

AMENDING THE INTERNAL REVENUE CODE OF 1986 TO
ELIMINATE CERTAIN TAX BENEFITS RELATING TO
ABORTION

APRIL 6, 2011.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

Mr. CAMP, from the Committee on Ways and Means,
submitted the following

R E P O R T

together with

DISSENTING AND ADDITIONAL VIEWS

[To accompany H.R. 1232]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 1232) to amend the Internal Revenue Code of 1986 to eliminate certain tax benefits relating to abortion, 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. DEDUCTION FOR MEDICAL EXPENSES NOT ALLOWED FOR ABORTIONS.

(a) IN GENERAL.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(g) AMOUNTS PAID FOR ABORTION NOT TAKEN INTO ACCOUNT.—

“(1) IN GENERAL.—An amount paid during the taxable year for an abortion shall not be taken into account under subsection (a).

“(2) EXCEPTIONS.—Paragraph (1) shall not apply to—

“(A) an abortion—

“(i) in the case of a pregnancy that is the result of an act of rape or incest, or

“(ii) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy, and

“(B) the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 2. DISALLOWANCE OF REFUNDABLE CREDIT FOR COVERAGE UNDER QUALIFIED HEALTH PLAN WHICH PROVIDES COVERAGE FOR ABORTION.

(a) IN GENERAL.—Subparagraph (A) of section 36B(c)(3) of the Internal Revenue Code of 1986 is amended by inserting before the period at the end the following: “or any health plan that includes coverage for abortions (other than any abortion or treatment described in section 213(g)(2)).”

(b) OPTION TO PURCHASE OR OFFER SEPARATE COVERAGE OR PLAN.—Paragraph (3) of section 36B(c) of such Code is amended by adding at the end the following new subparagraph:

“(C) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—

“(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

“(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).”

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 3. DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.

(a) IN GENERAL.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(1) by striking “Any term” and inserting the following:

“(1) IN GENERAL.—Any term”, and

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

“(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—The terms ‘qualified health plan’ and ‘health insurance coverage’ shall not include any health plan or benefit that includes coverage for abortions (other than any abortion or treatment described in section 213(g)(2)).”

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 4. DISTRIBUTIONS FOR ABORTION EXPENSES FROM CERTAIN ACCOUNTS AND ARRANGEMENTS INCLUDED IN GROSS INCOME.

(a) **FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.**—Section 125 of the Internal Revenue Code of 1986 is amended by redesignating subsections (k) and (l) as subsections (l) and (m), respectively, and by inserting after subsection (j) the following new subsection:

“(k) **ABORTION REIMBURSEMENT FROM FLEXIBLE SPENDING ARRANGEMENT INCLUDED IN GROSS INCOME.**—Notwithstanding section 105(b), gross income shall include any reimbursement for expenses incurred for an abortion (other than any abortion or treatment described in section 213(g)(2)) from a health flexible spending arrangement provided under a cafeteria plan. Such reimbursement shall not fail to be a qualified benefit for purposes of this section merely as a result of such inclusion in gross income.”

(b) **ARCHER MSAs.**—Paragraph (1) of section 220(f) of such Code is amended by inserting before the period at the end the following: “, except that any such amount used to pay for an abortion (other than any abortion or treatment described in section 213(g)(2)) shall be included in the gross income of such holder”.

(c) **HSAs.**—Paragraph (1) of section 223(f) of such Code is amended by inserting before the period at the end the following: “, except that any such amount used to pay for an abortion (other than any abortion or treatment described in section 213(g)(2)) shall be included in the gross income of such beneficiary”.

(d) **EFFECTIVE DATES.**—

(1) **FSA REIMBURSEMENTS.**—The amendment made by subsection (a) shall apply to expenses incurred with respect to taxable years beginning after the date of the enactment of this Act.

(2) **DISTRIBUTIONS FROM SAVINGS ACCOUNTS.**—The amendments made by subsection (b) and (c) shall apply to amounts paid with respect to taxable years beginning after the date of the enactment of this Act.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 1232, as amended, reported by the Committee on Ways and Means, extends the principles of the Hyde amendment¹ to certain tax expenditures. The bill amends the Internal Revenue Code to include the principles of the Hyde amendment and to eliminate certain tax benefits relating to abortion.

Specifically, section 1 provides that an itemized personal deduction is not allowed for an amount paid for an abortion. Section 2 disallows the refundable premium assistance credit for coverage under any qualified health plan that includes coverage for abortions. Section 3 disallows the small employer health insurance tax credit with respect to health plans that include coverage for abortions. Section 4 provides that any reimbursement from a health flexible spending arrangement under a cafeteria plan for the expenses incurred for an abortion is includible in the gross income of the employee. Section 4 also provides that a distribution from a health savings account or Archer medical savings account that is used for the cost of an abortion is includible in gross income. The bill includes the exceptions provided under the Hyde amendment for abortion of any pregnancy that places the mother in danger of death unless an abortion is performed, or is the result of rape or incest. The provisions of the bill do not apply to amounts paid, health coverage, reimbursements, or amounts used, for abortions in

¹ The Hyde amendment is language added to appropriations bills to prevent the use of Federal funds for abortions except where the life of the mother would be endangered unless an abortion is performed or where the pregnancy is the result of an act of rape or incest. For examples of this provision, see section 508 of Title V of Division D of the Consolidated Appropriations Act, 2010, Pub. L. No. 111–117.

these limited circumstances. The bill also does not apply to treatment for infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion. The provisions of the bill generally apply to taxable years beginning after the date of enactment except for section 2, which applies to taxable years ending after December 31, 2013.

B. BACKGROUND AND NEED FOR LEGISLATION

On January 20, 2011, two Members of Congress introduced bills seeking to codify the Hyde Amendment prohibiting taxpayer funding of abortion, and extending the principles of the Hyde Amendment to certain tax expenditures that encourage abortion. Rep. Chris Smith (R-NJ) introduced H.R. 3, the “No Taxpayer Funding for Abortion Act,” and Rep. Joseph Pitts (R-PA) introduced H.R. 358, the “Protect Life Act.” The Committee on Ways and Means received sequential referrals on both bills because the bills include tax provisions that fall within the jurisdiction of the Committee. The Committee believed it was appropriate to review the tax language in both bills to ensure the tax provisions would be clear for taxpayers and administrable for the Internal Revenue Service. The tax language in H.R. 3, specifically, created ambiguities and thus the Committee on Ways and Means decided to develop substitute tax provisions, embodied in the text of H.R. 1232, that provide greater clarity to taxpayers, with the intent that these provisions be added to the non-tax provisions of H.R. 3.

C. LEGISLATIVE HISTORY

Background

H.R. 1232 was introduced on March 29, 2011, and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up the bill on March 31, 2011, and ordered the bill, as amended, favorably reported.

