118TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
118–107

CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENT ACT

JUNE 12, 2023.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. SMITH of Missouri, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 3799]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3799) to amend the Internal Revenue Code of 1986 to provide for health reimbursement arrangements integrated with individual health insurance coverage, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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39–006

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 "Custom Health Option and Individual Care Expense Arrangement Act" or the "CHOICE Arrangement Act".

SEC. 2. TREATMENT OF HEALTH REIMBURSEMENT ARRANGEMENTS INTEGRATED WITH INDIVIDUAL MARKET COVERAGE.

(a) IN GENERAL.—Section 9815(b) of the Internal Revenue Code of 1986 is amended—

(1) by striking "EXCEPTION.—Notwithstanding subsection (a)" and inserting the following: "EXCEPTIONS.—

"(1) SELF-INSURED GROUP HEALTH PLANS.—Notwithstanding subsection (a)", and

(2) by adding at the end the following new paragraph:

"(2) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS.—

"(A) IN GENERAL.—For purposes of this subchapter, a custom health option and individual care expense arrangement shall be treated as meeting the requirements of section 2711 and 2713 of title XXVII of the Public Health Service Act.

"(B) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS DEFINED.—For purposes of this section, the term 'custom health option and individual care expense arrangement' means a health reimbursement arrangement—

"(i) which is an employer-provided group health plan funded solely by employer contributions to provide payments or reimbursements for medical care subject to a maximum fixed dollar amount for a period,

"(ii) under which such payments or reimbursements may only be made for medical care provided during periods during which the individual is covered—

"(I) under individual health insurance coverage (other than coverage that consists solely of excepted benefits), or

"(II) under part A and B of title XVIII of the Social Security Act or part C of such title,

"(iii) which meets the nondiscrimination requirements of subparagraph (C),

"(iv) which meets the substantiation requirements of subparagraph (D), and

"(v) which meets the notice requirements of subparagraph (E).

"(C) NONDISCRIMINATION.—

"(i) IN GENERAL.—An arrangement meets the requirements of this subparagraph if an employer offering such arrangement to an employee within a specified class of employee—

"(I) offers such arrangement to all employees within such specified class on the same terms, and

"(II) does not offer any other group health plan to any employees within such specified class.

"(ii) SPECIFIED CLASS OF EMPLOYEE.—For purposes of this subparagraph, any of the following may be designated as a specified class of employee:

"(I) Full-time employees.

"(II) Part-time employees.

"(III) Salaried employees.

"(IV) Non-salaried employees.

"(V) Employees whose primary site of employment is in the same rating area.

"(VI) Employees who are included in a unit of employees covered under a collective bargaining agreement to which the employer is

subject (determined under rules similar to the rules of section 105(h)).

"(VII) Employees who have not met a group health plan, or health insurance issuer offering group health insurance coverage, waiting period requirement that satisfies the of section 2708 of the Public Health Service Act.

"(VIII) Seasonal employees.

"(IX) Employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

"(X) Such other classes of employees as the Secretary may designate.

An employer may designate (in such manner as is prescribed by the Secretary) two or more of the classes described in the preceding subclauses as the specified class of employees to which the arrangement is offered for purposes of applying this subparagraph.

"(iii) SPECIAL RULE FOR NEW HIRES.—An employer may designate prospectively so much of a specified class of employees as are hired after a date set by the employer. Such subclass of employees shall be treated as the specified class for purposes of applying clause (i).

"(iv) RULES FOR DETERMINING TYPE OF EMPLOYEE.—For purposes for clause (ii), any determination of full-time, part-time, or seasonal employment status shall be made under rules similar to the rules of section 105(h) or 4980H, whichever the employer elects for the plan year. Such election shall apply with respect to all employees of the employer for the plan year.

"(v) PERMITTED VARIATION.—For purposes of clause (i)(I), an arrangement shall not fail to be treated as provided on the same terms within a specified class merely because the maximum dollar amount of payments and reimbursements which may be made under the terms of the arrangement for the year with respect to each employee within such class—

"(I) increases as additional dependents of the employee are covered under the arrangement, and

"(II) increases with respect to a participant as the age of the participant increases, but not in excess of an amount equal to 300 percent the lowest maximum dollar amount with respect to such a participant determined without regard to age.

