114TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { 114–268

EQUITABLE ACCESS TO CARE AND HEALTH ACT

SEPTEMBER 28, 2015.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. RYAN of Wisconsin, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 2061]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2061) to amend section 5000A of the Internal Revenue Code of 1986 to provide an additional religious exemption from the individual health coverage mandate, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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49–006

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Equitable Access to Care and Health Act" or the "EACH Act".

SEC. 2. ADDITIONAL RELIGIOUS EXEMPTION FROM HEALTH COVERAGE RESPONSIBILITY REQUIREMENT.

(a) IN GENERAL.—Section 5000A(d)(2)(A) of the Internal Revenue Code of 1986 is amended to read as follows:

"(A) RELIGIOUS CONSCIENCE EXEMPTIONS.—

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

"(I) such individual is a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and is adherent of established tenets or teachings of such sect or division as described in such section, or

"(II) such individual is a member of a religious sect or division thereof which is not described in section 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.

"(ii) SPECIAL RULES.—

"(I) MEDICAL HEALTH SERVICES DEFINED.—For purposes of this subparagraph, the term 'medical health services' does not include routine dental, vision, and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide in implementing section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act.

"(II) ATTESTATION REQUIRED.—Clause (i)(II) shall apply to an individual for months in a taxable year only if the information provided by the individual under section 1411(b)(5)(A) of such Act includes an attestation that the individual has not received medical health services during the preceding taxable year.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2013.

(c) CONSTRUCTION.—Nothing in the amendment made by subsection (a) shall preempt any State law requiring the provision of medical treatment for children, especially those who are seriously ill.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 2061, as reported by the Committee on Ways and Means, expands the religious conscience exemption from the Affordable Care Act individual mandate to include individuals for whom the acceptance of medical health services would be inconsistent with their religious beliefs.

B. Background and Need for Legislation

While the Committee continues to actively pursue health care reform to relieve unnecessary burdens on the broader economy and on taxpayers in need of access to quality health care, the Committee also believes it is important to provide immediate relief from taxes imposing excessive constraints on individual choice and personal religious belief. The Committee believes that expanding the religious conscience exemption from the Affordable Care Act individual mandate will relieve an unfair tax burden.

C. Legislative History

Background

H.R. 2061 was introduced on April 28, 2015, and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up H.R. 2061, the "Equitable Access to Care and Health Act" on September 17, 2015, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

The harmful effects of the individual mandate were discussed at no less than three hearings during the 114th Congress:

- Health Subcommittee Hearing on the Individual and Employer Mandates in the President's Healthcare Law (April 14, 2015);
- Full Committee Hearing on Obamacare Implementation and the Department of Health and Human Services FY 16 Budget Request (June 10, 2015); and
- Oversight Subcommittee Hearing on Rising Health Insurance Premiums Under Obamacare (June 24, 2015).

II. EXPLANATION OF THE BILL

A. Additional Religious Exemption From Health Coverage Responsibility Requirement (sec. 2 of the bill and sec. 5000A of the Code)

PRESENT LAW

Requirement to maintain coverage

Effective as of 2014, individuals must be covered by a health plan that provides at least minimum essential coverage or be subject to a tax for failure to maintain the coverage.[1] If an individual is a dependent[2] of another taxpayer, the other taxpayer is liable for any tax for failure to maintain the required coverage with respect to the individual. The tax is imposed for any month that an

[1] Section 5000A which was added to the Code by section 1501 of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No 111–148, enacted March 23, 2010, as amended by section 10106 of PPACA and 1002 of the Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111–152, enacted March 30, 2010. PPACA and HCERA are collectively referred to as the Affordable Care Act ("ACA"). Except where otherwise stated, all references are to the Internal Revenue Code of 1986, as amended.

[2] Sec. 152.

individual does not have minimum essential coverage, unless the individual qualifies for an exemption for the month as described below.

Minimum essential coverage

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of HHS in coordination with the Secretary of the Treasury. Certain individuals present or residing outside of the U.S.[3] and bona fide residents of territories of the U.S.[4] are deemed to maintain minimum essential coverage.

Minimum essential coverage does not include coverage that consists of certain excepted benefits.[5] Excepted benefits include: (1) coverage only for accident, or disability income insurance; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers' compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Other excepted benefits that do not constitute minimum essential coverage if offered under a separate policy, certificate or contract of insurance include long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance.

