDIVIDUALS WHO CANNOT AFFORD COVERAGE.**—

(A) **IN GENERAL.**—Any applicable individual for any month if the applicable individual’s required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer’s household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) **REQUIRED CONTRIBUTION.**—For purposes of this paragraph, the term “required contribution” means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest

cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for “8 percent” the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) MONTHS DURING SHORT COVERAGE GAPS.—

(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) SPECIAL RULES.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human

Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

(1) IN GENERAL.—The term “minimum essential coverage” means any of the following:

(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other market plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” shall not

include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) ADMINISTRATION AND PROCEDURE.—

(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) SPECIAL RULES.—Notwithstanding any other provision of law—

(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

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

\* \* \* \* \*

**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 made by the

bill, as reported, are shown as follows (new matter is printed in italics and existing law in which no change is proposed is shown in roman):

**INTERNAL REVENUE CODE OF 1986**

\* \* \* \* \*

**Subtitle D—Miscellaneous Excise Taxes**

\* \* \* \* \*

**CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE**

\* \* \* \* \*

**SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**

(a) **REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) **SHARED RESPONSIBILITY PAYMENT.**—

(1) **IN GENERAL.**—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) **INCLUSION WITH RETURN.**—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) **PAYMENT OF PENALTY.**—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) **AMOUNT OF PENALTY.**—

(1) **IN GENERAL.**—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of cov-

erage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) MONTHLY PENALTY AMOUNTS.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to  $\frac{1}{12}$  of the greater of the following amounts:

(A) FLAT DOLLAR AMOUNT.—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is \$695.

(B) PHASE IN.—The applicable dollar amount is \$95 for 2014 and \$325 for 2015.

(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$695, increased by an amount equal to—

(i) \$695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2015” 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.

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

(A) 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.

(B) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer for any taxable year, 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.

(C) 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, and

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

(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term “applicable individual” means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) RELIGIOUS EXEMPTIONS.—

(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) HEALTH CARE SHARING MINISTRY.—

(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) HEALTH CARE SHARING MINISTRY.—The term “health care sharing ministry” means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been

shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be

made by reference to required contribution of the employee.

(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for “8 percent” the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) MONTHS DURING SHORT COVERAGE GAPS.—

(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) SPECIAL RULES.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(6) CERTAIN INDIVIDUALS PREVIOUSLY ENROLLED IN HEALTH PLANS FUNDED THROUGH THE CONSUMER OPERATED AND ORIENTED PLAN (CO-OP) PROGRAM.—Any applicable individual for any month if—

(A) such individual was enrolled in minimum essential coverage offered by a qualified nonprofit health insurance issuer (as defined in subsection (c) of section 1322 of the Patient Protection and Affordable Care Act (42 U.S.C. 18042)) receiving funds with respect to such coverage through the Consumer Operated and Oriented Plan program established under such section,

*(B) during the calendar year which includes such month, such issuer terminated such coverage in the area in which the individual resides, and*

*(C) such month ends after the date on which such coverage was so terminated.*

(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

(1) IN GENERAL.—The term “minimum essential coverage” means any of the following:

(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) ADMINISTRATION AND PROCEDURE.—

(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) SPECIAL RULES.—Notwithstanding any other provision of law—

(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

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

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