"(D) SUBSTANTIATION REQUIREMENTS.—An arrangement meets the requirements of this subparagraph if the arrangement has reasonable procedures to substantiate—

"(i) that the participant is, or will be, enrolled in coverage described in subparagraph (B)(ii) as of the beginning of the plan year of the arrangement (or as of the beginning of coverage under the arrangement in the case of an employee who first becomes eligible to participate in the arrangement after the date notice is given with respect to the plan under subparagraph (E) (determined without regard to clause (iii) thereof), and

"(ii) any requests made for payment or reimbursement of medical care under the arrangement and that the participant remains so enrolled.

"(E) NOTICE.—

"(i) IN GENERAL.—Except as provided in clause (iii), an arrangement meets the requirements of this subparagraph if, under the arrangement, each employee eligible to participate is, not later than 90 days before the beginning of the plan year, given written notice of the employee's rights and obligations under the arrangement which—

"(I) is sufficiently accurate and comprehensive to appraise the employee of such rights and obligations, and

"(II) is written in a manner calculated to be understood by the average employee eligible to participate.

"(ii) NOTICE REQUIREMENTS.—Such notice shall include such information as the Secretary may by regulation prescribe.

"(iii) NOTICE DEADLINE FOR CERTAIN EMPLOYEES.—In the case of an employee—

"(I) who first becomes eligible to participate in the arrangement after the date notice is given with respect to the plan under clause (i) (determined without regard to this clause), or

"(II) whose employer is first established fewer than 120 days before the beginning of the first plan year of the arrangement,

the requirements of this subparagraph shall be treated as met if the notice required under clause (i) is provided not later than the date the arrangement may take effect with respect to such employee.".

(b) NO INFERENCE.—To the extent not inconsistent with the amendments made by this section—

(1) no inference shall be made from such amendments with respect to the rules prescribed in the Federal Register on June 20, 2019, (84 Fed. Reg. 28888) relating to health reimbursement arrangements and other account-based group health plans, and

(2) any reference to custom health option and individual care expense arrangements shall for purposes of such rules be treated as including a reference to individual coverage health reimbursement arrangements.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2023.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 3799, the "Custom Health Option and Individual Care Expense Arrangement Act," as ordered reported by the Committee on Ways and Means on June 7, 2023, codifies a 2019 rule (26 CFR 54.9802–4) which allows employers to offer their employees tax-advantaged funds for their employees to purchase qualified health insurance plans on the individual market through "CHOICE Arrangements".

B. BACKGROUND AND NEED FOR LEGISLATION

26 CFR 54.9802–4 allows employers to offer tax-exempt, defined contributions to their employees for the employees to purchase qualified health insurance on the individual market through Individual Coverage Health Reimbursement Arrangements (ICHRAs). Unlike Qualified Small Employer Health Reimbursement Arrangements (PL 114–255), these accounts do not have restrictions on business size or annual contribution limits. Additionally, ICHRAs may be offered to different classes of employees, such as part-time, full-time, or seasonal employees, while ensuring discrimination protections for the groups of employees.

While this coverage option is valuable to employers, this was created through administrative rulemaking and not legislation. The Committee believes legislation is needed to codify this important health coverage option so employers can be confident the option will be permanent.

C. LEGISLATIVE HISTORY

Background

H.R. 3799 was introduced on June 5, 2023, and was referred to the Committee on Ways and Means.

Committee hearings

On Thursday, March 23, 2023, the Ways and Means Subcommittee on Health held hearing on "Why Health Care is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses".

Committee action

The Committee on Ways and Means marked up H.R. 3799, the "Custom Health Option and Individual Care Expense Arrangement Act," on June 7, 2023, and ordered the bill, as amended, favorably reported (with a quorum being present).

D. LEGISLATIVE HISTORY

Pursuant to clause 3(c)(6) of rule XIII, the following hearings were used to develop and consider H.R. 3799:

Committee on Ways and Means Subcommittee on Health "Why Health Care is Unaffordable: The Fallout of Democrats' Inflation on Patients and Small Businesses".