Tax on failure to maintain minimum essential coverage

The tax for failure to maintain minimum essential coverage for any calendar month is one-twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of the flat dollar amount or the excess income amount. The flat dollar amount is the lesser of sum of the individual annual dollar amounts for the members of the taxpayer's family and 300 percent of adult individual dollar amount. The excess income amount is a specified percentage of the excess of the taxpayer's household income for the taxable year over the threshold amount of income for required income tax return filing for that taxpayer.[6] The total annual household payment may not exceed the national average annual premium for bronze level health plans offered through American Health Benefit Exchanges that year for the family size. The individual adult annual dollar amount is phased in over the first three

[3] This rule applies to any month that occurs during a period described in section 911(d)(1)(A) or (B) which is applicable to an individual. Such periods include: (1) for a United States citizen, an uninterrupted period which includes an entire taxable year during which the individual is a bona fide resident of a foreign country or countries, and (2) for a United States citizen or resident, a period of 12 consecutive months during which the individual is present in a foreign country at least 330 full days.

[4] Bona fide residence in a territory is determined under section 937(a). For this purpose, the territories include Puerto Rico, Guam, the Northern Marianna Islands, American Samoa, and United States Virgin Islands.

[5] Sec. 2791(c)(1)–(4) of PHSA (42 U.S.C. sec. 300gg–91(c)(1–4)). A parallel definition of excepted benefits is provided in section 9832(c)(1)–(4).

[6] Sec. 6012(a).

years as follows: $95 for 2014; $325 for 2015; and $695 in 2016.[7] For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount. The specified percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015.

Exemptions

Exemptions from the requirement to maintain minimum essential coverage are provided for the following: (1) an individual for whom coverage is unaffordable because the required contribution exceeds eight percent of household income, (2) an individual with household income below the income tax return filing threshold, (3) a member of an Indian tribe, (4) a member of certain recognized religious sects ("religious conscience exemption") or a health sharing ministry, (5) an individual with a coverage gap for a continuous period of less than three months, and (6) an individual who is determined by the Secretary of Health and Human Services to have suffered a hardship with respect to the capability to obtain coverage.[8]

The religious conscience exemption applies to members of religious sects (or divisions thereof) which are recognized religious sects for purposes of a previously existing exemption under the Self-Employment Contributions Act ("SECA"),[9] who are adherents of established tenets or teachings of the sect (or division) as described under the SECA exemption. The SECA exemption requires the Commissioner of Social Security to find that (1) the sect (or division) has established tenets or teachings that are conscientiously opposed to accepting benefits of any private or public insurance that makes payments in the event of death, disability, old age, or retirement, or makes payments toward the costs of, or provides services for, medical care (including the benefits of any insurance system established by the Social Security Act), and (2) it is the practice, and has been for a substantial period of time, for members of the sect (or division) to make reasonable provision for dependent members in view of their general level of living, and (3) the sect (or division) has been in existence continuously since December 31, 1950. For members of the sect to qualify for the religious conscience exemption, an exemption must be obtained from an American Health Benefit Exchange in accordance with Health and Human Services regulations.[10]

REASONS FOR CHANGE

The Committee believes that the present law religious conscience exemption from the requirement to maintain minimum essential coverage is too narrow. It only covers individuals who, due to membership in a recognized religious sect, do not accept the benefits of any private or public insurance, including Social Security and Medicare. The exemption does not apply to individuals who, as a

[7] For years after 2016, the $695 amount is indexed to CPI–U, rounded to the next lowest multiple of $50.

[8] These exemptions are generally provided under section 5000A(e). The religious conscience exemption and health care sharing ministry exemption are provided under section 5000A(d)(2).

[9] SECA consists of sections 1401–1403, relating to Social Security and Medicare taxes applicable to self-employed individuals. The SECA exemption for members of certain recognized religious sects is provided under section 1402(g)(1).

[10] Secs. 1311(d)(4)(H) and 1411(b)(5)(A) of the ACA and 45 C.F.R. sec 155.615(b).

matter of faith, do not use medical care services. The Committee believes that these individuals should not be required to purchase health insurance to pay for medical care services.

EXPLANATION OF PROVISION

The provision expands the religious conscience exemption to include any individual who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual. For purposes of this exemption, medical health services do not include routine dental, vision, and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide.

This exemption will apply to an individual for months in a taxable year only if the information required to be provided to obtain the exemption includes an attestation that the individual has not received medical health services during the preceding taxable year. The provision also specifies that nothing in the provision preempts any State law requiring the provision of medical treatment for children, especially those who are seriously ill.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2013.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 2061, the "Equitable Access to Care and Health Act" on September 17, 2015.

MOTION TO REPORT THE BILL

The bill, H.R. 2061, as amended, was ordered favorably reported to the House of Representatives by a voice vote (with a quorum being present).

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 2061, as reported.