Committee hearings

On March 16, 2011, the Subcommittee on Select Revenue Measures of the House Committee on Ways and Means held a hearing on H.R. 3, the “No Taxpayer Funding for Abortion Act,” as ordered reported by the House Committee on the Judiciary, and H.R. 358, the “Protect Life Act,” as reported by the Committee on Energy and Commerce.

II. EXPLANATION OF THE BILL

A. DEDUCTION FOR MEDICAL EXPENSES NOT ALLOWED FOR ABORTIONS (SEC. 1 OF THE BILL AND SEC. 213 OF THE CODE)

PRESENT LAW

Section 213 of the Internal Revenue Code (“Code”)² allows a deduction³ for certain expenses paid for medical care of the taxpayer, the taxpayer’s spouse, and the taxpayer’s dependents to the extent that such expenses exceed 7.5 percent of the taxpayer’s adjusted gross income⁴ (generally 10 percent for taxable years beginning after December 31, 2012).⁵

Medical care is defined for purposes of the deduction as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting the structure or function of the body, for certain transportation costs associated with such care, and for insurance covering such care.⁶ Operations or treatments affecting any portion of the body, including obstetric procedures, but excluding illegal procedures or treatments, are considered to be for the purpose of affecting the structure or function of the body, and thus constitute medical care.⁷ Costs associated with legal abortions are medical care expenses that are deductible under section 213.⁸

REASONS FOR CHANGE

The Committee believes it is appropriate to extend the principles of the Hyde amendment, which generally precludes the use of Federal funds to be expended for any abortion (except where the life of the mother would be endangered unless an abortion is performed or where the pregnancy is the result of an act of rape or incest) to certain tax expenditures under the Internal Revenue Code. As a result, the Committee does not believe that taxpayers should generally be able to claim a tax benefit for expenses paid for an abortion and thus believes that it is inappropriate for a deduction to be allowed for such expenses.

EXPLANATION OF PROVISION

Under the provision, an amount paid for an abortion is not taken into account for purposes of the deduction for medical expenses under section 213. Thus, such amount is both not deductible and not taken into account in determining whether the taxpayer has met the 7.5 (or 10) percent of adjusted gross income threshold for medical expenses that qualify for the deduction.

² Except where otherwise noted, all section references are to the Internal Revenue Code of 1986, as amended.

³ This deduction is available both to insured and uninsured individuals; thus, for example, an individual with employer-provided health insurance (or certain other forms of tax-subsidized health benefits) may also claim the itemized deduction for the individual’s medical expenses not covered by that insurance if the 7.5 (or 10) percent adjusted gross income threshold is met.

⁴ For purposes of the alternative minimum tax, medical expenses are deductible only to the extent that they exceed 10 percent of adjusted gross income.

⁵ For taxable years ending before January 1, 2017, if either the taxpayer or the taxpayer’s spouse turns 65 before the end of the taxable year, the threshold remains at 7.5 percent of adjusted gross income.

⁶ Sec. 213(d). Section 213(b) provides that any amount paid during a taxable year for medicine or drugs is taken into account for this deduction as a medical expense only if the medicine or drug is a prescribed drug or is insulin even though such medicine and drugs are included in the definition of medical care under section 213(d).

⁷ Treas. Reg. sec. 1.213-1(e).

⁸ Rev. Rul. 73-201, 1973-1 C.B. 140.

However, the provision does not apply to amounts paid for an abortion in the case of a pregnancy that is the result of rape or incest, or in the case of a woman who suffers from a physical disorder, injury, or illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself (“excluded abortions”). The provision also does not apply to medical expenses for any treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion (“excluded abortion-related treatment”).

EFFECTIVE DATE

The provision applies to taxable years beginning after date of enactment.

B. DISALLOWANCE OF REFUNDABLE CREDIT FOR COVERAGE UNDER QUALIFIED HEALTH PLAN WHICH PROVIDES COVERAGE FOR ABORTION (SEC. 2 OF THE BILL AND SEC. 36B OF THE CODE)

PRESENT LAW

In general

Section 36B, added to the Code by the Patient Protection and Affordable Care Act, as amended (“PPACA”),⁹ provides a refundable tax credit (the “premium assistance credit”) for eligible individuals and families who purchase health insurance through a health insurance exchange.¹⁰ The premium assistance credit, which is refundable and payable in advance directly to the insurer, subsidizes the purchase of qualified health plans through an exchange.¹¹

In order to receive advance payment of the premium assistance credit, an eligible individual enrolls in a plan offered through an exchange and reports his or her income to the exchange. Based on the information provided to the exchange, the individual receives a premium assistance credit based on income and the Treasury pays the premium assistance credit amount directly to the insurance plan in which the individual is enrolled. The individual then pays to the plan in which he or she is enrolled the dollar difference between the premium tax credit amount and the total premium charged for the plan.¹² Individuals who fail to pay all or part of the remaining premium amount are given a mandatory three-month grace period prior to an involuntary termination of their participation in the plan. Initial eligibility for the premium assistance credit is based on the individual’s income for the taxable year ending two years prior to the enrollment period. Individuals (or couples) who experience a change in marital status or other household circumstance, experience a decrease in income of more than 20 per-

⁹Pub. L. No. 111–148.

¹⁰Individuals enrolled in multi-state plans, pursuant to section 1334 of PPACA, are also eligible for the credit.

¹¹Under PPACA, States are to establish American Health Benefit Exchanges, commonly referred to simply as “exchanges.” These exchanges will be governmental agencies or nonprofit entities that, among other services, facilitate the purchase of health plans that meet certain minimum enrollment and benefit requirements.

¹²Although the credit is generally payable in advance directly to the insurer, individuals may choose to purchase health insurance out-of-pocket and claim the credit at the end of the taxable year. The amount of the reduction in premium is required to be included with each bill sent to the individual.

cent, or receive unemployment insurance, may update eligibility information or request a redetermination of their tax credit eligibility. Excess advance payments may be subject to recapture.¹³

Eligible individuals

The premium assistance credit is available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved.¹⁴ Individuals who are eligible for certain other health insurance, including certain health insurance through an employer or a spouse’s employer, may not be eligible for the credit. Household income is defined as the sum of: (1) the taxpayer’s modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining that taxpayer’s family size (but only if such individuals are required to file a tax return for the taxable year). To be eligible for the premium assistance credit, taxpayers who are married (within the meaning of section 7703) must file a joint return. Individuals who are listed as dependents on a return are ineligible for the premium assistance credit.

Calculation of the credit

The premium assistance credit amount is determined based on the percentage of income the cost of premiums represents, rising from two percent of income for those at 100 percent of FPL to 9.5 percent of income for those at 400 percent of FPL. Beginning in 2014, the percentages of income are indexed to the excess of premium growth over income growth for the preceding calendar year. Beginning in 2018, if the aggregate amount of premium assistance credits and cost-sharing reductions¹⁵ exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year. For purposes of calculating family size, individuals who are in the country illegally are not included.

