

THE “RESTORING ACCESS TO MEDICATION ACT OF 2018”

—————  
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. 6199]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6199) to amend the Internal Revenue Code of 1986 to include certain over-the-counter medical products as qualified medical expenses, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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 submitted the following

### R E P O R T

together with

### MINORITY VIEWS

[To accompany H.R. 6199]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6199) to amend the Internal Revenue Code of 1986 to include certain over-the-counter medical products as qualified medical expenses, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the “Restoring Access to Medication Act of 2018”.

**SEC. 2. INCLUSION OF CERTAIN OVER-THE-COUNTER MEDICAL PRODUCTS AS QUALIFIED MEDICAL EXPENSES.**

(a) HSAS.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended—  
 (1) by striking the last sentence of subparagraph (A) and inserting the following: “For purposes of this subparagraph, amounts paid for menstrual care products shall be treated as paid for medical care.”, and

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

“(D) MENSTRUAL CARE PRODUCT.—For purposes of this paragraph, the term ‘menstrual care product’ means a tampon, pad, liner, cup, sponge, or similar product used by women with respect to menstruation or other genital-tract secretions.”.

(b) ARCHER MSAS.—Section 220(d)(2)(A) of such Code is amended by striking the last sentence and inserting the following: “For purposes of this subparagraph, amounts paid for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as paid for medical care.”.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by striking subsection (f) and inserting the following new subsection:

“(f) REIMBURSEMENTS FOR MENSTRUAL CARE PRODUCTS.—For purposes of this section and section 105, expenses incurred for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as incurred for medical care.”.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM HEALTH SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid after December 31, 2018.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred after December 31, 2018.

## I. SUMMARY AND BACKGROUND

### A. PURPOSE AND SUMMARY

The bill H.R. 6199, as reported by the Committee on Ways and Means, allows all tax-favored health accounts to be used to purchase over-the-counter (OTC) medical products and adds feminine or “menstrual care” products to the list of qualified medical expenses for the purposes of these tax-favored health accounts.

### B. BACKGROUND AND NEED FOR LEGISLATION

The This tax, also known as the “Medicine Cabinet Tax” was created under the Affordable Care Act (ACA) in order to raise revenue to help pay for the law’s new, entitlement spending. The treatment of OTC drugs in ACA has left these consumers with three options: (1) seek an unnecessary appointment with a doctor to obtain a prescription—saddling physician offices with needless appointments and resulting in longer wait times for other patients; (2) purchase OTC medicine out-of-pocket, which significantly increases the cost to the consumer because it is after-tax; or (3) forego treatment entirely and suffer from the symptoms of the condition. All three options increase costs to the consumer and to the health care system.

Millions of Americans would benefit from the ability to use tax-favored accounts for the purchase of over-the-counter products. According to a survey by America’s Health Insurance Plans (AHIP), 21.8 million people were covered by a high-deductible plan (HDHP) with an HSA as of January 2017. In addition, another survey found

that 44 percent of all civilian workers had access to a health FSA offered under a cafeteria plan in 2017. A separate annual survey of employer benefits found that among firms offering health benefits, 9 percent offer an HDHP with an HRA.

## C. LEGISLATIVE HISTORY

### *Background*

H.R. 6199 was introduced on June 22, 2018, and was referred to the Committee on Ways and Means.

### *Committee action*

The Committee on Ways and Means marked up H.R. 6199, the “Restoring Access to Medication Act of 2018,” on July 12, 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) and need for legislative response 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 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. INCLUSION OF CERTAIN OVER-THE-COUNTER MEDICAL PRODUCTS AS QUALIFIED MEDICAL EXPENSES

#### PRESENT LAW

#### *Individual deduction for medical expenses*

Expenses for medical care, not compensated for by insurance or otherwise, are deductible by an individual under the rules relating to itemized deductions to the extent the expenses exceed 7.5 percent (for 2017 and 2018) of adjusted gross income (“AGI”).<sup>1</sup> Medical care generally is defined broadly as amounts paid for diagnoses, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure of the body.<sup>2</sup>

Under an explicit limitation in the Code, any amount paid during a taxable year for medicine or drugs is deductible as a medical ex-

<sup>1</sup>Sec. 213(a). The 7.5 percent of AGI threshold increases to 10 percent for taxable years beginning after December 31, 2018 under section 9013 of the Affordable Care Act. However, this increase in the percentage does not apply until taxable years beginning after December 31, 2016 with respect to any taxpayer if the taxpayer or the taxpayer’s spouse has attained age 65 before the close of the taxable year.

