

THE “BIPARTISAN HSA IMPROVEMENT ACT OF 2018”

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JULY 19, 2018.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

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Mr. BRADY of Texas, from the Committee on Ways and Means,
submitted the following

R E P O R T

[To accompany H.R. 6305]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6305) to amend the Internal Revenue Code of 1986 to improve access to health care through modernized health savings accounts, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:
Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Bipartisan HSA Improvement Act of 2018”.

SEC. 2. CERTAIN EMPLOYMENT RELATED SERVICES NOT TREATED AS DISQUALIFYING COVERAGE FOR PURPOSES OF HEALTH SAVINGS ACCOUNTS.

(a) **IN GENERAL.**—Section 223(c)(1) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

“(D) **SPECIAL RULE FOR QUALIFIED ITEMS AND SERVICES.**—

“(i) **IN GENERAL.**—An individual shall not be treated as covered under a health plan for purposes of subparagraph (A)(ii) merely because the individual, in connection with the employment of the individual or the individual’s spouse, receives (or is eligible to receive) qualified items and services at—

“(I) a healthcare facility located at a facility owned or leased by the employer of the individual (or of the individual’s spouse), or operated primarily for the benefit of such employer’s employees, or

“(II) a healthcare facility located within a supermarket, pharmacy, or similar retail establishment.

“(ii) **QUALIFIED ITEMS AND SERVICES DEFINED.**—For purposes of this subparagraph, the term ‘qualified items and services’ means the following:

“(I) Physical examinations.

“(II) Immunizations, including injections of antigens provided by employees.

“(III) Drugs other than a prescribed drug (as such term is defined in section 213(d)(3)).

“(IV) Treatment for injuries occurring in the course of employment.

“(V) Drug testing, if required as a condition of employment.

“(VI) Hearing or vision screenings.

“(VII) Other similar items and services that do not provide significant benefits in the nature of medical care.

“(iii) **AGGREGATION.**—For purposes of clause (i)(I), all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to months beginning after December 31, 2018, in taxable years ending after such date.

SEC. 3. CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ACCOUNT.

(a) **CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ACCOUNT.**—Section 223(c)(1)(B) of the Internal Revenue Code of 1986 is amended by striking “and” at the end of clause (ii), by striking the period at the end of clause (iii) and inserting “, and”, and by inserting after clause (iii) the following new clause:

“(iv) coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reimbursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual.”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to plan years beginning after December 31, 2018.

SEC. 4. FSA AND HRA TERMINATIONS OR CONVERSIONS TO FUND HSAS.

(a) **IN GENERAL.**—Section 106(e)(2) of the Internal Revenue Code of 1986 is amended to read as follows:

“(2) **QUALIFIED HSA DISTRIBUTION.**—For purposes of this subsection—

“(A) **IN GENERAL.**—The term ‘qualified HSA distribution’ means, with respect to any employee, a distribution from a health flexible spending arrangement or health reimbursement arrangement of such employee directly to a health savings account of such employee if—

“(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) after a significant period of not having such coverage, and

- “(ii) such arrangement is described in section 223(c)(1)(B)(iii) with respect to the portion of the plan year after such distribution is made.
- “(B) DOLLAR LIMITATION.—The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).”
- (b) PARTIAL REDUCTION OF LIMITATION ON DEDUCTIBLE HSA CONTRIBUTIONS.—Section 223(b)(4) of such Code is amended by striking “and” at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting “, and”, and by inserting after subparagraph (C) the following new subparagraph:
- “(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).”
- (c) CONVERSION TO HSA-COMPATIBLE ARRANGEMENT FOR REMAINDER OF PLAN YEAR.—Section 223(c)(1)(B)(iii) of such Code, as amended by the preceding provisions of this Act, is amended to read as follows:
- “(iii) coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2)) determined without regard to subparagraph (A)(ii) thereof is made, if the terms of such arrangement which apply for such portion of the plan year are such that, if such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year, and”.
- (d) INCLUSION OF QUALIFIED HSA DISTRIBUTIONS ON W-2.—
- (1) IN GENERAL.—Section 6051(a) of such Code is amended by striking “and” at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting “, and”, and by inserting after paragraph (17) the following new paragraph:
- “(18) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.”
- (2) CONFORMING AMENDMENT.—Section 6051(a)(12) of such Code is amended by inserting “(other than any qualified HSA distribution, as defined in section 106(e)(2))” before the comma at the end.
- (e) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2018, in taxable years ending after such date.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill H.R. 6305, as reported by the Committee on Ways and Means, expands access and enhances the utility of health savings accounts (HSAs) through three common-sense improvements to the rules governing HSAs: (1) clarifying that certain employment related services (such as on-site clinics) are not treated as disqualifying coverage for purposes of HSAs; (2) allowing an eligible individual to make HSA contributions if a spouse has a Flexible Spending Arrangement (FSA), provided that FSA does not also reimburse for expenses of the spouse with the HSA; and (3) allowing FSA and Health Reimbursement Account (HRA) terminations or conversions to fund HSAs.

B. BACKGROUND AND NEED FOR LEGISLATION

According to a survey of 52 health insurers conducted by America’s Health Insurance Plans (AHIP), 21.8 million people were covered by a High Deductible Health Plan (HDHP) with an HSA as

of January 2017. These plans and accounts are an increasingly popular option for workers and enrollment growth shows no sign of slowing. A survey of employer-sponsored health benefits found that 17 percent of all employers offered a HDHP with an HSA in 2017 compared to 2 percent in 2005.

HSA account holders are diverse. According to WageWorks, Inc., the administrator of benefits for more than 7 million people, the median household income for an HSA accountholder is \$57,060. In addition, a JCT analysis found that of the tax returns that took an HSA deduction in 2015, 71 percent of the returns reported an income of \$200,000 or less, and 28 percent reported an income of \$75,000 or less. Account holders are also distributed across age groups, with nearly a third between the ages of 25–44 and another third of account holders between the ages 45–64.

Most critically, research has consistently found that such coverage, which empowers individuals and families to be more engaged health care consumers, is capable of significantly reducing health care costs.