II. EXPLANATION OF THE BILL

A. TREATMENT OF HEALTH REIMBURSEMENT ARRANGEMENTS INTEGRATED WITH INDIVIDUAL MARKET COVERAGE (SEC. 2 OF THE BILL AND SEC. 9815 OF THE CODE)

PRESENT LAW

Group health plan requirements

The Internal Revenue Code (the "Code") imposes various requirements with respect to employment-related health plans, referred to for this purpose as group health plans.[1] The Patient Protection and Affordable Care Act ("PPACA")[2] expanded the market reform requirements applicable to group health plans.[3]

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.[4] Generally, if the failure is due to reasonable cause and not to willful neglect, the maximum tax that can be imposed for failures during a taxable year is the lesser of 10 percent of the employer's group health plan expenses for the prior year or $500,000. In some cases, the excise tax does not apply if the failure is due to reasonable cause and not to willful neglect and the failure is corrected within a certain period. In addition, in some cases in which failure is due to reasonable cause and not to willful neglect, some or all of the excise tax may be waived to the extent payment of the tax would be excessive relative to the failure involved.

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[1] See, *e.g.*, sec. 4980B (relating to continuation coverage or "COBRA" requirements) and Chapter 100 (secs. 9801–9834, relating to various additional requirements, such as prohibitions on preexisting condition exclusions and discrimination based on health status). Code section 5000 also imposes Medicare secondary payor requirements on group health plans.

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

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

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

Other health rules under the Code

Under the PPACA, "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.[5] 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, the premium tax credit ("PTC"), is available to certain individuals who purchase health insurance coverage in the individual market through an Exchange ("Exchange coverage").[6] However, an employee is generally not eligible for the PTC if his or her employer offers affordable minimum essential coverage under a group health plan and the coverage provides minimum value. For this purpose, coverage is affordable if the employee's share of the premium for self-only coverage under the group health plan is not more than 9.12 percent (for 2023)[7] of the employee's household income. To provide minimum value, the coverage offered under the group health plan must cover at least 60 percent of the total costs of benefits covered under the plan. An individual who applies for advance PTC with respect to Exchange coverage for a year must provide the Exchange with certain information, including information relating to employer-provided minimum essential coverage.[8]

If an applicable large employer fails to offer employees minimum essential coverage, or offers minimum essential coverage that either is not affordable (under the standard described above) or fails to provide minimum value, and any employee is allowed PTC, the employer may be subject to a tax penalty.[9] For this purpose, applicable large employer generally means, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalents) on business days during the preceding calendar year.[10]

Health reimbursement arrangements

In addition to offering health coverage, employers sometimes reimburse medical expenses of their employees (and their spouses and dependents). These arrangements are sometimes used by employers to pay or reimburse employees for medical expenses that are not covered by health insurance and are commonly referred to as health reimbursement arrangements ("HRAs").[11]

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[5] Sec. 5000A.

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

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

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

[9] Sec. 4980H.

[10] In determining whether an employer is an applicable large employer (that is, whether the employer has at least 50 full-time employees), besides the number of full-time employees, the employer must include the number of its full time equivalent employees for a month, determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. In addition, in determining applicable large employer status, members of the same controlled group, group under common control, and affiliated service group under section 414(b), (c), (m) and (o) are treated as a single employer.

[11] See secs. 105(b) and 106; Rev. Rul. 61–146, 1961–2 C.B. 25; Notice 2002–45, 2002–2 C.B. 93, July 15, 2002, and Rev. Rul. 2002–41, 2002–2 C.B. 75. Under section 105(h), a self-insured

The amounts in an HRA can be used only to reimburse medical expenses (including health insurance premiums) and not for other purposes, and HRAs cannot be funded on a salary reduction basis. HRAs must have a maximum dollar amount for each coverage period, and amounts remaining in an HRA at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[12]

An employee may exclude amounts provided through an HRA from gross income. For employer payments or reimbursements under an HRA to be excluded from gross income, expenses must be substantiated and an employee must be entitled to receive payments from the employer only if he or she incurs qualifying expenses.[13]

After the enactment of the PPACA and before the establishment of individual coverage HRAs (as described below), an HRA generally failed to meet the group health plan requirements imposed by the PPACA unless the HRA complied with Internal Revenue Service ("IRS") rules relating to HRAs provided in conjunction with (or "integrated" with) certain other employer-sponsored coverage that met the group health plan requirements.[14] An HRA that is integrated with such employer-sponsored coverage is often referred to as an "integrated" HRA, and an HRA that is not integrated with such employer-sponsored coverage is often referred to as a "stand-alone" HRA. Thus, an employer could be subject to an excise tax if it provided employees a stand-alone HRA covering medical expenses, with the exception of certain limited benefits, for example, coverage only for vision or dental medical services.[15]