Premium assistance credits are not available for months in which an individual has a free choice voucher (as defined in section 10108 of PPACA).

Qualified health plans

In general, qualified health plans are those plans that are certified as being qualified by the Secretary of Health and Human Services (“HHS”), provide essential health benefits packages,¹⁶ are offered by a qualifying health insurance issuer, and comply with the regulations and requirements developed by the Secretary of HHS for exchange participation.¹⁷ For purposes of the premium assistance credit, however, catastrophic plans (as described in section 1302(e) of PPACA) are not considered qualified health plans.

¹³Sec. 36B(f)(2).

¹⁴Individuals who are lawfully present in the United States but are not eligible for Medicaid because of their immigration status are treated as having a household income equal to 100 percent of FPL (and thus eligible for the premium assistance credit) as long as their household income does not actually exceed 100 percent of FPL.

¹⁵As described in section 1402 of PPACA.

¹⁶As defined in section 1302(a) of PPACA.

¹⁷Section 1301 of PPACA.

Treatment of abortions

Premium assistance credits, or any amounts that are attributable to them, cannot be used to pay for abortions for which Federal funding is prohibited. To prevent the premium assistance credit from being used for the cost of abortion coverage, section 1303 of PPACA requires that the portion of any premium attributable to the cost of abortion coverage be paid separately, either with a separate check or, in the case of payroll deductions, a separate deduction. Section 1303 further requires that the separate payments be allocated to a segregated account under the health plan and that the cost of abortion services covered under the plan only be reimbursed from funds in the segregated account. Under preexisting law, this separate payment of premiums and segregation of the assets alone is not sufficient to treat abortion coverage as being offered under a separate health plan. Rather, there must also be a separate election to purchase the coverage of abortion and a separate election to purchase the portion of the plan that does not cover abortion.¹⁸

REASONS FOR CHANGE

The Committee believes it is appropriate to extend the principles of the Hyde amendment, which generally precludes the use of Federal funds to be expended for any abortion (except where the life of the mother would be endangered unless an abortion is performed or where the pregnancy is the result of an act of rape or incest) to certain tax expenditures under the Internal Revenue Code. In the case of premium assistance credits, Federal outlays constitute most of the budget effect, and therefore it is proper to view the credits similarly to Federal spending programs already subject to the Hyde amendment. Given this, the Committee believes it is inappropriate for a premium assistance credit to be used for health plans that include abortion coverage.

EXPLANATION OF PROVISION

The provision amends section 36B in three ways. First, it amends the definition of qualified health plan so that the definition excludes health plans that cover abortion. As a result, premium assistance credits may not be applied towards plans that offer such coverage.

Second, the provision adds a new subparagraph to section 36B stating that, despite the change to the definition of qualified health plan, individuals are not prohibited from purchasing separate abortion coverage or health plans that include abortion coverage, as long as premium assistance credits are not used to purchase the separate coverage or plan. Third, the provision adds a second new subparagraph to section 36B explicitly stating that, despite the change to the definition of qualified health plan, non-Federal health insurance issuers (for example, private issuers that offer plans through an exchange) that offer qualified health plans are not prohibited from offering separate abortion coverage, or plans that have abortion coverage, as long as the premiums for such coverage are not paid for with premium assistance credits.

¹⁸See Treas. Reg. sec. 54.9831-1(c)(3) for the rules for determining when limited excepted benefits are not an integral part of a group health plan.

For purposes of the provision, qualified health plans may cover excluded abortions and excluded abortion-related treatment.

EFFECTIVE DATE

The provision applies to taxable years ending after December 31, 2013.

C. DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION (SEC. 3 OF THE BILL AND SEC. 45R OF THE BILL)

PRESENT LAW

Small business employers eligible for the credit

PPACA provides a tax credit for qualified small employers for nonelective contributions to purchase health insurance for their employees. A qualified small employer for this purpose generally is an employer with no more than 25 full-time equivalent employees (“FTEs”) employed during the employer’s taxable year, and whose employees have annual full-time equivalent wages that average no more than \$50,000. However, the full amount of the credit is available only to an employer with 10 or fewer FTEs and whose employees have average annual full-time equivalent wages from the employer of not more than \$25,000. These wage limits are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) for years beginning in 2014.

An employer’s FTEs are calculated by dividing the total hours worked by all employees during the employer’s taxable year by 2080. For this purpose, the maximum number of hours that are counted for any single employee is 2080 (rounded down to the nearest whole number). Wages are defined in the same manner as under section 3121(a) (as determined for purposes of FICA taxes but without regard to the dollar limit for covered wages) and the average wage is determined by dividing the total wages paid by the small employer by the number of FTEs (rounded down to the nearest \$1,000).

The number of hours of service worked by, and wages paid to, a seasonal worker of an employer is not taken into account in determining the FTEs and average annual wages of the employer unless the worker works for the employer on more than 120 days during the taxable year.

The contributions must be provided under an arrangement that requires the eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in certain defined qualifying health insurance offered to employees by the employer equal to a uniform percentage (not less than 50 percent) of the premium cost of the qualifying health plan.

The credit is not payable in advance to the taxpayer or refundable. Thus, the employer must pay the employees’ premiums during the year and claim the credit at the end of the year on its income tax return. The credit is a general business credit, and may be carried back for one year and carried forward for 20 years. The credit is available to offset tax liability under the alternative minimum tax.

Years the credit is available

The credit is initially available for any taxable year of an employer beginning in 2010, 2011, 2012, or 2013. Qualifying health insurance for claiming the credit for this first phase of the credit is health insurance coverage within the meaning of section 9832, which is generally health insurance coverage purchased from an insurance company licensed under State law.

For taxable years beginning in years after 2013, the credit is only available to a qualified small employer that purchases health insurance coverage for its employees through a State exchange and is only available for a maximum coverage period of two consecutive taxable years beginning with the first year in which the employer or any predecessor first offers one or more qualified plans to its employees through an exchange.

The maximum two-year coverage period does not take into account any taxable years beginning before 2014. Thus a qualified small employer could potentially qualify for this credit for six taxable years, four years under the first phase and two years under the second phase.

Calculation of credit amount

Only nonelective contributions by the employer are taken into account in calculating the credit. Therefore, any amount contributed pursuant to a salary reduction arrangement under a cafeteria plan within the meaning of section 125 is not treated as an employer contribution for purposes of this credit. The credit is equal to the lesser of the following two amounts multiplied by an applicable tax credit percentage: (1) the amount of contributions the employer made on behalf of the employees during the taxable year for the qualifying health coverage, and (2) the amount of contributions that the employer would have made during the taxable year if each employee had enrolled in coverage with a small business benchmark premium. As discussed above, this tax credit is only available if this uniform percentage is at least 50 percent.