The bill, as reported, is estimated to have the following effect on Federal budget receipts for fiscal years 2016–2025:

ESTIMATED REVENUE EFFECTS [1] [2] [3]

Fiscal Years

[Millions of Dollars]

2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016–20	2016–25
−135	−120	−100	−110	−115	−115	−125	−135	−140	−140	−580	−1,235

[1] Estimate provided by the staff of the Joint Committee on Taxation and the Congressional Budget Office.

[2] Estimate includes the following change in off-budget receipts:

2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016–20	2016–25
[3]	5	[3]	[3]	[3]	[3]	5	5	5	5	5	25

[3] Gain of less than $500,000.
[4] Estimate includes the following change in outlays:

2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016–20	2016–25
−15	−35	−55	−60	−65	−70	−75	−75	−80	−85	−230	−615

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

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee further states that there are 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, September 25, 2015.

Hon. Paul Ryan,
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. 2061, the Equitable Access to Care and Health Act.

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

Sincerely,

Keith Hall.

Enclosure.

H.R. 2061—Equitable Access to Care and Health Act

Summary: H.R. 2061 would expand the religious conscience exemption from the requirement that most people in the United States must obtain health insurance coverage or pay a penalty for not doing so (a provision of the Affordable Care Act known as the individual mandate). Specifically, the bill would newly exempt members of religious sects or divisions that do not meet the criteria

for the religious conscience exemption under current law, but who rely solely on a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.[1]

On net, CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting H.R. 2061 would increase federal deficits by $1.2 billion over the 2016–2025 period. That 10-year total consists of a $1.9 billion net reduction in revenues, primarily stemming from forgone penalties from uninsured individuals, partially offset by a $0.6 billion decrease in direct spending resulting from fewer people enrolling in Medicaid and subsidized health insurance coverage obtained through exchanges. The estimated reduction in revenues exceeds the estimated reduction in direct spending because CBO and JCT estimate that most of the people that would newly claim an exemption from the individual mandate under the bill are and will continue to be uninsured under current law. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues.

CBO and JCT estimate that enacting the legislation would not increase net direct spending in any of the four consecutive 10-year periods beginning in 2026; however, the agencies estimate that enacting the legislation would increase on-budget deficits by at least $5?billion in at least one of the four consecutive 10-year periods beginning in 2026.

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

Estimated cost to the Federal Government: The estimated budgetary effects of H.R. 2061 are shown in the following table. The spending effects of the legislation fall primarily within budget function 550 (health). For this estimate, CBO assumes that H.R. 2061 will be enacted near the end of calendar year 2015.

[1] Under current law, people qualify for the religious conscience exemption from the individual mandate only if they are members of religious sects or divisions that are conscientiously opposed to accepting insurance benefits—including Social Security and Medicare—and who meet other requirements listed under section 1402(g)(1) of the Internal Revenue Code.

	By fiscal year, in millions of dollars—											
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016–2020	2016–2025
CHANGES IN DIRECT SPENDING												
Estimated Budget Authority	−15	−35	−55	−60	−65	−70	−75	−75	−80	−85	−230	−615
Estimated Outlays	−15	−35	−55	−60	−65	−70	−75	−75	−80	−85	−230	−615
CHANGES IN REVENUES												
Estimated Revenues [a]	−150	−155	−155	−170	−180	−185	−200	−210	−220	−225	−810	−1,850
On-Budget	−150	−160	−155	−170	−180	−185	−205	−215	−225	−230	−815	−1,875
Off-Budget [b]	*	5	*	*	*	*	5	5	5	5	5	25
NET INCREASE OR DECREASE (−) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
Impact on Deficit	135	120	100	110	115	115	125	135	140	140	580	1,235
On-Budget	135	125	100	110	115	115	130	140	145	145	585	1,260
Off-Budget [b]	*	−5	*	*	*	*	−5	−5	−5	−5	−5	−25

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.
Note: * = for revenues, an increase of less than $0.5 million; for deficits, a reduction of less than $0.5 million.
a. Negative numbers indicate a reduction in revenues, and positive numbers indicate an increase in revenues.
b. All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as "off-budget.")