Individual coverage HRAs

In August 2019, final rules were issued permitting employers to contribute to HRAs used for the purpose of purchasing individual health insurance coverage, without violating the group health plan requirements (the "final rules").[16] The final rules provide that employers may offer employees an "individual coverage HRA," and, that if those individuals use the amounts contributed to that HRA to purchase health insurance coverage on the individual market, the group health plan meets the relevant group health plan re-

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HRA must meet certain nondiscrimination requirements in order for the benefits provided to a highly compensated individual to be excluded from income. For this purpose, the following groups of employees may be excluded: employees who have not completed three years of service with the employer, employees under age 25, part-time or seasonal employees, employees covered by a collective bargaining agreement if health benefits were the subject of good faith bargaining, and nonresident aliens with no earned income from sources within the United States. Employer payments and reimbursements for health insurance and medical expenses are also excluded from wages for employment tax purposes. Secs. 3121(a)(2), 3231(e)(1), 3306(b)(2), 3401(a)(20), Rev. Rul. 56–632, 1956–2 C.B. 101. For simplicity, this document refers to "HRAs" to indicate all arrangements to which the individual coverage HRA final rules (described later in this document) apply.

[12] General guidance with respect to HRAs is provided in Notice 2002–45.

[13] Treas. Reg. sec. 1.105–2.

[14] See, *e.g.*, Notice 2013–54, 2013–40 I.R.B. 287, September 30, 2013. The 21st Century Cures Act created a limited exception to this rule in the form qualified small employer health reimbursement arrangements (QSEHRAs). Unlike traditional HRAs, QSEHRAs are designed so that small employers may subsidize employees' purchase of individual coverage on an Exchange. Pub. L. No. 114–255, sec. 18001, December 13, 2016.

[15] See Notice 2015–87, 2015–52 I.R.B. 889, December 28, 2015.

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

quirements. An individual coverage HRA may also be used in conjunction with coverage under Medicare Part A and B or C.[17]

Individual coverage HRAs are subject to detailed regulations, including the following requirements: the terms of the individual coverage HRA must require that employees, spouses, and dependents enrolled in the HRA also be enrolled in individual health insurance coverage;[18] employers are not permitted to allow employees to choose between an individual coverage HRA and traditional employment-related health coverage;[19] employers are required to offer individual coverage HRAs on the same terms to all employees within enumerated classes of employees;[20] generally, employers are required to provide employees notice regarding the individual coverage HRA at least 90 calendar days before the beginning of the plan year;[21] and employers are required to adopt reasonable procedures for substantiation regarding individuals' enrollment in qualifying individual coverage.[22]

Because individual coverage HRAs are employer-sponsored group plans, individuals enrolled in individual coverage HRAs are not eligible for PTCs. Furthermore, the final rules include an affordability test, under which the value of the employer contribution to the individual coverage HRA is compared to the price of the lowest cost silver plan available to the employee. Similar to the rule for traditional group health plans, if the employee's share of the premium for self-only coverage under that plan is more than 9.12 percent (for 2023) of the employee's household income, the individual coverage HRA is not considered affordable and the employee may be entitled to PTCs for individual health coverage purchased on an Exchange.[23]

In addition to amounts contributed to an individual coverage HRA by the employer, employees may make contributions through a cafeteria plan to purchase individual coverage, if, for example, the employer's contribution to the individual coverage HRA is less than the premium for the individual coverage selected by the employee. However, amounts available through a cafeteria plan may not be used to purchase individual health coverage on an Exchange, so, in these circumstances, employees must use the individual coverage HRA to purchase off-Exchange coverage.[24]

REASONS FOR CHANGE

The Committee believes that individual coverage HRAs have greatly enhanced the health coverage options available to individuals, families, and employers. Individual coverage HRAs have provided more choice and flexibility for working people, and have saved employers, particularly small businesses, on the administrative expenses and burdens associated with traditional employer-sponsored health insurance. The Committee therefore believes it is appropriate to codify the regulations permitting the adoption of

[17] Treas. Reg. sec. 54.9802–4(e).
[18] Treas. Reg. sec. 54.9802–4(c)(1).
[19] Treas. Reg. sec. 54.9802–4(c)(2).
[20] Treas. Reg. sec. 54.9802–4(c)(3).
[21] Treas. Reg. sec. 54.9802–4(c)(6).
[22] Treas. Reg. sec. 54.9802–4(c)(5).
[23] Treas. Reg. sec. 1.36B–2(c)(3). An individual coverage HRA that is affordable is also treated as providing minimum value.
[24] Sec. 125(f)(3), providing that an employer generally may not provide a qualified health plan offered through an Exchange as a cafeteria plan benefit.

these arrangements, to ensure that families and businesses may continue to benefit from them.

