

**DESCRIPTION OF H.R. \_\_\_\_.**

Scheduled for Markup  
By the  
HOUSE COMMITTEE ON WAYS AND MEANS  
on March 31, 2011

Prepared by the Staff  
of the  
JOINT COMMITTEE ON TAXATION



March 29, 2011  
JCX-21-11

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## INTRODUCTION

The House Committee on Ways and Means has scheduled a markup on March 31, 2011 of H.R. \_\_\_\_\_. This document<sup>1</sup> provides a description of present law and the proposals contained in H.R. \_\_\_\_\_.

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<sup>1</sup> This document may be cited as follows: Joint Committee on Taxation, *Description of H.R.\_\_\_\_\_*,” (JCX-21-11), March 29, 2011. This document can also be found on our website at [www.jct.gov](http://www.jct.gov).

## **A. Deduction for Medical Expenses Not Allowed for Abortions**

### **Present Law**

Section 213 of the Internal Revenue Code (“Code”)<sup>2</sup> allows a deduction<sup>3</sup> 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 income<sup>4</sup> (generally 10 percent for tax years beginning after December 31, 2012<sup>5</sup>).

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.<sup>6</sup> Operations or treatments affecting any portion of the body, including obstetric expenses, 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.<sup>7</sup> Costs associated with legal abortions are medical care expenses that are deductible under section 213.<sup>8</sup>

### **Description of Proposal**

Under the proposal, 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.

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

<sup>3</sup> 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.

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

<sup>5</sup> 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.

<sup>6</sup> Sec. 213(d). Section 213(b) provides that any amount paid during a taxable year for medicine or drugs is explicitly 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).

<sup>7</sup> Treas. Reg. sec. 1.213-1(e).

<sup>8</sup> Rev. Rul. 73-201, 1973-1 C.B. 140.

However, the proposal disallowing the deduction for amounts paid for an abortion does not apply to 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 proposal 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 proposal 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**

### **Present Law**

#### **In general**

Section 36B, added to the Code by the Patient Protection and Affordable Care Act, as amended (“PPACA”),<sup>9</sup> provides a refundable tax credit (the “premium assistance credit”) for eligible individuals and families who purchase health insurance through a health insurance exchange.<sup>10</sup> 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.<sup>11</sup>

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.<sup>12</sup> 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 tax 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 percent, 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.<sup>13</sup>

#### **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

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<sup>9</sup> Pub. L. No. 111-148.

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

<sup>11</sup> Under 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.

<sup>12</sup> Although 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.

<sup>13</sup> Sec. 36B(f)(2).

family size involved.<sup>14</sup> 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 reductions<sup>15</sup> 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,<sup>16</sup> are offered by a qualifying health insurance issuer, and comply with the regulations and requirements developed by the Secretary of HHS for exchange participation.<sup>17</sup> For purposes of the premium assistance credit, however, catastrophic plans (as described in section 1302(e) of PPACA) are not considered qualified health plans.

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<sup>14</sup> Individuals 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.

<sup>15</sup> As described in section 1402 of PPACA.

<sup>16</sup> As defined in section 1302(a) of PPACA.

<sup>17</sup> Section 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.<sup>18</sup>

## **Description of Proposal**

The proposal 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 proposal 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 proposal adds a second new subparagraph to 36B providing that, despite the change to the definition of qualified health plan, non-Federal health insurance issuers 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.

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

## **Effective Date**

The proposal applies to taxable years ending after December 31, 2011.

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<sup>18</sup> See 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.

## **C. Disallowance of Small Employer Health Insurance Expense Credit for Plan Which Includes Coverage for Abortion**

### **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 tax 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 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 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) which is exempt under section 501(a) that 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 shareholders 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.

### **Description of Proposal**

Under the proposal, 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 proposal, qualified health plans may cover excluded abortions and excluded abortion-related treatment.

### **Effective Date**

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

## **D. Distributions from Certain Accounts and Arrangements Includible in Gross Income**

### **1. Health flexible spending arrangement**

#### **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 dependents<sup>19</sup> is excludible from gross income.<sup>20</sup> 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.<sup>21</sup>

Medical care for purposes of section 105(b) generally has the same meaning as for purposes of the deduction for medical expenses 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 expenses, 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.<sup>22</sup> The costs associated with legal abortions are medical care under this definition.<sup>23</sup>

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<sup>19</sup> For 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.

<sup>20</sup> Health 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.

<sup>21</sup> Secs. 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.

<sup>22</sup> Treas. Reg. sec. 1.213-1(e).

<sup>23</sup> Rev. Rul. 73-201, 1973-1 C.B. 140.

## **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 includable in gross income.<sup>24</sup> Qualified benefits under a cafeteria plan are generally employer-provided benefits that are excludable 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 excludable from gross income is group term life insurance in excess of the \$50,000 limit.<sup>25</sup> 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.<sup>26</sup>

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 includable 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;<sup>27</sup> employer-provided meals and lodging;<sup>28</sup> educational assistance;<sup>29</sup> and fringe benefits.<sup>30</sup> A plan offering any nonqualified benefit is not a cafeteria plan.<sup>31</sup>

## **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

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<sup>24</sup> Sec. 125(a).

<sup>25</sup> Under 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.

<sup>26</sup> Prop. Treas. Reg. sec. 1.125-1(b).

<sup>27</sup> Sec. 117.

<sup>28</sup> Sec. 119.

<sup>29</sup> Sec. 127.

<sup>30</sup> Sec. 132.

<sup>31</sup> Prop. 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.

expenses for medical care of the employee and the employee's dependents.<sup>32</sup> 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 salary<sup>33</sup> 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.<sup>34</sup> 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”).<sup>35</sup> 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.<sup>36</sup> 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.<sup>37</sup>

### **Description of Proposal**

Under the proposal, 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.

The amount of a reimbursement for an abortion includible in gross income is not subject to FICA tax or income tax withholding as wages. However, it is reasonable to expect that Internal Revenue Service may require the amount of the reimbursement to be reported on the

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<sup>32</sup> Under 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 which 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.

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

<sup>34</sup> Prop. Treas. Reg. sec. 125-5(d).

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

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

<sup>37</sup> Prop. Treas. Reg. sec. 1-125-5(b).

employee's Form W-2 (for the year the reimbursement is paid) as wages, tips, and other compensation includable in gross income.<sup>38</sup>

### **Effective Date**

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

## **2. Health savings accounts and Archer medical savings accounts**

### **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”).<sup>39</sup> 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. Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

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<sup>38</sup> The instructions to Form W-2 (2011) provide that other compensation that must be included in Box 1 includes taxable amounts that an employer paid to an employee from which federal income tax was not withheld.

<sup>39</sup> An 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.

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.<sup>40</sup> 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 made 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 diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting the structure or function of the body, and for certain

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<sup>40</sup> Sec. 220.

transportation costs associated with such care. Operations or treatments affecting any portion of the body, including obstetric expenses, 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.<sup>41</sup> The costs associated with legal abortions are medical care under this definition.<sup>42</sup>

### **Description of Proposal**

Under the proposal, 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 made for qualified medical expenses.

### **Effective Date**

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

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<sup>41</sup> Treas. Reg. sec. 1.213-1(e).

<sup>42</sup> Rev. Rul. 73-201, 1973-1 C.B. 140.