<sup>2</sup>Sec. 213(d). There are certain limitations on the general definition including a rule that cosmetic surgery or similar procedures are generally not medical care.

pense only if the medicine or drug is a prescribed drug or insulin.<sup>3</sup> The term prescribed drug means a drug or biological which requires a prescription of a physician for its use by an individual.<sup>4</sup> Thus, any amount paid for medicine available without a prescription (“over-the-counter medicine”) is not deductible as a medical expense, including any medicine prescribed or recommended by a physician.<sup>5</sup>

#### *Exclusion for employer-provided health care*

The Code generally provides that employees are not taxed on (that is, may exclude from gross income) the value of employer-provided health coverage under an accident or health plan.<sup>6</sup> In addition, any reimbursements under an accident or health plan for medical care expenses for employees, their spouses, and their dependents generally are excluded from gross income.<sup>7</sup> An employer may agree to reimburse expenses for medical care of its employees (and their spouses and dependents), not covered by a health insurance plan, through a flexible spending account (“FSA”) which allows reimbursement not in excess of a specified dollar amount. Such dollar amount is either elected by an employee under a cafeteria plan (“Health FSA”) or otherwise specified by the employer under a health reimbursement account (“HRA”). Reimbursements under these arrangements are also excludible from gross income as reimbursements for medical care under employer-provided health coverage.

#### *Health savings accounts*

Present law provides that individuals with a high deductible health plan (and generally no other health plan) purchased either through the individual market or through an employer may establish and make tax-deductible contributions to a health savings account (“HSA”).<sup>8</sup> Subject to certain limitations,<sup>9</sup> contributions made to an HSA by an employer, including contributions made through a cafeteria plan through salary reduction, are excluded from income (and from wages for payroll tax purposes). Contributions made by individuals are deductible for income tax purposes, regardless of whether the individuals itemize. 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

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<sup>3</sup>Sec. 213(b).

<sup>4</sup>Sec. 213(d)(3).

<sup>5</sup>Rev. Rul. 2003–58, 2003–1 CB 959.

<sup>6</sup>Sec. 106.

<sup>7</sup>Sec. 105(b).

<sup>8</sup>Sec. 223.

<sup>9</sup>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 2018 limitation for family coverage was revised by the IRS to permit taxpayers to disregard the \$6,850 limitation under the modified inflation adjustment of Pub. L. No. 115–97. Rev. Rul. 2018–27, 2018–20 I.R.B. 591, May 14, 2018.) 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).

(i.e., age 65). Similar rules apply for another type of medical savings arrangement called an Archer MSA.<sup>10</sup>

*Medical care for excludible reimbursements*

For purposes of the exclusion for reimbursements under employer-provided accident and health plans (including under Health FSAs and HRAs), and for distributions from HSAs and Archer MSAs used for qualified medical expenses, the definition of medical care is generally the same as the definition that applies for the itemized deduction for the cost of medical care. However, prior to the enactment of the Patient Protection and Affordable Care Act (referred to as the “Affordable Care Act”),<sup>11</sup> the limitation (applicable to the itemized deduction) that only prescription medicines or drugs and insulin are taken into account did not apply. Thus, for example, amounts paid from a Health FSA or HRA, or funds distributed from an HSA to reimburse a taxpayer for nonprescription drugs, such as nonprescription aspirin, allergy medicine, antacids, or pain relievers, were excludable from income even though, if the taxpayer paid for such amounts directly (without such reimbursement), the expenses could not be taken into account in determining the itemized deduction for medical expenses.<sup>12</sup> For years beginning after December 31, 2010, the Affordable Care Act changed the definition of medical care for purposes of the exclusion for reimbursements for medical care under employer-provided accident and health plans and for distributions from HSAs and Archer MSAs used for qualified medical expenses to require that over-the-counter medicine (other than insulin) be prescribed by a physician in order for the medicine to be medical care for these purposes.<sup>13</sup> Thus, under present law, a Health FSA or an HRA is only permitted to reimburse an employee for the cost of over-the-counter medicine if the medicine is prescribed by a physician and distributions from an HSA or an Archer MSA used to purchase over-the-counter medicine is not a qualified medical expense unless the medicine is prescribed by a physician.