In addition, FSAs are employer-established accounts to reimburse employees for qualified medical expenses. Under current law, FSAs can be used to reimburse expenses for the enrollee, their spouse, and dependents. This prohibits an FSA enrollee’s spouse from contributing to an HSA, even when they are covered under two separate health plans.

C. LEGISLATIVE HISTORY

Background

H.R. 6305 was introduced on July 3, 2018 and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up H.R. 6305, the “Bipartisan HSA Improvement Act of 2018,” on July 11, 2018, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

The policy issues associated with Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs) were discussed at the following Ways and Means hearings during the 114th and 115th Congress:

- Full Committee Hearing on the Tax Treatment of Health Care (April 14, 2016)
- Subcommittee on Tax Policy Member Day Hearing on Tax Legislation (May 12, 2016)
- Subcommittee on Health Member Day Hearing on Tax-Related Proposals to Improve Health Care (May 17, 2016)
- Subcommittee on Health Hearing on Rising Health Insurance Premiums Under the Affordable Care Act (July 12, 2016)
- Subcommittee on Health Hearing on Lowering Costs and Expanding Access to Health Care through Consumer-Directed Health Plans (June 6, 2018)

II. EXPLANATION OF THE BILL

A. CERTAIN EMPLOYMENT RELATED SERVICES NOT TREATED AS DISQUALIFYING COVERAGE FOR PURPOSES OF HEALTH SAVINGS ACCOUNTS

Health Savings Accounts

An individual with a high deductible health plan (“HDHP”) and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage)¹ may establish a health savings account (“HSA”).² Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an “above-the-line” deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 20 percent. The 20-percent additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

A high deductible health plan (“HDHP”) is a health plan that has an annual deductible that is at least \$1,350 for self-only coverage or \$2,700 for family coverage for 2018 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 \$6,650 in the case of self-only coverage and \$13,300 in the case of family coverage for 2018.

Qualified medical expenses generally are defined as under Code section 213(d) and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) certain premiums

¹An 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. Also see Notice 2004–50, 2004–33 IRB 1, Q & A–7 and Q & A–8 (“an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP”), but such coverage must be provided through insurance contracts and not on a self-insured basis.

Pursuant to Q & A–10 of Notice 2004–50, coverage under a disease management program does not make an individual ineligible to contribute to an HSA as long as the program does not provide significant benefits in the nature of medical care or treatment so that it is not considered a “health plan” for purposes of Code section 223(c)(1). Where a disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan including monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks it is not considered a “health plan.”

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.

²Sec. 223.

paid for long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for Medigap policies.

Eligible individuals

Eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that (1) is not a high deductible health plan and (2) provides coverage for any benefit which is covered under the high deductible health plan. After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to an HSA.³

On-Site Employee Clinics

On-site employer-sponsored health clinics may provide a range of health services to employees for free or at a reduced cost. Under IRS guidance, an otherwise eligible individual who has access to free health care or health care at charges below fair market value from a clinic on an employer's premises will not fail to be an eligible individual merely because of this free or reduced cost care as long as the clinic does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care.

For example, an employer who provides the following free health care for employees does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care: (1) physicals and immunizations, (2) injecting antigens provided by employees, such as performing allergy injections, (3) a variety of aspirin and other nonprescription pain relievers, and (4) treatment for injuries caused by accidents at the plant. However, a hospital that permits its employees to receive care at its facilities for all their medical needs for free (when the employee does not have insurance) or that waives copays and deductibles (when the employee does have health insurance) provides significant benefits in the nature of medical care, and the hospital's employees fail to be eligible individuals for purposes of HSA contributions.⁴

REASONS FOR CHANGE

The Committee believes that coverage which would otherwise constitute a high deductible health plan should be treated as such for determining eligibility to make HSA contributions, and not disqualified merely by reason of offering certain employment related services. The Committee believes that employers must have the flexibility to offer quality health care in the setting that is best for them, like on-site or retail clinics and that individuals with HSAs should not be prevented from utilizing these same services.

³See Sec. 223(b)(7), as interpreted by Notice 2004-2, 2004-2 I.R.B. 269, corrected by Announcement 2004-67, 2004-36 I.R.B. 459.

⁴Notice 2008-59, Q&A-10.

EXPLANATION OF PROVISION

Under the proposal, certain employment related services are not treated as coverage under a health plan for purposes of determining eligibility for health savings accounts. An individual is therefore not treated as covered under a health plan, merely because the individual receives, or is eligible to receive qualified items and services in connection with employment at an on-site or retail clinic. These qualified items and services include: physical examinations, immunizations, drugs other than a prescribed drug, and treatment for injuries occurring in the course of employment, drug testing as a condition of employment, hearing or vision screenings, and other similar items and services that do not provide significant benefits in the nature of medical care.

EFFECTIVE DATE

The provision applies for months beginning after December 31, 2018, in taxable years ending after such date.

B. CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ACCOUNT

PRESENT LAW

Health Savings Accounts

An individual with a high deductible health plan (“HDHP”) and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage)⁵ may establish a health savings account (“HSA”).⁶ Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an “above-the-line” deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.

HSA contributions for a year are subject to basic dollar limits that are also adjusted annually as needed to reflect annual cost-of-

⁵ 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. Also see Notice 2004–50, 2004–33 IRB 1, Q & A–7 and Q & A–8 (“an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP”), but such coverage must be provided through insurance contracts and not on a self-insured basis.

Pursuant to Q & A–10 of Notice 2004–50, coverage under a disease management program does not make an individual ineligible to contribute to an HSA as long as the program does not provide significant benefits in the nature of medical care or treatment so that it is not considered a “health plan” for purposes of Code section 223(c)(1). Where a disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan including monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks it is not considered a “health plan.”

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.

⁶ Sec. 223.

living increases. For 2018, the basic limit on annual contributions that can be made to an HSA is \$3,450 in the case of self-only coverage and \$6,900 in the case of family coverage. The basic annual contributions limits are increased by \$1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up” contributions). Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 20 percent. The 20-percent additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

An HDHP is a health plan that has an annual deductible that is at least \$1,350 for self-only coverage or \$2,700 for family coverage for 2018 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 \$6,650 in the case of self-only coverage and \$13,300 in the case of family coverage for 2018.