Basis of estimate: CBO and JCT estimate that enacting H.R. 2061 would increase the number of people claiming an exemption from the individual mandate by roughly 200,000 annually. That estimate stems primarily from two judgments, both of which are highly uncertain:

- CBO and JCT estimate that up to 500,000 people would newly qualify for the religious conscience exemption, on the basis of a review of the limited information that is publicly available. However, the agencies anticipate that a significant share of those people qualify for other exemptions from the mandate under current law and therefore would not newly claim an exemption under the bill. In particular, some may qualify for income-based exemptions such as having income below the threshold for filing income tax returns or having income below 138 percent of federal poverty guidelines and being ineligible for Medicaid because their state did not expand the program.
- CBO and JCT expect that some people may falsely claim the expanded religious conscience exemption under the bill; however, that number would be limited for two reasons. First, people would have to apply for the exemption through the health insurance exchange in their area (as is the case under current law) and the current application requires people to provide detailed information about the religious sect or division to which they belong.[2] Second, H.R. 2061 would require people to attest that they have not received medical health services, with limited exceptions, during the preceding taxable year.

Of the estimated 200,000 people who would newly claim an exemption from the individual mandate under the bill, CBO and JCT estimate that roughly 90 percent would otherwise pay a penalty for being uninsured. (The agencies estimate that most of the people affected by this bill will be uninsured under current law because the acceptance of medical health services would be inconsistent with their religious beliefs.) As a result, the agencies estimate that enacting H.R. 2061 would reduce collections from penalties assessed to uninsured individuals by $2.0 billion over the 2016–2025 period.

The remaining 10 percent of people newly claiming an exemption from the individual mandate would be insured under current law and would forgo health insurance coverage as a result of the bill, the agencies estimate. Some of those people would falsely claim the new exemption under the bill; others are expected to obtain health insurance under current law in order to comply with the individual mandate, even though they will not use that insurance because of their religious convictions. Accordingly, under the bill, fewer people would enroll in Medicaid, subsidized health insurance coverage obtained through exchanges, and employment-based health insurance, which the agencies estimate would reduce outlays by $0.6 billion and increase revenues by $0.1 billion over the 2016–2025 period. The effects on revenues stem from increases in taxable compensation associated with reductions in employment-based insurance and increases in tax liability associated with reductions in the number of people receiving tax credits to purchase health insurance through exchanges.

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[2] See *https://marketplace.cms.gov/applications-and-forms/religious-sect-exemption.pdf.*

On net, CBO and JCT estimate that enacting H.R. 2061 would increase federal deficits by $1.2 billion over the 2016–2025 period, which consists of a $1.9 billion net reduction in revenues and a $0.6 billion decrease in direct spending. The net decrease in revenues reflects an estimated $1.9 billion reduction in on-budget revenues, partially offset by an estimated $25 million increase in off-budget (Social Security) revenues.

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

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 2061, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON SEPTEMBER 17, 2015

	By fiscal year, in millions of dollars—												
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015–2020	2015–2025
NET INCREASE IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Impact	0	135	125	100	110	115	115	130	140	145	145	585	1,260
Memorandum:													
Changes in Outlays	0	−15	−35	−55	−60	−65	−70	−75	−75	−80	−85	−230	−615
Changes in Revenues	0	−150	−160	−155	−170	−180	−185	−205	−215	−225	−230	−815	−1,875

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Increase in long-term deficit and net direct spending: CBO and JCT estimate that enacting the legislation would not increase net direct spending by at least $5 billion in any of the four consecutive 10-year periods beginning in 2026; however, CBO and JCT estimate that enacting the legislation would increase on-budget deficits by at least $5 billion in at least one of the four consecutive 10-year periods beginning in 2026. Specifically, on the basis of the budgetary effects projected for the 2021–2025 period, CBO and JCT estimate that the deficit increase resulting from enactment of the bill would grow by between 4 percent and 5 percent per year, thereby increasing on-budget deficits by a total of more than $5 billion during the decade from 2056 through 2065.

Intergovernmental and private-sector impact: JCT has determined that the bill contains no intergovernmental or private-sector mandates as defined in UMRA.

Estimate prepared by: Federal costs: Sarah Masi and staff of the Joint Committee on Taxation; Impact on state, local, and tribal governments: staff of the Joint Committee on Taxation; Impact on the private sector: staff of the Joint Committee on Taxation.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

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

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of H.R. 2061 that the Committee concluded that it is appropriate to report the bill, as amended, favorably to the House of Representatives with the recommendation that the bill do pass.

B. Statement of General Performance Goals and Objectives

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

C. Information Relating to Unfunded Mandates

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

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

D. Applicability of House Rule XXI5(b)

Rule XXI5(b) of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a

vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the bill, and states that the bill does not involve any Federal income tax rate increases within the meaning of the rule.