REASONS FOR CHANGE

The Committee observes that the requirement that over-the-counter medicine requires a prescription in order to be an eligible expense for individuals and families covered by a health FSA, HSA, HRA, or Archer MSA has left consumers with three options: (1) seek an unnecessary appointment with a doctor to obtain a prescription; (2) purchase the over-the-counter medicine out-of-pocket, which increases the after-tax cost to the consumer; or (3) forego treatment entirely. The Committee notes that all three options increase costs to the consumer and to our healthcare system. The Committee also believes that amounts paid for menstrual care products should be treated as qualified medical expenses.

<sup>10</sup> Sec. 220.

<sup>11</sup> Patient Protection and Affordable Care Act, Pub. L. No 111-148. Various provisions of the Affordable Care Act are amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

<sup>12</sup> Rev. Rul. 2003-102, 2993-2 C.B. 559, now obsolete by Rev. Rul. 2010-23, 2010-39 I.R.B. 388, September 3, 2010.

<sup>13</sup> Sec. 9003 of the Affordable Care Act. Notice 2010-59, 2010-39 I.R.B. 388, provides guidance on this change to the definition of medical care for these purposes.

The Committee therefore believes that the provision of the Affordable Care Act that disqualified expenses for all over-the-counter medicine (unless obtained with a prescription) from being medical expenses under health FSAs, HRAs, HSAs, and Archer MSAs should be modified. In addition, the Committee believes that amounts paid for menstrual care products should be treated as qualified medical expenses.

#### EXPLANATION OF PROVISION

Under the proposal, amounts paid from HSAs and MSAs that are qualified medical expenses are no longer limited only to those medicines and drugs which are prescribed, and include amounts paid for menstrual care products, such as tampons, pads, liners, cups, sponges, or similar products used by women with respect to menstruation or other genital-tract secretions.

Similarly, the proposal amends the definition of qualified medical expense for health FSAs and HRAs. Qualified medical expenses are no longer limited only to those medicines and drugs which are prescribed, and include expenses incurred for menstrual care products as described above.

#### EFFECTIVE DATE

The proposal for amendments to amounts paid from HSAs and MSAs is effective for amounts paid after December 31, 2018.

The proposal for amendments to health FSAs and HRAs is effective for expenses incurred after December 31, 2018.

### 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. 6199, the “Restoring Access to Medication Act of 2018,” on July 12, 2018.

H.R. 6199 was ordered favorably reported to the House of Representatives as amended by an amendment in the nature of a substitute offered by Mr. Roskam by a roll call vote of 24 yeas to 10 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady .....				Mr. Neal .....		X	
Mr. Johnson .....	X			Mr. Levin .....		X	
Mr. Nunes .....	X			Mr. Lewis .....		X	
Mr. Reichert .....	X			Mr. Doggett .....			
Mr. Roskam .....	X			Mr. Thompson .....		X	
Mr. Buchanan .....	X			Mr. Larson .....		X	
Mr. Smith (NE) .....	X			Mr. Blumenauer .....			
Ms. Jenkins .....	X			Mr. Kind .....	X		
Mr. Paulsen .....	X			Mr. Pascrell .....	X		
Mr. Marchant .....	X			Mr. Crowley .....			
Ms. Black .....				Mr. Davis .....		X	
Mr. Reed .....	X			Ms. Sanchez .....			
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						

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
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. 6199, 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
Include Certain Over-The-Counter Medical Expenses as Qualified Medical Expenses <sup>1</sup> .....	- 279	- 538	- 618	- 645	- 674	- 703	- 734	- 799	- 848	- 887	- 2,753	- 6,723
<b>NOTE:</b> Details do not add to totals due to rounding.												
<sup>1</sup> Estimate includes the following off-budget effects .....	- 86	- 165	- 189	- 198	- 207	- 216	- 225	- 235	- 246	- 257	- 846	- 2,026

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

The following statement is made pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives. Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses. For each such provision identified by the staff of the Joint Committee on Taxation a summary description of the provision is provided along with an estimate of the number and type of affected taxpayers, and a discussion regarding the relevant complexity and administrative issues.