Qualified medical expenses generally are defined as under Code section 213(d) and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) certain premiums paid for long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for Medigap policies.

Eligible individuals

Eligible individuals for HSAs are individuals who are covered by an HDHP and no other health plan that (1) is not an HDHP and (2) provides coverage for any benefit which is covered under the HDHP. After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to an HSA.⁷

If both spouses of a married couple are eligible individuals and either spouse has family coverage, both spouses are treated as having only family coverage, so that the annual contribution limit for family coverage applies. This annual contribution limit (without regard to any catch-up contribution amounts) is reduced by any Archer MSA contributions and then divided equally between the spouses unless they agree on a different division.⁸

If both spouses of a married couple are eligible individuals, each may contribute to an HSA, but are not permitted a joint HSA.⁹ Under the rule described above, however, the spouses may divide

⁷ See Sec. 223(b)(7), as interpreted by Notice 2004-2, 2004-2 I.R.B. 269, corrected by Announcement 2004-67, 2004-36 I.R.B. 459.

⁸ Sec. 223(b)(5).

⁹ Notice 2004-50, 2004-2 C.B. 196, Q&A-63.

their annual contribution limit by allocating the entire amount to one spouse to be contributed to that spouse's HSA.¹⁰ This rule does not apply to catch-up contribution amounts.

Health flexible spending accounts

In addition to offering health insurance, employers often agree to reimburse medical expenses of their employees (and their spouses and dependents). These arrangements are commonly used by employers to pay or reimburse employees for medical expenses that are not covered by health insurance. These arrangements include health flexible spending arrangements ("health FSAs").

Health FSAs typically are funded on a salary reduction basis under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses. If the health FSA meets certain requirements, the compensation that is forgone is not includible in gross income or wages for payroll tax purposes.

Under IRS guidance, an individual who is covered by an HDHP and a health FSA that pays or reimburses certain medical expenses that are not limited to the exceptions for permitted insurance, permitted coverage, or preventive care is generally not an eligible individual for the purpose of making deductible contributions to an HSA. Similarly, if the individual is covered by a health FSA sponsored by the employer of the individual's spouse, the individual is not an eligible individual.¹¹

REASONS FOR CHANGE

The Committee believes that an individual should not be prevented from making HSA contributions merely because his spouse has a health FSA. Fixing this spousal penalty, while preventing double-dipping in tax benefits will ultimately help modernize health care delivery and give employers the freedom to innovate and improve their employees' health insurance.

EXPLANATION OF PROVISION

Under the proposal, an individual's eligibility for HSAs is determined without regard to whether or not the spouse of the individual has coverage under a health FSA for any taxable year as long as the aggregate reimbursements under the arrangement for the year do not exceed the total expenses which would be eligible for reimbursement if determined without regard to the individual's expenses paid or incurred.

EFFECTIVE DATE

The provision applies to plan years beginning after December 31, 2018.

¹⁰ Notice 2004-50, Q&A-32. Funds from that HSA can be used to pay qualified medical expenses for either spouse on a tax-free basis. Notice 2004-50, Q&A-36.

¹¹ Rev. Rul. 2004-45.

C. FSA AND HRA TERMINATIONS OR CONVERSIONS TO FUND HSAs
PRESENT LAW

Health savings accounts

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage)¹² may establish a health savings account (“HSA”).¹³ Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an “above-the-line” deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.

HSA contributions for a year are subject to basic dollar limits that are also adjusted annually as needed to reflect annual cost-of-living increases. For 2018, the basic limit on annual contributions that can be made to an HSA is \$3,450 in the case of self-only coverage and \$6,900 in the case of family coverage. The basic annual contributions limits are increased by \$1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as “catch-up” contributions). Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 20 percent. The 20-percent additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

A high deductible health plan is a health plan that has an annual deductible that is at least \$1,350 for self-only coverage or \$2,700 for family coverage for 2018 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 \$6,650 in

¹²An 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. Also see Notice 2004–50, 2004–33 IRB 1, Q & A–7 and Q & A–8 (“an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP”), but such coverage must be provided through insurance contracts and not on a self-insured basis.

Pursuant to Q & A–10 of Notice 2004–50, coverage under a disease management program does not make an individual ineligible to contribute to an HSA as long as the program does not provide significant benefits in the nature of medical care or treatment so that it is not considered a “health plan” for purposes of Code section 223(c)(1). Where a disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan including monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks it is not considered a “health plan.”

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.

¹³Sec. 223.

the case of self-only coverage and \$13,300 in the case of family coverage for 2018.

Qualified medical expenses generally are defined as under Code section 213(d) and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) certain premiums paid for long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for Medigap policies.

Eligible individuals

Eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that (1) is not a high deductible health plan and (2) provides coverage for any benefit which is covered under the high deductible health plan. After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to an HSA.¹⁴

Health flexible spending accounts and health reimbursement arrangements

In addition to offering health insurance, employers often agree to reimburse medical expenses of their employees (and their spouses and dependents). These arrangements are commonly used by employers to pay or reimburse employees for medical expenses that are not covered by health insurance. These arrangements include health flexible spending arrangements (“health FSAs”) and health reimbursement arrangements (“HRAs”).

Health FSAs typically are funded on a salary reduction basis under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses. If the health FSA meets certain requirements, the compensation that is forgone is not includible in gross income or wages for payroll tax purposes.

Health FSAs that are funded on a salary reduction basis are subject to the requirements for cafeteria plans, including a requirement that amounts remaining in a health FSA at the end of a plan year must be forfeited by the employee (referred to as the “use-it-or-lose-it rule”).¹⁵

Health reimbursement arrangements (“HRAs”) operate in a manner similar to health FSAs, in that they are an employer-maintained arrangement that reimburses employees and their dependents¹⁶ for medical expenses. Some of the rules applicable to HRAs and health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular,

¹⁴ See Sec. 223(b)(7), as interpreted by Notice 2004–2, 2004–2 I.R.B. 269, corrected by Announcement 2004–67, 2004–36 I.R.B. 459.

¹⁵ Sec. 125(d)(2).

¹⁶ As defined in Sec. 152.

HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.¹⁷ Unlike a health FSA, an HRA is permitted to reimburse an employee for health insurance premiums.