For the first phase of the credit (any taxable years beginning in 2010, 2011, 2012, or 2013), the applicable tax credit percentage is 35 percent. The benchmark premium is the average total premium cost in the small group market for employer-sponsored coverage in the employer's State. The premium and the benchmark premium vary based on the type of coverage provided to the employee (e.g., single or family).

For taxable years beginning in years after 2013, the applicable tax credit percentage is 50 percent. The benchmark premium is the average premium cost in the small group market in the rating area in which the employee enrolls in coverage. The premium and the benchmark premium vary based on the type of coverage being provided to the employee (e.g., single or family).

The credit is reduced for an employer with between 10 and 25 FTEs. The amount of this reduction is equal to the amount of the credit (determined before any reduction) multiplied by a fraction, the numerator of which is the number of FTEs of the employer in excess of 10 and the denominator of which is 15. The credit is also reduced for an employer for whom the average wages per employee is between \$25,000 and \$50,000. The amount of this reduction is equal to the amount of the credit (determined before any reduction)

multiplied by a fraction, the numerator of which is the average annual wages of the employer in excess of \$25,000 and the denominator of which is \$25,000. For an employer with both more than 10 FTEs and average annual wages in excess of \$25,000, the reduction is the sum of the amounts of the two reductions.

Tax-exempt organizations as qualified small employers

Any organization described in section 501(c) that is exempt under section 501(a) and otherwise qualifies for the small business tax credit is eligible to receive the credit. However, for tax-exempt organizations, the applicable percentage for the credit during the first phase of the credit (any taxable year beginning in 2010, 2011, 2012, or 2013) is limited to 25 percent, and the applicable percentage for the credit during the second phase (taxable years beginning in years after 2013) is limited to 35 percent. The small business tax credit is otherwise calculated in the same manner for tax-exempt organizations that are qualified small employers as for all other qualified small employers. However, for tax-exempt organizations, instead of being a general business credit, the small business tax credit is a refundable tax credit limited to the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins. For this purpose, payroll taxes of an employer means: (1) the amount of income tax required to be withheld from its employees' wages; (2) the amount of hospital insurance tax under section 3101(b) required to be withheld from its employees' wages; and (3) the amount of the hospital insurance tax under section 3111(b) imposed on the employer.

Special rules

The employer is entitled to a deduction under section 162 equal to the amount of the employer contribution minus the dollar amount of the credit.

The employer is determined by applying the employer aggregations rules in section 414(b), (c), and (m). In addition, the definition of employee includes a leased employee within the meaning of section 414(n).

Self-employed individuals, including partners and sole proprietors, two percent share-holders of an S Corporation, and five percent owners of the employer (within the meaning of section 416(i)(1)(B)(i)) are not treated as employees for purposes of this credit. There is also a special rule to prevent sole proprietorships from receiving the credit for the owner and their family members. Thus, no credit is available for any contribution to the purchase of health insurance for these individuals and these individuals are not taken into account in determining the number of FTEs or average full-time equivalent wages.

REASONS FOR CHANGE

The Committee believes it is appropriate to extend the principles of the Hyde amendment, which generally precludes the use of Federal funds to be expended for any abortion (except where the life of the mother would be endangered unless an abortion is performed or where the pregnancy is the result of an act of rape or incest) to certain tax expenditures under the Internal Revenue Code. In the case of small employer health insurance expense credits, Fed-

eral outlays constitute much of the budget effect, and therefore it is proper to view the credits similarly to Federal spending programs already subject to the Hyde amendment. Given this, the Committee believes that it is inappropriate for an employer to be eligible for the small employer health insurance tax credit on the basis of health insurance that includes abortion coverage.

EXPLANATION OF PROVISION

Under the provision, health plans that include abortion coverage are not considered qualifying health plans for purposes of determining eligibility for the small employer health insurance tax credit. Thus, contributions by small employers toward the cost of health insurance premiums for plans that cover abortion are disregarded when determining whether the employer is eligible for the small employer health insurance tax credit.

For purposes of the provision, qualified health plans may cover excluded abortions and excluded abortion-related treatment.

EFFECTIVE DATE

The provision applies to taxable years beginning after date of enactment.

D. DISTRIBUTIONS FROM CERTAIN ACCOUNTS AND ARRANGEMENTS INCLUDIBLE IN GROSS INCOME

1. Health flexible spending arrangements (sec. 4 of the bill and secs. 105(b) and 125 of the Code)

PRESENT LAW

Exclusion from income for employer-provided health coverage

Section 106 generally provides that the value of coverage under an employer-provided health plan for employees (including retirees) and their dependents¹⁹ is excludible from gross income.²⁰ The exclusion applies both to coverage under a self-funded health plan (self-insured coverage) and health insurance purchased from an insurance company. In addition, under section 105(b), any reimbursements under the health plan for incurred expense for medical care for employees (including retirees) and their dependents (such as when the plan pays the doctor and the hospital for an employee's surgery) generally are excludible from gross income. A similar rule excludes the value of coverage under an employer-provided health plan, and reimbursement for incurred expenses for medical care, from the employees' wages for payroll tax purposes.²¹

Medical care for purposes of section 105(b) generally has the same meaning as for purposes of the deduction for medical ex-

¹⁹For purposes of employer sponsored coverage, the term dependents when used with respect to an individual (including an employee) is intended to include the individual's spouse, dependents (as defined in section 152, determined without regard to section 152(b)(1), (b)(2), and (d)(1)(B)), and any child (as defined in section 152(f)(1)) of the individual who as of the end of the taxable year has not attained age 27.

²⁰Health coverage provided to active members of the uniformed services, military retirees, and their dependents is excludable under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

²¹Secs. 3121(a)(2), 3306(a)(2), and 3401(a)(20). Also see sec. 3231(e)(1) for a similar rule with respect to compensation for purposes of Railroad Retirement Tax.

penses under section 213 except that medical care includes an amount paid for medicine or a drug only if such medicine or drug is insulin or is prescribed by a physician but does include prescribed drugs that are also available without a prescription. Medical care is defined as including amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting the structure or function of the body, and for certain transportation costs associated with such care. Operations or treatments affecting any portion of the body, including obstetric procedures, but excluding illegal procedures or treatments, are considered to be for the purpose of affecting the structure or function of the body, and thus constitute medical care.²² The costs associated with legal abortions are medical care under this definition.²³

Requirements for a cafeteria plan

If an employee receives a qualified benefit based on the employee's election between the qualified benefit and a taxable benefit under a cafeteria plan, the qualified benefit generally is not includible in gross income.²⁴ Qualified benefits under a cafeteria plan are generally employer-provided benefits that are excludible from gross income under an express provision of the Code and include employer-provided coverage under a health plan. The one specified qualified benefit that is not excludible from gross income is group term life insurance in excess of the \$50,000 limit.²⁵ However, if a plan offering an employee an election between taxable benefits (including cash) and nontaxable qualified benefits does not meet the requirements for being a cafeteria plan, the election between taxable and nontaxable benefits results in gross income to the employee, regardless of what benefit is elected and when the election is made.²⁶