##### 1. *Modifications to definition of medical care with respect to over-the-counter-medicine*

###### *Summary description of the provisions*

The provision changes the definition of medical care for purposes of the exclusion for reimbursements for medical care under employer-provided accident and health plans (which include health FSAs and HRAs) and for distributions from HSAs or Archer MSAs used for qualified medical expenses to include over-the-counter medicine not prescribed by a physician, including menstrual care products.

###### *Number of affected taxpayers*

It is estimated that the provision will affect over ten percent of individual tax returns.

###### *Discussion*

Taxpayers voluntarily claiming reimbursement for over-the-counter medicines may have an increased burden in record keeping and claim submissions.

#### 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.

(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.]

*(f) REIMBURSEMENTS FOR MENSTRUAL CARE PRODUCTS.—For purposes of this section and section 105, expenses incurred for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as incurred for medical care.*

(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. 220. ARCHER MSAS.**

(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 such individual to an Archer MSA 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 the amount equal to 1/12 of—

(A) in the case of an individual who has self-only coverage under the high deductible health plan as of the first day of such month, 65 percent of the annual deductible under such coverage, and

(B) in the case of an individual who has family coverage under the high deductible health plan as of the first day of such month, 75 percent of the annual deductible under such coverage.

(3) **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) of this paragraph) shall be divided equally between them unless they agree on a different division.

(4) **DEDUCTION NOT TO EXCEED COMPENSATION.**—

(A) **EMPLOYEES.**—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (I) of subsection (c)(1)(A)(iii) shall not exceed such individual's wages, salaries, tips, and other employee compensation which are attributable to such individual's employment by the employer referred to in such subclause.

(B) **SELF-EMPLOYED INDIVIDUALS.**—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (II) of subsection (c)(1)(A)(iii) shall not exceed such individual's earned income (as defined in section 401(c)(1)) derived by the taxpayer from the trade or business with respect to which the high deductible health plan is established.

(C) **COMMUNITY PROPERTY LAWS NOT TO APPLY.**—The limitations under this paragraph shall be determined without regard to community property laws.

(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to an Archer MSA of an individual if—

(A) any amount is contributed to any Archer MSA of such individual for such year which is excludable from gross income under section 106(b), or

(B) if such individual's spouse is covered under the high deductible health plan covering such individual, any amount is contributed for such year to any Archer MSA of such spouse which is so excludable.

(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.

(c) DEFINITIONS.—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,

(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, and

(iii)(I) the high deductible health plan covering such individual is established and maintained by the employer of such individual or of the spouse of such individual and such employer is a small employer, or

(II) such individual is an employee (within the meaning of section 401(c)(1)) or the spouse of such an employee and the high deductible health plan covering such individual is not established or maintained by any employer of such individual or spouse.

(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph

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

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

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(C) CONTINUED ELIGIBILITY OF EMPLOYEE AND SPOUSE ESTABLISHING ARCHER MSAS.—If, while an employer is a small employer—

(i) any amount is contributed to an Archer MSA of an individual who is an employee of such employer or the spouse of such an employee, and

(ii) such amount is excludable from gross income under section 106(b) or allowable as a deduction under this section,

such individual shall not cease to meet the requirement of subparagraph (A)(iii)(I) by reason of such employer ceasing to be a small employer so long as such employee continues to be an employee of such employer.

(D) LIMITATIONS ON ELIGIBILITY.—For limitations on number of taxpayers who are eligible to have Archer MSAs, see subsection (i).

(2) HIGH DEDUCTIBLE HEALTH PLAN.—

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

(i) in the case of self-only coverage, which has an annual deductible which is not less than \$1,500 and not more than \$2,250,

(ii) in the case of family coverage, which has an annual deductible which is not less than \$3,000 and not more than \$4,500, and

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

(I) \$3,000 for self-only coverage, and

(II) \$5,500 for family coverage.

(B) SPECIAL RULES.—

(i) 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).

(ii) 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 if the absence of a deductible for such care is required by State law.

(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) SMALL EMPLOYER.—

(A) IN GENERAL.—The term “small employer” means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar

years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) CERTAIN GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—The term “small employer” includes, with respect to any calendar year, any employer if—

(i) such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,

(ii) any amount was contributed to the Archer MSA of any employee of such employer with respect to coverage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and

(iii) such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.