Interactions of health savings accounts with other health arrangements

In general, an individual with an HDHP and no other health plan (other than a plan that provides certain permitted insurance, or permitted coverage) may establish an HSA. Permitted insurance is coverage under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. Permitted coverage is coverage for accidents, disability, dental care, vision care, or long-term care.¹⁸

Under IRS guidance, a health FSA and an HRA are (with some exceptions) considered health plans under this definition and therefore, an individual who is covered by an HDHP and a general purpose health FSA or general purpose HRA that pays or reimburses qualified medical expenses,¹⁹ is not an eligible individual for the purpose of making contributions to an HSA.²⁰ However, an individual does not fail to be an eligible individual for the purpose of making contributions to an HSA if the individual is covered under the following arrangements (or some combination of the following arrangements): (1) a limited-purpose health FSA that pays or reimburses only permitted coverage or preventive care services, (2) a limited-purpose HRA that pays or reimburses benefits for permitted insurance, permitted coverage or preventive care services, (3) a suspended HRA that does not pay or reimburse any medical expense incurred during the suspension period except permitted insurance, permitted coverage, or preventive care services, (4) a post-deductible health FSA or HRA, which does not pay or reimburse any medical expense incurred before the minimum annual deductible for a plan to be an HDHP.²¹

If a general purpose health FSA allows reimbursement for expenses incurred during a grace period following the end of the plan year, an otherwise eligible individual participating in the health FSA is generally not eligible to make contributions to an HSA until the first day of the first month following the end of the grace period.²² However, if an individual has a zero balance in a general purpose health FSA, as determined on a cash basis,²³ on the last day of the health FSA plan year, the individual does not fail to be

¹⁷ Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in IRS Notice 2002-45, 2002-2 C.B. 93.

¹⁸ Notice 2004-23.

¹⁹ Defined in Sec. 213(d).

²⁰ Rev. Rul. 2004-45.

²¹ As defined in Sec. 223(c)(2)(A)(i).

²² Notice 2005-42, 2005-1, C.B. 1204.

²³ "Cash basis" means the balance as of any date, without taking into account expenses incurred that have not been reimbursed as of that date. Thus, pending claims, claims submitted, claims received or claims under review that have not been paid as of a date are not taken into account for purposes of determining the account balance as of that date.

an eligible individual as of the first day of the immediately following health FSA plan year solely because of coverage during a health FSA grace period. Similarly, an individual with a zero balance in a general purpose HRA, determined on a cash basis, on the last day of the HRA plan year, does not fail to be an eligible individual on the first day of the immediately following HRA plan year, as long as certain requirements are satisfied.²⁴

Coverage by an HSA-compatible health FSA or HRA (these include, limited-purpose health FSA or HRA, post-deductible health FSA or HRA, retirement HRA, or suspended HRA), does not affect an employee's eligibility to contribute to an HSA, including during a health FSA grace period.²⁵ In addition, IRS guidance holds that an individual covered by an HDHP that does not provide prescription drug coverage, along with a separate prescription drug plan or rider that provides benefits before the minimum annual deductible of the HDHP has been satisfied is not eligible to contribute to HSAs.²⁶

FSA and HRA terminations to fund HSAs

The Health Opportunity Empowerment Act of 2006²⁷ amended the Code to allow for certain amounts in a health FSA or HRA to be rolled over into an HSA with favorable tax treatment. To allow this, the plan must be amended in writing, the employee must elect the rollover, and the year-end balance must be frozen. In addition, funds must be transferred by the employer within two and a half months after the end of the plan year and result in a zero balance in the health FSA or HRA.²⁸ The Act provides for distributions of an amount from a health FSA or HRA to an HSA ("qualified HSA distribution") before January 1, 2012. The distribution must not exceed the lesser of the balance in the health FSA or HRA on September 21, 2006, or as of the date of distribution.

Under these rules, a qualified HSA distribution must be contributed directly to the HSA trustee by the employer. Only one qualified health distribution is allowed with respect to each health FSA or HRA of an individual. Qualified HSA distributions are not taken into account in applying the annual limit for HSA contributions. Qualified HSA distributions are treated as rollovers, and thus are not deductible.

If an employee fails to remain HSA-eligible for 12 months ("the testing period"²⁹) following the distribution, the employee is not eligible directly following the distribution, and the amount of the rollover is included in gross income and is subject to an additional 20 percent tax unless the individual dies or becomes disabled. Fail-

²⁴These requirements are: (1) effective on the first of the immediately following HRA plan year, the employee elects to waive participation in the HRA, or (2) effective on or before the first day of the following HRA plan year, the employer terminates the general purpose HRA with respect to all employees, or (3) effective on or before the first day of the following HRA plan year, with respect to all employees, the employer converts the general purpose HRA to an HSA-compatible HRA. See Rev. Rul. 2004-45.

²⁵Rev. Rul. 2004-45.

²⁶See Rev. Rul. 2004-38, 2004-15.

²⁷The Health Opportunity Patient Empowerment Act of 2006, included in the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, sec. 302, December 20, 2006.

²⁸The IRS provided guidance on special transition relief for amounts remaining at the end of 2006. See Notice 2007-22.

²⁹The testing period is defined to be the period beginning with the month in which the qualified HSA distribution is contributed to the HSA and ending on the last day of the 12th month following that month.

ure to remain an eligible individual does not require the withdrawal of the qualified HSA distribution, and the amount is not an excess contribution.

REASONS FOR CHANGE

The Committee believes that streamlining the conversion of other tax-preferred health accounts to HSAs will make it easier for individuals to establish HSAs to save for their health care costs.

EXPLANATION OF PROVISION

The proposal defines “qualified HSA distribution” as a distribution from an employee’s health FSA or HRA directly to an employee’s HSA if such distribution is made in connection with the employee establishing coverage under an HDHP after a significant period of not having such coverage.

The aggregate amount of qualified HSA distributions may not exceed the total annual limit on FSA contributions (\$2,650 in 2018)³⁰ or twice this amount in the case of an eligible individual who has family coverage under an HDHP.