A cafeteria plan is required to be a separate written plan under which all participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit. Finally, a cafeteria plan must not provide for deferral of compensation, except as specifically permitted in sections 125(d)(2)(B), (C), or (D). Some employer-provided benefits that are not includible in gross income under an express provision of the Code are explicitly not allowed in a cafeteria plan. These benefits are generally referred to as nonqualified benefits. Examples of nonqualified benefits include scholarships,²⁷ employer-provided meals and lodging,²⁸ educational assistance,²⁹ and fringe benefits.³⁰ A plan offering any nonqualified benefit is not a cafeteria plan.³¹

²²Treas. Reg. sec. 1.213-1(e).

²³Rev. Rul. 73-201, 1973-1 C.B. 140.

²⁴Sec. 125(a).

²⁵Under section 79, employer-provided group term life insurance is only excludable from gross income to the extent not in excess of \$50,000. Group term life insurance not in excess of the \$50,000 limit is also a qualified benefit under a cafeteria plan.

²⁶Prop. Treas. Reg. sec. 1.125-1(b).

²⁷Sec. 117.

²⁸Sec. 119.

²⁹Sec. 127.

³⁰Sec. 132.

³¹Prop. Treas. Reg. sec. 1.125-1(q). Long-term care services, contributions to Archer medical savings accounts, group term life insurance for an employee's spouse, child or dependent, and elective deferrals to section 403(b) plans are also nonqualified benefits.

Flexible spending arrangement under a cafeteria plan

A flexible spending arrangement for medical expenses under a cafeteria plan (“health FSA”) is health coverage in the form of an unfunded arrangement under which employees are given the option to reduce their current cash compensation and instead have the amount of the salary reduction contributions made available for use in reimbursing the employee for incurred expenses for medical care of the employee and the employee’s dependents.³² In the case of a health FSA, the employee makes a choice under a cafeteria plan before the beginning of the coverage period between (1) receiving cash compensation, and (2) a reduction in salary³³ equal to an amount not exceeding the maximum amount of reimbursement. Under a health FSA, the maximum amount of reimbursement must be available at all times during the coverage period (reduced by any reimbursements already made during the coverage period) even though salary reduction contributions are made ratably over the coverage period.³⁴ The reimbursements for incurred expense for medical care under a health FSA are excludible from gross income under section 105(b). A health FSA is not required to reimburse all medical expenses within the definition of medical care for purposes of section 105(b). The employer can specify that only certain medical expenses are reimbursed.

Health FSAs are subject to the general requirements for cafeteria plans, including the requirement that the plan not provide deferred compensation. This requires that amounts remaining under a health FSA at the end of a plan year be forfeited by the employee (referred to as the “use-it-or-lose-it rule”).³⁵ A health FSA is permitted to allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be used.³⁶ A health FSA can also include employer flex-credits, which are non-elective employer contributions that the employer makes for every employee eligible to participate in the employer’s cafeteria plan, to be used only for one or more qualified benefits.³⁷

REASONS FOR CHANGE

The Committee believes it is appropriate to extend the principles of the Hyde amendment, which generally precludes the use of Federal funds to be expended for any abortion (except where the life of the mother would be endangered unless an abortion is performed or where the pregnancy is the result of an act of rape or incest) to certain tax expenditures under the Internal Revenue Code. Thus, the Committee does not believe that reimbursements from a health FSA under a cafeteria plan that may be attributable to sal-

³²Under Prop. Treas. Reg. sec. 1.125-5(b), a health FSA is generally distinguishable from other employer-provided health coverage offered under a cafeteria plan by the relationship between the value of the coverage for a year and the maximum amount of reimbursement reasonably available during the same period. A health FSA generally is defined as a benefit program that provides employees with coverage under which specific incurred medical care expenses may be reimbursed (subject to reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.

³³Under section 125(i), for taxable years beginning after December 31, 2012, salary reduction contributions under a health FSA are not permitted to exceed \$2,500.

³⁴Prop. Treas. Reg. sec. 1.125-5(d).

³⁵Sec. 125(d)(2) and Prop. Treas. Reg. sec. 1.125-5(c).

³⁶Notice 2005-42, 2005-1 C.B. 1204 and Prop. Treas. Reg. sec. 1.125-1(e).

³⁷Prop. Treas. Reg. sec. 1-125-5(b).

ary reduction contributions that reimburse the medical expenses of an abortion should generally be tax-preferred and believes that such reimbursements should not be excludible from gross income.

EXPLANATION OF PROVISION

Under the provision, any reimbursement from a health FSA under a cafeteria plan for the expenses incurred for an abortion (other than for excluded abortions and excluded abortion-related treatment) is includible in the gross income of the employee. However, the reimbursement does not cause the health FSA to fail to satisfy the requirements of section 125.

EFFECTIVE DATE

The provision applies to expenses incurred with respect to taxable years beginning after date of enactment.

2. *Health savings accounts and Archer medical savings accounts (sec. 4 of the bill and secs. 220 and 223 of the Code)*

PRESENT LAW

Health savings account

Present law provides that individuals with a high deductible health plan (and generally no other health plan) may establish and make tax-deductible contributions to a health savings account (“HSA”).³⁸ An HSA is a tax-exempt account held by a trustee or custodian for the benefit of the individual. An HSA is subject to a condition that the individual is covered under a high deductible health plan (purchased either through the individual market or through an employer). The decision to create and fund an HSA is made on an individual-by-individual basis and does not require any action on the part of the employer.

Subject to certain limitations, contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excludible from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize their deductions on their tax return (rather than claiming the standard deduction).

For 2011, the maximum aggregate annual contribution that can be made to an HSA is \$3,050 in the case of self-only coverage and \$6,150 in the case of family coverage. The annual contribution limits are increased for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up contributions”). In the case of policyholders and covered spouses who are age 55 or older, the HSA annual contribution limit is greater than the otherwise applicable limit by \$1,000 in 2011 and thereafter. Contribu-

³⁸An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is “permitted insurance” or “permitted coverage.” Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker’s compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health FSA is disregarded in determining eligibility for an HSA.

tions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

A high deductible health plan is a health plan that has an annual deductible that is at least \$1,200 for self-only coverage or \$2,400 for family coverage for 2011 and that limits the sum of the annual deductible and other payments that the individual must make with respect to covered benefits to no more than \$5,950 in the case of self-only coverage and \$11,900 in the case of family coverage for 2011.