(D) SPECIAL RULES.—

(i) CONTROLLED GROUPS.—For purposes of this paragraph, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

(ii) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

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

(d) ARCHER MSA.—For purposes of this section—

(1) ARCHER MSA.—The term “Archer MSA” means a trust created or organized in the United States as a medical savings account exclusively for the purpose of paying the qualified medical expenses of the account holder, 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), 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 75 percent of the highest annual limit deductible permitted under subsection (c)(2)(A)(ii) for such calendar year.

(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 holder, amounts paid by such holder 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.] *For purposes of this subparagraph, amounts paid for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as paid for medical care.*

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

(ii) EXCEPTIONS.—Clause (i) 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)), or

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

(C) MEDICAL EXPENSES OF INDIVIDUALS WHO ARE NOT ELIGIBLE INDIVIDUALS.—Subparagraph (A) shall apply to an amount paid by an account holder for medical care of an individual who is not described in clauses (i) and (ii) of subsection (c)(1)(A) for the month in which the expense for such care is incurred only if no amount is contributed (other than a rollover contribution) to any Archer MSA of such account holder for the taxable year which includes such month. This subparagraph shall not apply to any expense for coverage described in subclause (I) or (III) of subparagraph (B)(ii).

(3) ACCOUNT HOLDER.—The term “account holder” means the individual on whose behalf the Archer MSA 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(b), 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.—An Archer MSA is exempt from taxation under this subtitle unless such account has ceased to be an Archer MSA. 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 Archer MSAs, 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 an Archer MSA which is used exclusively to pay qualified medical expenses of any account holder shall not be includible in gross income.
  - (2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of an Archer MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be included in the gross income of such holder.
  - (3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—
    - (A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any Archer MSA of an individual, paragraph (2) shall not apply to distributions from the Archer MSAs 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) which is neither excludable from gross income under section 106(b) 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 holder for any taxable year in which there is a payment or distribution from an Archer MSA of such holder 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 holder 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 holder 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 an Archer MSA to the account holder to the extent the amount received is paid into an Archer MSA or a health savings account (as defined in section 223(d)) for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from an Archer MSA 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 an Archer MSA 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 an Archer MSA 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 an Archer MSA 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 an Archer MSA with respect to which such spouse is the account holder.

(8) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account holder's surviving spouse acquires such holder's interest in an Archer MSA by reason of being the designated beneficiary of such account at the death of the account holder, such Archer MSA shall be treated as if the spouse were the account holder.

(B) OTHER CASES.—

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

(I) such account shall cease to be an Archer MSA 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 holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

(ii) SPECIAL RULES.—

(I) REDUCTION OF INCLUSION FOR PRE-DEATH 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.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

(1) such dollar amount, multiplied by

(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting "calendar year 1997" for "calendar year 2016" in subparagraph (A)(ii) thereof.

If any increase under the preceding sentence is not a multiple of \$50, such increase shall be rounded to the nearest multiple of \$50.

(h) REPORTS.—The Secretary may require the trustee of an Archer MSA to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters 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.

(i) LIMITATION ON NUMBER OF TAXPAYERS HAVING ARCHER MSAs.—

(1) IN GENERAL.—Except as provided in paragraph (5), no individual shall be treated as an eligible individual for any taxable year beginning after the cut-off year unless—

(A) such individual was an active MSA participant for any taxable year ending on or before the close of the cut-off year, or