The statutory annual contribution limits to an HSA are \$2,250 for an individual with single coverage or \$4,500 for an individual with family coverage and indexed for cost-of-living adjustments. The contribution limits for 2018 are \$3,450 for self-only HDHP coverage, and \$6,900 for an individual with family coverage. The proposal allows deductible HSA contributions up to these limits for a given year, reduced by the amount of the qualified HSA distribution attributable to that year.

The proposal also specifies that if a general-purpose health FSA or HRA is converted to an HSA-compatible FSA or HRA, coverage under this health FSA or HRA for the portion of the plan year after a qualified HSA distribution is made is disregarded in determining whether the individual is eligible to make deductible contributions to an HSA.

Finally, the proposal provides that the amount of any qualified HSA distribution is to be included on the information to be reported on Form W-2.³¹

EFFECTIVE DATE

The proposal is effective for distributions made after December 31, 2018, in taxable years ending after such date.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 6305, the ‘Bipartisan HSA Improvement Act of 2018,’ on July 11, 2018.

H.R. 6305 was ordered favorably reported to the House of Representatives as amended by an amendment in the nature of a substitute offered by Chairman Brady by a roll call vote of 26 yeas to 13 nays. The vote was as follows:

³⁰Sec. 125(i).

³¹Sec. 6051(a)

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson	X			Mr. Levin		X	
Mr. Nunes	X			Mr. Lewis		X	
Mr. Reichert	X			Mr. Doggett		X	
Mr. Roskam	X			Mr. Thompson		X	
Mr. Buchanan	X			Mr. Larson		X	
Mr. Smith (NE)	X			Mr. Blumenauer	X		
Ms. Jenkins				Mr. Kind	X		
Mr. Paulsen	X			Mr. Pascrell		X	
Mr. Marchant	X			Mr. Crowley		X	
Ms. Black	X			Mr. Davis		X	
Mr. Reed	X			Ms. Sanchez		X	
Mr. Kelly	X			Mr. Higgins		X	
Mr. Renacci	X			Ms. Sewell	X		
Ms. Noem	X			Ms. DelBene		X	
Mr. Holding	X			Ms. Chu		X	
Mr. Smith (MO)	X						
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						
Mr. LaHood	X						
Mr. Wenstrup	X						

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 6305, as reported.

The bill, as reported, is estimated to have the following effect on Federal fiscal year budget receipts for the period 2019–2028:

Item	FISCAL YEARS (Millions of Dollars)											
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-23	2019-28
Certain Employment Related Services Not treated as Dis-qualifying Coverage for Purposes of Health Savings Accounts ¹	-165	-248	-274	-310	-350	-392	-440	-518	-588	-655	-1,347	-3,939
Contributions Permitted if Spouse has a Health Flexible Spending Account ¹	-1	-2	-2	-2	-2	-2	-2	-2	-2	-2	-8	-18
FSA and HRA Terminations or Conversions to Fund Health Savings Accounts ¹	-11	-28	-28	-29	-30	-31	-32	-38	-38	-39	-127	-302
Total	-177	-278	-304	-341	-382	-425	-474	-555	-628	-696	-1,482	-4,259

NOTE: Details may not add to totals due to rounding.
¹ Estimate includes the following off-budget effects:

Item	FISCAL YEARS (Millions of Dollars)											
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-23	2019-28
Certain Employment Related Services Not treated as Dis-qualifying Coverage for Purposes of Health Savings Accounts ¹	-36	-49	-53	-61	-70	-80	-92	-107	-126	-149	-269	-823
Contributions Permitted if Spouse has a Health Flexible Spending Account ¹	2	2	2	2	2	-1	-1	-1	-1	-1	-2	-5
Flexible Spending Arrangement and Health Savings Account Terminations or Conversions to Fund Health Savings Accounts ¹	-3	-7	-8	-8	-8	-9	-9	-9	-9	-10	-34	-80

² Loss of less than \$500,000.

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

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee further states that the revenue-reducing tax provision involves a new tax expenditure. See Part IV.A., above.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

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. 6138, as reported. As of the filing of this report, the Committee had not received an estimate prepared by the Congressional Budget Office (CBO).

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

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated into the description portions of this report.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

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

C. INFORMATION RELATING TO UNFUNDED MANDATES

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

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

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that “A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present.” The Committee has carefully reviewed the bill and states that the bill does not involve any Federal income tax rate increases within the meaning of the rule.

E. TAX COMPLEXITY ANALYSIS

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 (“IRS Reform Act”) requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code of 1986 and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Internal Revenue Code of 1986 and that have “widespread applicability” to individuals or small businesses, within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

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

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with Sec. 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. DISCLOSURE OF DIRECTED RULE MAKINGS

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings: The Committee advises 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

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):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

INTERNAL REVENUE CODE OF 1986

* * * * *

Subtitle A—Income Taxes

* * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

Subchapter B—Computation of Taxable Income

* * * * *

PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

* * * * *

SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

(a) **GENERAL RULE.**—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) **CONTRIBUTIONS TO ARCHER MSAs.**—

(1) **IN GENERAL.**—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any Archer MSA of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

(3) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to an Archer MSA, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the Archer MSAs of such individual or such individual's spouse for such taxable year.

(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

(6) DEFINITIONS.—For purposes of this subsection, the terms “eligible individual” and “Archer MSA” have the respective meanings given to such terms by section 220.

(7) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the Archer MSAs of comparable employees, see section 4980E.

(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—Gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

(d) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account (as defined in section 223(d)) of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

(3) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.

(e) FSA AND HRA TERMINATIONS TO FUND HSAs.—

(1) IN GENERAL.—A plan shall not fail to be treated as a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because such plan provides for a qualified HSA distribution.

[(2) QUALIFIED HSA DISTRIBUTION.—The term “qualified HSA distribution” means a distribution from a health flexible spending arrangement or health reimbursement arrangement to the extent that such distribution—

[(A) does not exceed the lesser of the balance in such arrangement on September 21, 2006, or as of the date of such distribution, and

[(B) is contributed by the employer directly to the health savings account of the employee before January 1, 2012. Such term shall not include more than 1 distribution with respect to any arrangement.]