Archer medical savings account

An Archer medical savings account (“Archer MSA”) is also a tax-exempt trust or custodial account to which tax-deductible contributions may be made by individuals with a high deductible health plan.³⁹ Archer MSAs provide tax benefits similar to, but generally not as favorable as, those provided by HSAs for individuals covered by high deductible health plans. The main differences include: (1) only self-employed individuals and employees of small employers are eligible to have an Archer MSA; (2) for Archer MSA purposes, a high deductible health plan is a health plan with (a) an annual deductible for 2011 of at least \$2,050 and no more than \$3,050 in the case of self-only coverage and at least \$4,100 and no more than \$6,050 in the case of family coverage and (b) maximum out-of-pocket expenses for 2011 of no more than \$4,100 in the case of self-only coverage and no more than \$7,500 in the case of family coverage. After 2007, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had made Archer MSA contributions and employees who are employed by a participating employer.

Tax treatment of distributions

General rule

Distributions from an HSA or Archer MSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA or Archer MSA that are not used for qualified medical expenses are includible in gross income. An additional 20-percent tax is added for all HSA and Archer MSA distributions not used for qualified medical expenses. The additional 20-percent tax does not apply, however, if the distribution is made after death, disability, or attainment of age of Medicare eligibility (currently, age 65).

Qualified medical expenses

The definition of qualified medical expense generally means amounts paid for medical care as defined for purposes of the deduction for medical expenses under section 213 with the exception that insurance premiums are qualified medical expenses in only limited circumstances. Also qualified medical expense includes an amount paid for medicine or a drug (other than insulin) only if such medicine or drug is prescribed by a physician but does include prescribed drugs that are also available without a prescription.

Medical care is defined for purposes of the deduction for medical expenses under section 213 as including amounts paid for the diag-

³⁹Sec. 220.

nosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting the structure or function of the body, and for certain transportation costs associated with such care. Operations or treatments affecting any portion of the body, including obstetric procedures, but excluding illegal procedures or treatments, are considered to be for the purpose of affecting the structure or function of the body, and thus constitute medical care.⁴⁰ The costs associated with legal abortions are medical care under this definition.⁴¹

REASONS FOR CHANGE

The Committee believes it is appropriate to extend the principles of the Hyde amendment, which generally precludes the use of Federal funds to be expended for any abortion (except where the life of the mother would be endangered unless an abortion is performed or where the pregnancy is the result of an act of rape or incest) to certain tax expenditures under the Internal Revenue Code. Thus, the Committee does not believe that distributions from a taxpayer's funds in HSAs and Archer MSAs that are used to pay for an abortion should generally be tax-preferred and thus believes that such distributions should not be excludible from gross income.

EXPLANATION OF PROVISION

Under the provision, a distribution from an HSA or Archer MSA used for the cost of an abortion (other than for excluded abortions and excluded abortion-related treatment) is includible in gross income. However, because the distribution is a qualified medical expense for purposes of the HSA and Archer MSA rules, the distribution is not subject to the 20-percent additional tax applicable to distributions not used for qualified medical expenses.

EFFECTIVE DATE

The provision applies to amounts paid from an HSA or Archer MSA with respect to taxable years beginning after date of enactment.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill, H.R. 1232.

The bill H.R. 1232, was ordered favorably reported, as amended, by a rollcall vote of 22 yeas to 14 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp	X	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Herger	X	.....	.....	Mr. Rangel .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Stark .....	.....	X	.....
Mr. Brady	X	.....	.....	Mr. McDermott .....	.....	X	.....
Mr. Ryan	X	.....	.....	Mr. Lewis .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Tiberi	X	.....	.....	Mr. Becerra .....	.....	X	.....

⁴⁰Treas. Reg. sec. 1.213-1(e).

⁴¹Rev. Rul. 73-201, 1973-1 C.B. 140.

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Davis	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Boustany	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Heller	X	.....	.....	Mr. Blumenauer .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Kind .....	.....	X	.....
Mr. Gerlach	X	.....	.....	Mr. Pascrell .....	.....	.....	.....
Mr. Price	X	.....	.....	Ms. Berkley .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Smith	X	.....	.....		
Mr. Schock	X	.....	.....		
Ms. Jenkins	X	.....	.....		
Mr. Paulsen	X	.....	.....		
Mr. Marchant	X	.....	.....		
Mr. Berg	X	.....	.....		
Ms. Black	X	.....	.....		

VOTES ON AMENDMENTS

The Crowley Amendment to the Chairman’s Amendment in the Nature of a Substitute to H.R. 1232 failed to pass by a rollcall vote of 14 yeas to 22 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Camp	X	.....	Mr. Levin	X	.....	.....
Mr. Herger	X	.....	Mr. Rangel	X	.....	.....
Mr. Johnson	X	.....	Mr. Stark	X	.....	.....
Mr. Brady	X	.....	Mr. McDermott	X	.....	.....
Mr. Ryan	X	.....	Mr. Lewis	X	.....	.....
Mr. Nunes	X	.....	Mr. Neal	X	.....	.....
Mr. Tiberi	X	.....	Mr. Becerra	X	.....	.....
Mr. Davis	X	.....	Mr. Doggett	X	.....	.....
Mr. Reichert	X	.....	Mr. Thompson	X	.....	.....
Mr. Boustany	X	.....	Mr. Larson	X	.....	.....
Mr. Heller	X	.....	Mr. Blumenauer	X	.....	.....
Mr. Roskam	X	.....	Mr. Kind	X	.....	.....
Mr. Gerlach	X	.....	Mr. Pascrell .....	.....	.....	.....
Mr. Price	X	.....	Ms. Berkley .....	.....	X	.....
Mr. Buchanan	X	.....	Mr. Crowley .....	.....	X	.....
Mr. Smith	X	.....			
Mr. Schock	X	.....			
Ms. Jenkins	X	.....			
Mr. Paulsen	X	.....			
Mr. Marchant	X	.....			
Mr. Berg	X	.....			
Ms. Black	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 revenue provisions of the bill, H.R. 1232 as reported.

The bill, as reported, is estimated to have the following effects on budget receipts for fiscal years 2011–2021:

ESTIMATED BUDGET EFFECTS OF H.R. 1232,
AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS

Fiscal Years 2011 - 2021

[Millions of Dollars]

Provision	Effective	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2011-16	2011-21
A. Deduction and Credits for Medical Expenses Not Allowed for Abortions.....	tyba DOE													
B. Disallowance of Refundable Credit for Coverage Under Qualified Health Plan Which Provides Coverage for Abortion.....	tyea 12/31/13													
C. Disallowance of Small Employer Health Insurance Expense Credit for Plan Which Includes Coverage for Abortion.....	tyba DOE													
D. Reimbursements From Health FSAs Under Cafeteria Plans for Expenses Incurred for Abortions Includable in Gross Income.....	eiwrt tyba DOE													
E. Distributions From HSAs and Archer MSAs Used for Abortions Includable in Gross Income.....	apwrt tyba DOE													
NET TOTAL														

Joint Committee on Taxation

Legend for "Effective" column:

apwrt = amounts paid with respect to
DOE = date of enactment

eiwrt = expenses incurred with respect to
tyba = taxable years beginning after

tyea = taxable years ending after

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

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, April 5, 2011.