- (B) such individual first became an active MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an MSA-participating employer.
- (2) CUT-OFF YEAR.—For purposes of paragraph (1), the term “cut-off year” means the earlier of—
- (A) calendar year 2007, or
  - (B) the first calendar year before 2007 for which the Secretary determines under subsection (j) that the numerical limitation for such year has been exceeded.
- (3) ACTIVE MSA PARTICIPANT.—For purposes of this subsection—
- (A) IN GENERAL.—The term “active MSA participant” means, with respect to any taxable year, any individual who is the account holder of any Archer MSA into which any contribution was made which was excludable from gross income under section 106(b), or allowable as a deduction under this section, for such taxable year.
  - (B) SPECIAL RULE FOR CUT-OFF YEARS BEFORE 2007.—In the case of a cut-off year before 2007—
    - (i) an individual shall not be treated as an eligible individual for any month of such year or an active MSA participant under paragraph (1)(A) unless such individual is, on or before the cut-off date, covered under a high deductible health plan, and
    - (ii) an employer shall not be treated as an MSA-participating employer unless the employer, on or before the cut-off date, offered coverage under a high deductible health plan to any employee.
  - (C) CUT-OFF DATE.—For purposes of subparagraph (B)—
    - (i) IN GENERAL.—Except as otherwise provided in this subparagraph, the cut-off date is October 1 of the cut-off year.
    - (ii) EMPLOYEES WITH ENROLLMENT PERIODS AFTER OCTOBER 1.—In the case of an individual described in subclause (I) of subsection (c)(1)(A)(iii), if the regularly scheduled enrollment period for health plans of the individual’s employer occurs during the last 3 months of the cut-off year, the cut-off date is December 31 of the cut-off year.
    - (iii) SELF-EMPLOYED INDIVIDUALS.—In the case of an individual described in subclause (II) of subsection (c)(1)(A)(iii), the cut-off date is November 1 of the cut-off year.
    - (iv) SPECIAL RULES FOR 1997.—If 1997 is a cut-off year by reason of subsection (j)(1)(A)—
      - (I) each of the cut-off dates under clauses (i) and (iii) shall be 1 month earlier than the date determined without regard to this clause, and
      - (II) clause (ii) shall be applied by substituting “4 months” for “3 months”.
- (4) MSA-PARTICIPATING EMPLOYER.—For purposes of this subsection, the term “MSA-participating employer” means any small employer if—

(A) such employer made any contribution to the Archer MSA of any employee during the cut-off year or any preceding calendar year which was excludable from gross income under section 106(b), or

(B) at least 20 percent of the employees of such employer who are eligible individuals for any month of the cut-off year by reason of coverage under a high deductible health plan of such employer each made a contribution of at least \$100 to their Archer MSAs for any taxable year ending with or within the cut-off year which was allowable as a deduction under this section.

(5) ADDITIONAL ELIGIBILITY AFTER CUT-OFF YEAR.—If the Secretary determines under subsection (j)(2)(A) that the numerical limit for the calendar year following a cut-off year described in paragraph (2)(B) has not been exceeded—

(A) this subsection shall not apply to any otherwise eligible individual who is covered under a high deductible health plan during the first 6 months of the second calendar year following the cut-off year (and such individual shall be treated as an active MSA participant for purposes of this subsection if a contribution is made to any Archer MSA with respect to such coverage), and

(B) any employer who offers coverage under a high deductible health plan to any employee during such 6-month period shall be treated as an MSA-participating employer for purposes of this subsection if the requirements of paragraph (4) are met with respect to such coverage.

For purposes of this paragraph, subsection (j)(2)(A) shall be applied for 1998 by substituting “750,000” for “600,000”.

(j) DETERMINATION OF WHETHER NUMERICAL LIMITS ARE EXCEEDED.—

(1) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1997.—The numerical limitation for 1997 is exceeded if, based on the reports required under paragraph (4), the number of Archer MSAs established as of—

(A) April 30, 1997, exceeds 375,000, or

(B) June 30, 1997, exceeds 525,000.

(2) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1998, 1999, 2001, 2002, 2004, 2005, OR 2006.—

(A) IN GENERAL.—The numerical limitation for 1998, 1999, 2001, 2002, 2004, 2005, or 2006 is exceeded if the sum of—

(i) the number of MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

(ii) the Secretary’s estimate (determined on the basis of the returns described in clause (i)) of the number of MSA returns for such taxable years which will be filed after such date,

exceeds 750,000 (600,000 in the case of 1998). For purposes of the preceding sentence, the term “MSA return” means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for 1998, 1999, 2001, 2002, 2004, 2005, or 2006 is also exceeded if the sum of—

(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

(ii) the product of 2.5 and the number of Archer MSAs established during the portion of such year preceding July 1 (based on the reports required under paragraph (4)) for taxable years beginning in such year,

exceeds 750,000.

(C) NO LIMITATION FOR 2000 OR 2003.—The numerical limitation shall not apply for 2000 or 2003.