EXPLANATION OF PROVISION

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

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

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

The provision includes the following classes of employees:

- Full-time employees;
- Part-time employees;
- Salaried employees;
- Non-salaried employees;
- Employees whose primary site of employment is in the same rating area;
- Employees who are included in a collective bargaining unit;
- Employees who have not met a waiting period requirement;
- Seasonal employees;
- Employees who are non-resident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States;[25] and
- Such other classes as designated by the Treasury.

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

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

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

EFFECTIVE DATE

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

III. VOTE OF THE COMMITTEE

In Compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 3799, The "Custom Health Option and Individual Care Expense Arrangement Act" on June 7, 2023.

H.R. 3799 was ordered favorably reported to the house of representatives as amended by a roll call vote of 25 Yeas To 18 Nays (With A Quorum Being Present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)	X			Mr. Neal		X	
Mr. Buchanan	X			Mr. Doggett		X	
Mr. Smith (NE)	X			Mr. Thompson		X	
Mr. Kelly	X			Mr. Larson		X	
Mr. Schweikert	X			Mr. Blumenauer		X	
Mr. LaHood	X			Mr. Pascrell		X	
Dr. Wenstrup	X			Mr. Davis		X	
Mr. Arrington	X			Ms. Sanchez		X	
Dr. Ferguson	X			Mr. Higgins		X	
Mr. Estes	X			Ms. Sewell		X	
Mr. Smucker	X			Ms. DelBene		X	
Mr. Hern	X			Ms. Chu		X	
Ms. Miller	X			Ms. Moore		X	
Dr. Murphy	X			Mr. Kildee		X	
Mr. Kustoff	X			Mr. Beyer		X	
Mr. Fitzpatrick	X			Mr. Evans		X	
Mr. Steube	X			Mr. Schneider		X	
Ms. Tenney	X			Mr. Panetta		X	
Mrs. Fischbach	X						
Mr. Moore	X						
Mrs. Steel	X						

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Ms. Van Duyne	X						
Mr. Feenstra	X						
Ms. Malliotakis	X						
Mr. Carey	X						

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. 3799, as reported.

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

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 states further that the bill involves no new or increased tax expenditures.

C. Cost Estimate Prepared by the Congressional Budget Office

The Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether this bill contains any new budget authority, spending authority, credit authority, or an increase or decrease in revenues or tax expenditures.

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, the Committee made findings and recommendations that are reflected in this report.

A. 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 does not authorize funding, so no statement of general performance goals and objectives is required.

B. 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.

C. 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.

D. Tax Complexity Analysis

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.

E. Duplication of Federal Programs

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, 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 (Pub. L. No. 95–220, as amended by Pub. L. No. 98–169).

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

A. Changes in Existing Law Proposed by the Bill, as Reported

In compliance with clause 3(e) 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 (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 K—Group Health Plan Requirements

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CHAPTER 100—GROUP HEALTH PLAN REQUIREMENTS

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Subchapter B—OTHER REQUIREMENTS

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SEC. 9815. ADDITIONAL MARKET REFORMS.

(a) GENERAL RULE.—Except as provided in subsection (b)—

(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter; and

(2) to the extent that any provision of this subchapter conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) [EXCEPTION.—] *EXCEPTIONS.—*

(1) SELF-INSURED GROUP HEALTH PLANS.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this subchapter shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(2) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS.—

(A) IN GENERAL.—For purposes of this subchapter, a custom health option and individual care expense arrangement shall be treated as meeting the requirements of section 2711 and 2713 of title XXVII of the Public Health Service Act.