Hon. DAVE CAMP,
*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. 1232, a bill to amend the Internal Revenue Code of 1986 to eliminate certain tax benefits relating to abortion.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

DOUGLAS W. ELMENDORF.

Enclosure.

H.R. 1232—A bill to amend the Internal Revenue Code of 1986 to eliminate certain tax benefits relating to abortion

H.R. 1232 would amend the Internal Revenue Code to remove certain tax benefits relating to abortion, except in cases of rape, incest, or when the life of the pregnant woman is in danger. The bill would not allow the costs of abortion services, other than under the excepted circumstances mentioned above, to count as a deductible medical expense in determining income tax liability. The bill would change the definition of a “qualified health plan” to exclude plans that offer coverage of abortion services, other than under the excepted circumstances. In addition, health insurance tax credits for small employers would not be available for health insurance plans that include such coverage. The bill also would require any reimbursements from health flexible spending arrangements and distributions by Archer medical savings accounts and health savings accounts for abortion services to be included as gross income.

Enacting H.R. 1232 could affect direct spending or revenues; therefore, pay-as-you-go procedures apply. According to the staff of the Joint Committee on Taxation (JCT), the bill would have negligible effects on tax revenues. Similarly, CBO estimates that any effects on direct spending would be negligible for each year and over the 2011–2021 period.

JCT has determined that H.R. 1232 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

D. MACROECONOMIC IMPACT ANALYSIS

In compliance with clause 3(h)(2) 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 effects of the bill on economic activity are so small as to be incalculable within the context of a model of the aggregate economy.

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 a result of the Committee's review of the tax provisions of H.R. 3, as ordered reported by the Committee on the Judiciary, 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 revenue provisions of the bill do not contain Federal mandates on the private sector. The Committee has determined that the revenue provisions of the bill do not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Clause 5(b) of rule XXI 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 provisions of the bill, and states that the provisions of the bill do 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 Reform and Restructuring Act of 1998 (the "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 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 Code 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.

CHANGES IN EXISTING LAW MADE 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 italic, existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

Subtitle A—Income Taxes

* * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

Subchapter A—Determination of Tax Liability

* * * * *

PART IV—CREDITS AGAINST TAX

* * * * *

Subpart C—Refundable Credits

* * * * *

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

(a) * * *

* * * * *

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

(1) * * *

* * * * *

(3) DEFINITIONS AND OTHER RULES.—

(A) QUALIFIED HEALTH PLAN.—The term “qualified health plan” has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act or any health plan that includes coverage for abortions (other than any abortion or treatment described in section 213(g)(2)).

* * * * *

(C) SEPARATE ABORTION COVERAGE OR PLAN ALLOWED.—

(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any non-Federal health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

* * * * *

Subpart D—Business Related Credits

* * * * *

SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

(a) * * *

* * * * *

(h) INSURANCE DEFINITIONS.—**[Any term]**

(1) *IN GENERAL.*—Any term used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.

(2) *EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.*—The terms “qualified health plan” and “health insurance coverage” shall not include any health plan or benefit that includes coverage for abortions (other than any abortion or treatment described in section 213(g)(2)).

* * * * *

Subchapter B—Computation of Taxable Income

* * * * *

PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

* * * * *

SEC. 125. CAFETERIA PLANS.

(a) * * *

* * * * *

(k) ABORTION REIMBURSEMENT FROM FLEXIBLE SPENDING ARRANGEMENT INCLUDED IN GROSS INCOME.—Notwithstanding section 105(b), gross income shall include any reimbursement for expenses incurred for an abortion (other than any abortion or treatment described in section 213(g)(2)) from a health flexible spending arrangement provided under a cafeteria plan. Such reimbursement shall not fail to be a qualified benefit for purposes of this section merely as a result of such inclusion in gross income.

[(k)] (l) CROSS REFERENCE.—For reporting and recordkeeping requirements, see section 6039D.

[(l)] (m) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

* * * * *

PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

* * * * *

SEC. 213. MEDICAL, DENTAL, ETC., EXPENSES.

(a) * * *

* * * * *

(g) AMOUNTS PAID FOR ABORTION NOT TAKEN INTO ACCOUNT.—

(1) IN GENERAL.—An amount paid during the taxable year for an abortion shall not be taken into account under subsection (a).

(2) EXCEPTIONS.—Paragraph (1) shall not apply to—

(A) an abortion—

(i) in the case of a pregnancy that is the result of an act of rape or incest, or

(ii) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy, and

(B) the treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion.

* * * * *

SEC. 220. ARCHER MSAS.

(a) * * *

* * * * *

(f) TAX TREATMENT OF DISTRIBUTIONS.—

(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of an Archer MSA which is used exclusively to pay qualified medical expenses of any account holder shall not be includible in gross income, *except that any such amount used to pay for an abortion (other than any abortion or treatment described in section 213(g)(2)) shall be included in the gross income of such holder.*

* * * * *

SEC. 223. HEALTH SAVINGS ACCOUNTS.

(a) * * *

* * * * *

(f) TAX TREATMENT OF DISTRIBUTIONS.—

(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income, *except that any such amount used to pay for an abortion (other than any abortion or treatment described in section 213(g)(2)) shall be included in the gross income of such beneficiary.*

* * * * *

DISSENTING AND ADDITIONAL VIEWS

DISSENTING VIEWS

We want the record to show that we strongly oppose H.R. 1232, a bill to amend the Internal Revenue Code of 1986 to eliminate certain tax benefits relating to abortion.

Our Republican colleagues on Ways and Means assert that H.R. 1232 represents the mere codification of the annual Hyde Amendment. The Hyde Amendment prohibits the use of federal funds to pay for abortions. However, H.R. 1232 goes well beyond the Hyde Amendment. For the first time, the bill would equate health expenses that are the subject of preferential tax treatment with federal spending under programs such as Medicaid. H.R. 1232 is a tax increase on women and families with respect to one of the most personal and private decisions that they will ever face.