(3) PREVIOUSLY UNINSURED INDIVIDUALS NOT INCLUDED IN DETERMINATION.—

(A) IN GENERAL.—The determination of whether any calendar year is a cut-off year shall be made by not counting the Archer MSA of any previously uninsured individual.

(B) PREVIOUSLY UNINSURED INDIVIDUAL.—For purposes of this subsection, the term “previously uninsured individual” means, with respect to any Archer MSA, any individual who had no health plan coverage (other than coverage referred to in subsection (c)(1)(B)) at any time during the 6-month period before the date such individual’s coverage under the high deductible health plan commences.

(4) REPORTING BY MSA TRUSTEES.—

(A) IN GENERAL.—Not later than August 1 of 1997, 1998, 1999, 2001, 2002, 2004, 2005, and 2006, each person who is the trustee of an Archer MSA established before July 1 of such calendar year shall make a report to the Secretary (in such form and manner as the Secretary shall specify) which specifies—

(i) the number of Archer MSAs established before such July 1 (for taxable years beginning in such calendar year) of which such person is the trustee,

(ii) the name and TIN of the account holder of each such account, and

(iii) the number of such accounts which are accounts of previously uninsured individuals.

(B) ADDITIONAL REPORT FOR 1997.—Not later than June 1, 1997, each person who is the trustee of an Archer MSA established before May 1, 1997, shall make an additional report described in subparagraph (A) but only with respect to accounts established before May 1, 1997.

(C) PENALTY FOR FAILURE TO FILE REPORT.—The penalty provided in section 6693(a) shall apply to any report required by this paragraph, except that—

(i) such section shall be applied by substituting “\$25” for “\$50”, and

(ii) the maximum penalty imposed on any trustee shall not exceed \$5,000.

(D) AGGREGATION OF ACCOUNTS.—To the extent practicable, in determining the number of Archer MSAs on the basis of the reports under this paragraph, all Archer MSAs of an individual shall be treated as 1 account and all ac-

counts of individuals who are married to each other shall be treated as 1 account.

(5) DATE OF MAKING DETERMINATIONS.—Any determination under this subsection that a calendar year is a cut-off year shall be made by the Secretary and shall be published not later than October 1 of such year.

\* \* \* \* \*

**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)).

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.

(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).

(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.] *For purposes of this subparagraph, amounts paid for menstrual care products shall be treated as paid for medical care.*

(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).

(D) MENSTRUAL CARE PRODUCT.—*For purposes of this paragraph, the term “menstrual care product” means a tampon, pad, liner, cup, sponge, or similar product used by women with respect to menstruation or other genital-tract secretions.*

(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 indi-

vidual 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 in-

cluded 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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## MINORITY VIEWS

### H.R. 6199 Restoring Access to Medication Act of 2018

H.R. 6199 (Jenkins, R-KS, Paulsen, R-MN, Kind, D-WI and Meng, D-NY) repeals provisions of the Internal Revenue Code that limit payments for medications from health savings accounts (HSAs), medical savings accounts, health flexible spending arrangements, and health reimbursement arrangements to only prescription drugs or insulin (allowing distributions from such accounts for over-the-counter drugs). The bill also allows the accounts to be used for menstrual care products. While the inclusion of menstrual care products addresses an unfair bias against women in the current tax code, the fact the legislation is unpaid for is a cause for concern and in no way addresses the broader discrimination women are facing in accessing health care under the Republican administration.

H.R. 6199 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. This bill explicitly repeals a provision of the ACA that prohibited tax-free reimbursements for over-the-counter medications.

Instead of focusing on expanding tax-preferred accounts that help only the wealthiest while continuing to undermine health care for millions of Americans, 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, help lower premiums for Americans, and improve affordability of health coverage. Additionally, Congress should instead consider undoing the 18 months of Republican actions that are harming women's access to health care.

The Joint Committee on Taxation (JCT) estimates the cost of this bill to be \$6.7 billion over 10 years. Altogether the 11 bills the Committee marked up would add another \$92 billion in unoffset tax cuts to the deficit. With these bills, 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 the deep cuts they plan to make to Medicare and Medicaid. Republicans already are 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 increase Republicans' call for further cuts to these critical programs.

RICHARD E. NEAL,  
*Ranking Member.*