(2) QUALIFIED HSA DISTRIBUTION.—*For purposes of this subsection—*

(A) IN GENERAL.—*The term “qualified HSA distribution” means, with respect to any employee, a distribution from a health flexible spending arrangement or health reimbursement arrangement of such employee directly to a health savings account of such employee if—*

(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) after a significant period of not having such coverage, and

(ii) such arrangement is described in section 223(c)(1)(B)(iii) with respect to the portion of the plan year after such distribution is made.

(B) DOLLAR LIMITATION.—*The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).*

(3) ADDITIONAL TAX FOR FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(A) IN GENERAL.—If, at any time during the testing period, the employee is not an eligible individual, then the amount of the qualified HSA distribution—

(i) shall be includible in the gross income of the employee for the taxable year in which occurs the first month in the testing period for which such employee is not an eligible individual, and

(ii) the tax imposed by this chapter for such taxable year on the employee shall be increased by 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Clauses (i) and (ii) of subparagraph (A) shall not apply if the em-

ployee ceases to be an eligible individual by reason of the death of the employee or the employee becoming disabled (within the meaning of section 72(m)(7)).

(4) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) TESTING PERIOD.—The term “testing period” means the period beginning with the month in which the qualified HSA distribution is contributed to the health savings account and ending on the last day of the 12th month following such month.

(B) ELIGIBLE INDIVIDUAL.—The term “eligible individual” has the meaning given such term by section 223(c)(1).

(C) TREATMENT AS ROLLOVER CONTRIBUTION.—A qualified HSA distribution shall be treated as a rollover contribution described in section 223(f)(5).

(5) TAX TREATMENT RELATING TO DISTRIBUTIONS.—For purposes of this title—

(A) IN GENERAL.—A qualified HSA distribution shall be treated as a payment described in subsection (d).

(B) COMPARABILITY EXCISE TAX.—

(i) IN GENERAL.—Except as provided in clause (ii), section 4980G shall not apply to qualified HSA distributions.

(ii) FAILURE TO OFFER TO ALL EMPLOYEES.—In the case of a qualified HSA distribution to any employee, the failure to offer such distribution to any eligible individual covered under a high deductible health plan of the employer shall (notwithstanding section 4980G(d)) be treated for purposes of section 4980G as a failure to meet the requirements of section 4980G(b).

(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(g) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).

* * * * *

PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

* * * * *

SEC. 223. HEALTH SAVINGS ACCOUNTS.

(a) **DEDUCTION ALLOWED.**—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.

(b) **LIMITATIONS.**—

(1) **IN GENERAL.**—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

(2) **MONTHLY LIMITATION.**—The monthly limitation for any month is $\frac{1}{12}$ of—

(A) in the case of an eligible individual who has self-only coverage under a high deductible health plan as of the first day of such month, \$2,250.

(B) in the case of an eligible individual who has family coverage under a high deductible health plan as of the first day of such month, \$4,500.

(3) **ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.**—

(A) **IN GENERAL.**—In the case of an individual who has attained age 55 before the close of the taxable year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by the additional contribution amount.

(B) **ADDITIONAL CONTRIBUTION AMOUNT.**—For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

For taxable years beginning in:	The additional contribution amount is:
2004	\$500
2005	\$600
2006	\$700
2007	\$800
2008	\$900
2009 and thereafter	\$1,000.

(4) **COORDINATION WITH OTHER CONTRIBUTIONS.**—The limitation which would (but for this paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not below zero) by the sum of—

(A) the aggregate amount paid for such taxable year to Archer MSAs of such individual,

(B) the aggregate amount contributed to health savings accounts of such individual which is excludable from the taxpayer's gross income for such taxable year under section 106(d) (and such amount shall not be allowed as a deduction under subsection (a)), **[and]**

(C) the aggregate amount contributed to health savings accounts of such individual for such taxable year under

section 408(d)(9) (and such amount shall not be allowed as a deduction under subsection (a))**[.1]**, and

(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).

Subparagraph (A) shall not apply with respect to any individual to whom paragraph (5) applies.

(5) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

(B) the limitation under paragraph (1) (after the application of subparagraph (A) and without regard to any additional contribution amount under paragraph (3))—

(i) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

(ii) after such reduction, shall be divided equally between them unless they agree on a different division.

(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.

(8) INCREASE IN LIMIT FOR INDIVIDUALS BECOMING ELIGIBLE INDIVIDUALS AFTER THE BEGINNING OF THE YEAR.—

(A) IN GENERAL.—For purposes of computing the limitation under paragraph (1) for any taxable year, an individual who is an eligible individual during the last month of such taxable year shall be treated—

(i) as having been an eligible individual during each of the months in such taxable year, and

(ii) as having been enrolled, during each of the months such individual is treated as an eligible individual solely by reason of clause (i), in the same high deductible health plan in which the individual was enrolled for the last month of such taxable year.

(B) FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(i) IN GENERAL.—If, at any time during the testing period, the individual is not an eligible individual, then—

(I) gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual is increased by the aggregate amount of all contributions to the health savings account of the individual which could not have been made but for subparagraph (A), and

(II) the tax imposed by this chapter for any taxable year on the individual shall be increased by 10 percent of the amount of such increase.

(ii) EXCEPTION FOR DISABILITY OR DEATH.—Subclauses (I) and (II) of clause (i) shall not apply if the individual ceased to be an eligible individual by reason of the death of the individual or the individual becoming disabled (within the meaning of section 72(m)(7)).

(iii) TESTING PERIOD.—The term “testing period” means the period beginning with the last month of the taxable year referred to in subparagraph (A) and ending on the last day of the 12th month following such month.

(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term “eligible individual” means, with respect to any month, any individual if—

(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

(I) which is not a high deductible health plan, and

(II) which provides coverage for any benefit which is covered under the high deductible health plan.