H.R. 1232 is very injurious because of its effect on middle class and lower income women and families who do not have an employer offer of health insurance coverage. This is because H.R. 1232 would deny the use of premium tax credits that are available under the Affordable Care Act for women and families under 400 percent of the poverty line (\$89,400 in 2011 for a family of four) if the coverage includes abortion services. If this bill becomes law, the overriding economic incentive for these women and families will be to choose coverage that does not include abortion services—there is no doubt about this conclusion. It is possible that, if H.R. 1232 is enacted, insurance companies would respond in the individual market by solely offering coverage that does not include abortion services given the value of the premium tax credits. The majority observes that insurance companies may offer “unplanned pregnancy only” coverage policies and that nothing in their bill would prevent a family from purchasing this additional coverage. This offers no practical assistance to middle class and lower income women and families. It is highly questionable that women and families would purchase coverage for unplanned pregnancies. Indeed, the likelihood of an insurance company even offering such coverage is also highly questionable—in fact, there is no evidence that this market even exists—and the likelihood that any woman or family would buy such coverage is even more remote.

We are also extremely concerned that H.R. 1232 represents an attack on the Affordable Care Act and the compromise contained in the Act on health coverage and abortion services. The Affordable Care Act is consistent with long standing federal law by prohibiting the use of federal funds to pay for abortions except under certain circumstances. The Act requires two separate premium payments for those women and families who receive premium tax credits and choose coverage that includes abortion services. The Affordable

Care Act is clear—no portion of premium tax credits may be used to pay for the portion of comprehensive health coverage that is purchased on state exchanges that relates to abortion services. The Act recognizes that the likelihood that insurers will offer unplanned pregnancy coverage is remote and the likelihood of purchase of such policies by women and families is even more remote. H.R. 1232, however, would require that insurers offer these improbable policies as the only source of coverage for middle class and lower income women and families.

H.R. 1232 is also injurious because it creates a significant divide between the coverage that large employers are able to offer their employees and the coverage that will be available to employees of smaller employers. This is because H.R. 1232 would deny a small employer the ability to use tax credits created by the Affordable Care Act to provide employee health coverage if the coverage includes abortion services. H.R. 1232 contains no similar restrictions on medium and large employers. The burden is placed only on the smallest employers. If this bill is enacted, the over-riding economic incentive of small employers will be to choose coverage for their employees that does not include abortion services—there is no doubt about this conclusion. It is even possible that, if H.R. 1232 is enacted, insurance companies would respond in the small group market by solely offering coverage that does not include abortion services given the value of the small business tax credits. There is no doubt that women who work for small businesses would lose access to the same type of comprehensive coverage they currently have today and that will remain available to women who work for medium and larger employers.

H.R. 1232 would certainly result in a tax increase for women and families when they are facing an extremely private and personal decision. The majority hides behind the fact that the Joint Committee on Taxation estimates the revenue impact of H.R. 1232 to be negligible. The fact behind this revenue estimate is that the Joint Committee on Taxation believes that increased tax liabilities on the part of women and families will be offset by the increased tax benefits when more pregnancies are carried to term. However, for any one particular woman or family, the fact is that H.R. 1232 would deny the itemized deduction for medical expenses in excess of 7.5 percent of adjusted gross income (10 percent in 2013) for expenses that relate to an abortion. For any one particular woman or family, the fact is that H.R. 1232 would treat as taxable any distribution from a health savings account (HSA), Archer medical savings account (MSA), or health flexible spending account (FSA) that is used to pay for abortion expenses. These clearly are tax increases.

Mr. Crowley of New York offered an amendment during the Committee's markup of H.R. 1232 that would have prevented the tax provisions of the bill from taking effect if the tax liability of any one woman, family, or small business would be increased. As the majority noted during the markup, the effect of the amendment would have been to eliminate the tax provisions of the bill. The amendment was defeated along a party-line vote.

The majority suggests that if H.R. 1232 is enacted, enforcement of the law by the Internal Revenue Service would result in minimal

intrusion on women and families. This assertion is highly suspect. While existing tax forms and instructions could be tailored so that a woman or family does not have to report whether there has been an abortion and the amount of the associated expense, there is nothing in H.R. 1232 that mandates such an approach. Further, the Internal Revenue Service would be required to use the tools currently available as part of its tax enforcement duties, including the Internal Revenue Service's ability to audit taxpayers, to determine whether tax benefits had properly or improperly been claimed with respect to expenses related to abortion services.

We are extremely concerned with the direction that the majority is taking with H.R. 1232. What further restrictions on medical procedures lie ahead? For example, will tomorrow's legislation seek to restrict tax benefits with respect to procedures that involve stem cells? Will restrictions be placed on an employer's deduction for employee health coverage if abortion services are covered? Will similar restrictions be placed on the employee's exclusion of the value of such coverage from income? Will medical providers and insurers be denied deductions with respect to their business expenses that involve abortions?

We are also extremely concerned that H.R. 1232 does not make an exception for a woman where continuing her pregnancy would result in severe and long-lasting damage to her health. The abortion exceptions that are allowed for in H.R. 1232 are extremely limited and do not apply to situations in which a woman's health is endangered. For example, a woman who is diagnosed with cancer and in need of chemotherapy or other treatments that are incompatible with a pregnancy would not qualify for an exception under H.R. 1232.

For the reasons listed above, we strongly oppose H.R. 1232. This bill not only represents an unprecedented move down a path that takes the Committee's jurisdiction squarely into an extremely private and personal decision that a woman and her family may have to make—it would also increase taxes on women and families during that difficult time.

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 MIKE THOMPSON.
 JOHN B. LARSON.
 EARL BLUMENAUER.
 RON KIND.
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 SHELLEY BERKLEY.
 JOSEPH CROWLEY.

ADDITIONAL VIEWS OF CONGRESSMAN BILL PASCRELL, JR.

Since I was first elected to Congress, I have opposed the federal funding of abortion, and I support the Hyde amendment's prohibitions. During last year's debate over the Affordable Care Act, I worked closely with Members on both sides of the aisle to craft a careful compromise that would ensure affordable access to health insurance while maintaining this federal prohibition.

The restrictions on abortion in H.R. 1232 go far beyond this compromise. Abortion is an intensely personal decision, and women should be able to make this decision in consultation with their families, their faith, and with their health professionals. I believe that H.R. 1232 will unnecessarily pull the Internal Revenue Service into the role of determining women's healthcare choices. I am not comfortable with such an increased reach of government into the constitutionally protected choices of our citizens.

Additionally, should H.R. 1232 become law, not only would it increase taxes on the middle class, but participants in state-based exchanges, who would be disproportionately lower income, will likely lose access completely to health plans that provide abortion coverage. Women have the right to choose a plan that covers this legal procedure.

Using the tax code in the way proposed by this bill will set a dangerous precedent. As Members of the Ways and Means Committee, we should be acutely aware of the unintended consequence that can occur when we use the code as a tool to enact a political agenda.

During the Committee's Markup of H.R. 1232, I missed the two roll call votes of the day. Had I been present I would have voted YEA on Mr. Crowley's amendment to protect the middle class from a tax increase. Additionally, had I been present I would have voted NAY on reporting H.R. 1232 favorably.

BILL PASCRELL, JR.

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