E. Tax Complexity Analysis

The following statement is made pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives. Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 ("IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

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

F. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

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

G. Duplication of Federal Programs

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

H. Disclosure of Directed Rule Makings

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

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

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

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

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

SECTION 5000A OF THE INTERNAL REVENUE CODE OF 1986

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

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

(b) SHARED RESPONSIBILITY PAYMENT.—

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

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

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

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

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

(c) AMOUNT OF PENALTY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

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

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

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

(B) HOUSEHOLD INCOME.—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

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

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

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

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

(C) MODIFIED ADJUSTED GROSS INCOME.—The term "modified adjusted gross income" means adjusted gross income increased by—

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

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

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

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

(2) RELIGIOUS EXEMPTIONS.—

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

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

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

(A) RELIGIOUS CONSCIENCE EXEMPTIONS.—

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

(I) such individual is a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and is adherent of established tenets or teachings of such sect or division as described in such section, or

(II) such individual is a member of a religious sect or division thereof which is not described in section 1402(g)(1), who relies solely on a religious

method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.

(ii) SPECIAL RULES.—

(I) MEDICAL HEALTH SERVICES DEFINED.—For purposes of this subparagraph, the term "medical health services" does not include routine dental, vision, and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide in implementing section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act.

(II) ATTESTATION REQUIRED.—Clause (i)(II) shall apply to an individual for months in a taxable year only if the information provided by the individual under section 1411(b)(5)(A) of such Act includes an attestation that the individual has not received medical health services during the preceding taxable year.

(B) HEALTH CARE SHARING MINISTRY.—

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

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

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

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

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

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

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

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

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

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

(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

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

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

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

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

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

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

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

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

(4) MONTHS DURING SHORT COVERAGE GAPS.—

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

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

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

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

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

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

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

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

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

(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

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

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

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

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

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

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

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act

for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) ADMINISTRATION AND PROCEDURE.—

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

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

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

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

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

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

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

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

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

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

SECTION 5000A OF THE INTERNAL REVENUE CODE OF 1986

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

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

(b) SHARED RESPONSIBILITY PAYMENT.—

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

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

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

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

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

(c) AMOUNT OF PENALTY.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

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

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

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

(B) HOUSEHOLD INCOME.—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

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

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

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

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

(C) MODIFIED ADJUSTED GROSS INCOME.—The term "modified adjusted gross income" means adjusted gross income increased by—

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

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

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

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

(2) RELIGIOUS EXEMPTIONS.—

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

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

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

(B) HEALTH CARE SHARING MINISTRY.—

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

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

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

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

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

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

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

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

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

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

(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

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

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

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

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

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

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

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

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

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

(4) MONTHS DURING SHORT COVERAGE GAPS.—

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

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

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

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

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

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

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

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

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

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

(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) ADMINISTRATION AND PROCEDURE.—

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

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

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

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

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

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

VII. ADDITIONAL VIEWS

H.R. 2061—the Equitable Access to Care and Health Act—costs $1.2 billion in lost tax revenue and this revenue loss is not offset. When combined with the other bills under consideration at the committee's markup, the total cost of lost revenue is over $400 billion over the next ten years—and the Majority did not set forth any options to pay for this cost. Not one cost offset option was offered by the Majority at the markup. It is unacceptable in this time of fiscal austerity to not pay the cost of these bills. It is irresponsible to add over $400 billion in lost revenue to the deficit.

This bill modifies the religious exemption of the individual shared responsibility provision of the Affordable Care Act (ACA). The ACA at Section 1501(d)(2)(A) cross references the existing religious exemption in the Internal Revenue Code at Section 1402(g)(1) for payroll tax purposes. Current law provides an exemption from the individual responsibility requirement for individuals who are members of religious sects that object to accepting benefits of any private or public insurance that makes payments in the event of death, disability, old age, or retirement—including any benefits established under the Social Security Act—provided that the members of the sect make reasonable provision for dependent members in view of their general level of living. It exempts individuals who do not accept benefits from government insurance programs like Social Security and Medicare from the individual responsibility requirement. Thus the current law mostly applies to Amish and Mennonite groups; it does not include Christian Scientists and other religious sects (who do use some public insurance benefits).

H.R. 2061 would expand the scope of individuals who can claim a religious conscience exemption to the individual shared responsibility provision. The bill would allow anyone who is a member of a religious sect that relies solely on religious methods of healing and for whom medical care is inconsistent with religious beliefs to claim a religious exemption from the individual mandate requirement. This definition is drafted narrowly so that individuals eligible to claim an exemption may not accept medical care beyond religious methods of healing or those services identified in the legislation (e.g., routine hearing, dental, and vision care).

The new legislation does not exempt individuals based on their objections to specific types of the medical care (e.g., refusal of blood transfusions or contraception, but acceptance of other medical care).

SANDER M. LEVIN,
Ranking Member.

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