(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph

(A)(ii) shall be applied without regard to—

(i) coverage for any benefit provided by permitted insurance,

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, **[and]**

[(iii) for taxable years beginning after December 31, 2006, coverage under a health flexible spending arrangement during any period immediately following the end of a plan year of such arrangement during which unused benefits or contributions remaining at the end of such plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during such period if—

[(I) the balance in such arrangement at the end of such plan year is zero, or

[(II) the individual is making a qualified HSA distribution (as defined in section 106(e)) in an amount equal to the remaining balance in such

arrangement as of the end of such plan year, in accordance with rules prescribed by the Secretary.】

(iii) *coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2) determined without regard to subparagraph (A)(ii) thereof) is made, if the terms of such arrangement which apply for such portion of the plan year are such that, if such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year, and*

(iv) *coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reimbursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual.*

(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR CERTAIN VETERANS BENEFITS.—An individual shall not fail to be treated as an eligible individual for any period merely because the individual receives hospital care or medical services under any law administered by the Secretary of Veterans Affairs for a service-connected disability (within the meaning of section 101(16) of title 38, United States Code).

(D) SPECIAL RULE FOR QUALIFIED ITEMS AND SERVICES.—

(i) IN GENERAL.—*An individual shall not be treated as covered under a health plan for purposes of subparagraph (A)(ii) merely because the individual, in connection with the employment of the individual or the individual’s spouse, receives (or is eligible to receive) qualified items and services at—*

(I) *a healthcare facility located at a facility owned or leased by the employer of the individual (or of the individual’s spouse), or operated primarily for the benefit of such employer’s employees, or*

(II) *a healthcare facility located within a supermarket, pharmacy, or similar retail establishment.*

(ii) QUALIFIED ITEMS AND SERVICES DEFINED.—*For purposes of this subparagraph, the term “qualified items and services” means the following:*

(I) *Physical examinations.*

(II) *Immunizations, including injections of antigens provided by employees.*

(III) *Drugs other than a prescribed drug (as such term is defined in section 213(d)(3)).*

(IV) *Treatment for injuries occurring in the course of employment.*

(V) *Drug testing, if required as a condition of employment.*

(VI) *Hearing or vision screenings.*

(VII) *Other similar items and services that do not provide significant benefits in the nature of medical care.*

(iii) *AGGREGATION.—For purposes of clause (i)(I), all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.*

(2) **HIGH DEDUCTIBLE HEALTH PLAN.—**

(A) **IN GENERAL.—**The term “high deductible health plan” means a health plan—

(i) which has an annual deductible which is not less than—

(I) \$1,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage, and

(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

(I) \$5,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage.

(B) **EXCLUSION OF CERTAIN PLANS.—**Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(C) **SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—**A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1861 of the Social Security Act, except as otherwise provided by the Secretary).

(D) **SPECIAL RULES FOR NETWORK PLANS.—**In the case of a plan using a network of providers—

(i) **ANNUAL OUT-OF-POCKET LIMITATION.—**Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

(ii) **ANNUAL DEDUCTIBLE.—**Such plan’s annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).

(3) **PERMITTED INSURANCE.—**The term “permitted insurance” means—

(A) insurance if substantially all of the coverage provided under such insurance relates to—

(i) liabilities incurred under workers’ compensation laws,

(ii) tort liabilities,

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations,

(B) insurance for a specified disease or illness, and

(C) insurance paying a fixed amount per day (or other period) of hospitalization.

(4) FAMILY COVERAGE.—The term “family coverage” means any coverage other than self-only coverage.

(5) ARCHER MSA.—The term “Archer MSA” has the meaning given such term in section 220(d).

(d) HEALTH SAVINGS ACCOUNT.—For purposes of this section—

(1) IN GENERAL.—The term “health savings account” means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5), no contribution will be accepted—

(i) unless it is in cash, or

(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—

(I) the dollar amount in effect under subsection (b)(2)(B), and

(II) the dollar amount in effect under subsection (b)(3)(B).

(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term “qualified medical expenses” means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise. Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A) shall not apply to any payment for insurance.

(C) EXCEPTIONS.—Subparagraph (B) shall not apply to any expense for coverage under—

(i) a health plan during any period of continuation coverage required under any Federal law,

(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),

(iii) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law, or

(iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act, any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act).

(3) ACCOUNT BENEFICIARY.—The term “account beneficiary” means the individual on whose behalf the health savings account was established.

(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

(A) Section 219(d)(2) (relating to no deduction for rollovers).

(B) Section 219(f)(3) (relating to time when contributions deemed made).

(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

(D) Section 408(g) (relating to community property laws).

(E) Section 408(h) (relating to custodial accounts).

(e) TAX TREATMENT OF ACCOUNTS.—

(1) IN GENERAL.—A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(f) TAX TREATMENT OF DISTRIBUTIONS.—

(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution. Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term “excess contribution” means any contribution (other than a rollover contribution described in paragraph (5) or section 220(f)(5)) which is neither excludable from gross income under section 106(d) nor deductible under this section.

(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 20 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was

not includible in the individual's gross income because of the application of this paragraph.

(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a health savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a health savings account to an individual's spouse or former spouse under a divorce or separation instrument described in clause (i) of section 121(d)(3)(C) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the account beneficiary.

(8) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—

(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—

If the account beneficiary's surviving spouse acquires such beneficiary's interest in a health savings account by reason of being the designated beneficiary of such account at the death of the account beneficiary, such health savings account shall be treated as if the spouse were the account beneficiary.

(B) OTHER CASES.—

(i) IN GENERAL.—If, by reason of the death of the account beneficiary, any person acquires the account beneficiary's interest in a health savings account in a case to which subparagraph (A) does not apply—

(I) such account shall cease to be a health savings account as of the date of death, and

(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such beneficiary, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such beneficiary, in such beneficiary's gross income for the last taxable year of such beneficiary.

(ii) SPECIAL RULES.—

(I) REDUCTION OF INCLUSION FOR PREDEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

(II) DEDUCTION FOR ESTATE TAXES.—An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

(g) COST-OF-LIVING ADJUSTMENT.—

(1) IN GENERAL.—Each dollar amount in subsections (b)(2) and (c)(2)(A) shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins determined by substituting for “calendar year 2016” in subparagraph (A)(ii) thereof—

(i) except as provided in clause (ii), “calendar year 1997”, and

(ii) in the case of each dollar amount in subsection (c)(2)(A), “calendar year 2003”.

In the case of adjustments made for any taxable year beginning after 2007, section 1(f)(4) shall be applied for purposes of this paragraph by substituting “March 31” for “August 31”, and the Secretary shall publish the adjusted amounts under subsections (b)(2) and (c)(2)(A) for taxable years beginning in any calendar year no later than June 1 of the preceding calendar year.