(B) CUSTOM HEALTH OPTION AND INDIVIDUAL CARE EXPENSE ARRANGEMENTS DEFINED.—For purposes of this section, the term "custom health option and individual care expense arrangement" means a health reimbursement arrangement—

(i) which is an employer-provided group health plan funded solely by employer contributions to provide payments or reimbursements for medical care subject to a maximum fixed dollar amount for a period,

(ii) under which such payments or reimbursements may only be made for medical care provided during periods during which the individual is covered—

(I) under individual health insurance coverage (other than coverage that consists solely of excepted benefits), or

(II) under part A and B of title XVIII of the Social Security Act or part C of such title,

(iii) which meets the nondiscrimination requirements of subparagraph (C),

(iv) which meets the substantiation requirements of subparagraph (D), and

(v) which meets the notice requirements of subparagraph (E).

(C) NONDISCRIMINATION.—

(i) IN GENERAL.—An arrangement meets the requirements of this subparagraph if an employer offering such arrangement to an employee within a specified class of employee—

(I) offers such arrangement to all employees within such specified class on the same terms, and

(II) does not offer any other group health plan to any employees within such specified class.

(ii) SPECIFIED CLASS OF EMPLOYEE.—For purposes of this subparagraph, any of the following may be designated as a specified class of employee:

(I) Full-time employees.

(II) Part-time employees.

(III) Salaried employees.

(IV) Non-salaried employees.

(V) Employees whose primary site of employment is in the same rating area.

(VI) Employees who are included in a unit of employees covered under a collective bargaining agreement to which the employer is subject (determined under rules similar to the rules of section 105(h)).

(VII) Employees who have not met a group health plan, or health insurance issuer offering group health insurance coverage, waiting period requirement that satisfies the of section 2708 of the Public Health Service Act.

(VIII) Seasonal employees.

(IX) Employees who are nonresident aliens and who receive no earned income (within the meaning of section 911(d)(2)) from the employer which constitutes income from sources within the United States (within the meaning of section 861(a)(3)).

(X) Such other classes of employees as the Secretary may designate.

An employer may designate (in such manner as is prescribed by the Secretary) two or more of the classes described in the preceding subclauses as the specified class of employees to which the arrangement is offered for purposes of applying this subparagraph.

(iii) SPECIAL RULE FOR NEW HIRES.—An employer may designate prospectively so much of a specified class of employees as are hired after a date set by the employer. Such subclass of employees shall be treated as the specified class for purposes of applying clause (i).

(iv) RULES FOR DETERMINING TYPE OF EMPLOYEE.—For purposes for clause (ii), any determination of full-

time, part-time, or seasonal employment status shall be made under rules similar to the rules of section 105(h) or 4980H, whichever the employer elects for the plan year. Such election shall apply with respect to all employees of the employer for the plan year.

(v) PERMITTED VARIATION.—For purposes of clause (i)(I), an arrangement shall not fail to be treated as provided on the same terms within a specified class merely because the maximum dollar amount of payments and reimbursements which may be made under the terms of the arrangement for the year with respect to each employee within such class—

(I) increases as additional dependents of the employee are covered under the arrangement, and

(II) increases with respect to a participant as the age of the participant increases, but not in excess of an amount equal to 300 percent the lowest maximum dollar amount with respect to such a participant determined without regard to age.

(D) SUBSTANTIATION REQUIREMENTS.—An arrangement meets the requirements of this subparagraph if the arrangement has reasonable procedures to substantiate—

(i) that the participant is, or will be, enrolled in coverage described in subparagraph (B)(ii) as of the beginning of the plan year of the arrangement (or as of the beginning of coverage under the arrangement in the case of an employee who first becomes eligible to participate in the arrangement after the date notice is given with respect to the plan under subparagraph (E) (determined without regard to clause (iii) thereof), and

(ii) any requests made for payment or reimbursement of medical care under the arrangement and that the participant remains so enrolled.

(E) NOTICE.—

(i) IN GENERAL.—Except as provided in clause (iii), an arrangement meets the requirements of this subparagraph if, under the arrangement, each employee eligible to participate is, not later than 90 days before the beginning of the plan year, given written notice of the employee's rights and obligations under the arrangement which—

(I) is sufficiently accurate and comprehensive to appraise the employee of such rights and obligations, and

(II) is written in a manner calculated to be understood by the average employee eligible to participate.

(ii) NOTICE REQUIREMENTS.—Such notice shall include such information as the Secretary may by regulation prescribe.