(2) ROUNDING.—If any increase under paragraph (1) is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

(h) REPORTS.—The Secretary may require—

(1) the trustee of a health savings account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, the return of excess contributions, and such other matters as the Secretary determines appropriate, and

(2) any person who provides an individual with a high deductible health plan to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.

The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart C—Information Regarding Wages Paid Employees

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SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

- (1) the name of such person,
- (2) the name of the employee (and an identifying number for the employee if wages as defined in section 3121(a) have been paid),
- (3) the total amount of wages as defined in section 3401(a),
- (4) the total amount deducted and withheld as tax under section 3402,
- (5) the total amount of wages as defined in section 3121(a),
- (6) the total amount deducted and withheld as tax under section 3101,
- (8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),
- (9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),
- (10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned income as determined for purposes of section 32 (relating to earned income credit),
- (11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,
- (12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse (*other than any qualified HSA distribution, as defined in section 106(e)(2)*),
- (13) the total amount of deferrals for the year under a non-qualified deferred compensation plan (within the meaning of section 409A(d)),
- (14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—
 - (A) coverage to which paragraphs (11) and (12) apply, or
 - (B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125),

(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee,

(16) the amount includible in gross income under subparagraph (A) of section 83(i)(1) with respect to an event described in subparagraph (B) of such section which occurs in such calendar year, **[and]**

(17) the aggregate amount of income which is being deferred pursuant to elections under section 83(i), determined as of the close of the calendar year**[.], and**

(18) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) ADDITIONAL REQUIREMENTS.—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) STATEMENTS TO CONSTITUTE INFORMATION RETURNS.—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) RAILROAD EMPLOYEES.—

(1) ADDITIONAL REQUIREMENT.—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) INFORMATION TO BE SUPPLIED TO EMPLOYEES.—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.—

(1) STATEMENTS REQUIRED FROM PAYOR.—

(A) IN GENERAL.—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

(i) the name and, if there is withholding under section 3402(o), the social security number of such employee,

(ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and

(iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term “third-party sick pay” means any sick pay (as defined in section 3402(o)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(o)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

(A) the information shown on the statement furnished under paragraph (1)(A), and

(B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable.

To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

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MINORITY VIEWS

H.R. 6305 Bipartisan Improvements to HSAs

H.R. 6305 (Kelly, R-PA and Blumenauer, D-OR) allows: (1) an individual to roll over Flexible Spending Account (FSA) and limited Health Reimbursement Accounts (HRAs; up to the annual Health Savings Account (HSA) contribution amount) at time of transition to an HSA-eligible High-Deductible Health Plan (HDHP); (2) an individual to maintain an HSA even if his/her spouse has an FSA, provided each spouse is under separate health insurance plans; and (3) employees to participate in an HSA even if his/her employer offers an on-site health clinic.

H.R. 6305 does not undo sabotage, premium hikes, and benefit cuts Republicans have caused over the past 18 months. This bill was one in a series of 11 bills the Committee marked up that Republicans claim will help lower health care costs for consumers. This legislation does not undo the disruption and sabotage the Republicans have continued to inflict on the American health care system. Instead of focusing on expansion of HSAs and HDHPs, Democrats encourage the Committee to redirect its attention to legislation that could actually ensure that uninsured, low-income, and vulnerable people have real access to care. For example H.R. 5155, sponsored by Reps. Pallone, Neal, and Scott would protect people with preexisting conditions, lower premiums for Americans, and improve affordability of health coverage.

Legislation busts the deficit to benefit the wealthy, again. Altogether the 11 bills the Committee marked up would add another \$92 billion in unoffset tax cuts to the deficit. Attempts to expand HSAs (and encourage more enrollment in plans with high deductibles, covering very few up-front health costs) represent a continuation of Republicans' platform of shifting families into health plans that provide fewer health benefits and higher out-of-pocket costs—while providing greater tax benefits for higher-income individuals and corporate special interests. According to 2014 Treasury data, only five percent of families with adjusted gross income of under \$100,000 held money in an HSA, and those users' average account balances were \$1,700.

HDHPs and HSAs do not promote healthy behavior. It is widely acknowledged that HSAs and HDHPs lead consumers to delay care. They do not encourage individuals to make better health care decisions, as Republicans' "skin in the game" talking points assert. Decades of research shows that exposure to high out-of-pocket costs leads consumers to delay or forgo both necessary and unnecessary care. Delaying care and increasing costs run counter to Democratic policy goals of better coordinated, high-value affordable care for American families. This legislation demonstrates why HDHPs in

their current format do not allow consumers to see value in their health insurance.

According to the American Hospital Association, “Hospitals and health systems report that increased enrollment in HDHPs over the past several years has reduced access to care and subjected patients to costs they cannot afford. In addition, patients enrolled in HDHPs appear to delay care until they have reached their deductible or are in an emergency situation, which could lead to poorer health outcomes.”

HSAs mostly benefit high-income taxpayers while doing little to help moderate-income families or the uninsured. High-income people can best afford to save for health care expenses and are, therefore, the most likely to contribute to HSAs. Higher income filers are much more likely to establish HSAs than lower income filers—70 percent of HSA contributions come from households with incomes over \$100,000, according to the Joint Commission on Taxation (JCT)—and they are also likelier to max out their contributions. Additionally, high-income individuals receive the biggest tax benefit for each dollar contributed to an HSA because the value of a tax deduction rises with an individual’s tax bracket. More than 44 percent of Americans cannot afford a \$400 emergency visit. For these families, it is unlikely they have excess income to devote to a tax-preferred account.

JCT estimates the cost of this bill to be \$4.3 billion over 10 years. With this bill, Republicans are adding more tax cuts and increasing the deficit. Republicans are using the deficit, which they keep making larger with cuts for the wealthy, to justify their deep cuts to Medicare and Medicaid. Republicans are already proposing to cut Medicare and Medicaid by nearly a trillion dollars to try to pay for the tax cuts they have already enacted. This bill will only add fuel to the fire.

RICHARD E. NEAL,
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