(iii) NOTICE DEADLINE FOR CERTAIN EMPLOYEES.—In the case of an employee—

(I) who first becomes eligible to participate in the arrangement after the date notice is given with re-

spect to the plan under clause (i) (determined without regard to this clause), or

(II) whose employer is first established fewer than 120 days before the beginning of the first plan year of the arrangement,

the requirements of this subparagraph shall be treated as met if the notice required under clause (i) is provided not later than the date the arrangement may take effect with respect to such employee.

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VII. DISSENTING VIEWS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, June 7, 2023.

DISSENTING VIEWS ON CHOICE ARRANGEMENT ACT, H.R. 3799

H.R. 3799 (Rep. Hern, R–OK) codifies a Trump Administration rule on Individual Coverage Health Reimbursement Arrangements, (ICHRAs) and renames them as CHOICE Accounts. ICHRAs allow employers to offer workers a fixed reimbursement for premiums that workers can use on the individual insurance market to purchase a health insurance product.

Employers can use ICHRAs to discriminate against certain classes of workers. The legislation allows employers to offer ICHRAs to only certain classes of workers, for example hourly workers or older workers but not C-suite executives. Employers might target groups of workers with higher health costs, sending them to the individual market with a voucher.

ICHRAs could increase premiums and worsen risk in the individual market. A Brookings analysis found that allowing employers to offer ICHRAs alongside a traditional group health insurance plan could increase marketplace premiums by 16 percent to 93 percent. To the extent employers find ways to offload high-cost or high-risk workers onto the individual market, the adverse selection would drive up premiums in the individual market.

The bill could result in circumvention of Affordable Care Act (ACA) protections on pre-existing conditions, lifetime and annual limits, or preventive care. The legislation describes individual market coverage but does not explicitly reference the code in defining an individual health insurance plan that requires the ACA market protections like pre-existing conditions protections.

The mere offer of an ICHRA may leave employees worse off. An employee who has an offer of an "affordable" HRA is prevented from accessing premium tax credits in the marketplace. This offer can be particularly problematic for lower-wage workers that would otherwise be able to find more affordable coverage in the Marketplace and could lead to higher premiums and out-of-pocket costs than under ACA coverage for the employee.

Mr. Doggett (D–TX) offered an amendment to prevent ICHRAs from being used to discriminate against certain classes of workers and ensure that insurance coverage purchased with ICHRA funds complies with critical ACA protections by explicitly defining the term individual health insurance coverage. The amendment was defeated by Republicans.

RICHARD E. NEAL,
Ranking Member.

RANKING MEMBER RICHARD E. NEAL, OPENING STATEMENT, COMMITTEE ON WAYS AND MEANS MARKUP OF H.R. 3799,

Wednesday, June 7, 2023.

I have big concerns about this bill, starting with the fact that 36 hours ago, it had never been mentioned in this Committee. This bill would codify a Trump Administration rule on Individual Coverage Health Reimbursement Accounts, or ICHRAS (ICK-rahs), renaming them as CHOICE Accounts. And it certainly allows employers to make choices. By codifying this rule, employers would be allowed to discriminate against certain classes of workers. I suppose we shouldn't be surprised—in the 13 years since Democrats stood up for the millions of Americans with pre-existing conditions, Republicans have tried time and time again to strike down the Affordable Care Act. The bill before us today seems like yet another Republican attempt to undermine the consumer protections the ACA provides.

Employers could offer lesser coverage through ICHRAs to lower-income workers, hourly workers, or seasonal workers, reserving better coverage for their C-suite executives. Employers can also single out only the high-cost workers to get Marketplace coverage, leaving a cheaper, healthier pool for the employer's group coverage.

We've seen this playbook from the Republicans before, using policies to make the Marketplace risk pool sicker, instead of robust. Once again, putting wealth before health. Republicans are so intent on serving Big Pharma and their wealthy donors that they want to build a sicker, poorer, and more segmented version of our country.

For many low wage workers, they may be better off with no ICHRA and using the Marketplace premium tax credits strengthened by Democrats last Congress for more generous and affordable coverage. Unfortunately, even being offered an ICHRA could cause employees to lose subsidized Marketplace coverage under this arrangement, leaving workers and their families worse off.

If we worked together, we could have mitigated these issues and included important safeguards that protect employees from discrimination and ensure they have the information to make the best health care choices for their families. Sadly, Republicans are doubling down on leaving America's workers and their families behind.

Thank you, and I yield back.

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