114TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
114–627

HEALTH CARE SECURITY ACT OF 2016

JUNE 17, 2016.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 5445]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5445) to amend the Internal Revenue Code of 1986 to improve the rules with respect to health savings accounts, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS

	Page
I. SUMMARY AND BACKGROUND	3
II. EXPLANATION OF THE BILL	4
A. Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account (sec. 2 of the bill and sec. 223 of the Code)	4
B. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account (sec. 3 of the bill and sec. 223 of the Code)	5
C. Maximum Contribution Limit to HSA Increased to Amount of Deductible and Out-of-Pocket Limitation (sec. 4 of the bill and sec. 223 of the Code)	6
III. VOTES OF THE COMMITTEE	8
IV. BUDGET EFFECTS OF THE BILL	8
A. Committee Estimate of Budgetary Effects	8
B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority	10
C. Cost Estimate Prepared by the Congressional Budget Office	10

59–006

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE 13
A. Committee Oversight Findings and Recommendations 13
B. Statement of General Performance Goals and Objectives 13
C. Information Relating to Unfunded Mandates 13
D. Applicability of House Rule XXI 5(b) 13
E. Tax Complexity Analysis 13
F. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits 14
G. Duplication of Federal Programs 14
H. Disclosure of Directed Rule Makings 14
VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED 14
A. Text of Existing Law Amended or Repealed by the Bill, as Reported 14
B. Changes in Existing Law Proposed by the Bill, as Reported 23
VII. DISSENTING VIEWS 34

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 "Health Care Security Act of 2016".

SEC. 2. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) of the Internal Revenue Code of 1986 is amended to read as follows:

"(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

"(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

"(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

"(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

"(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

"(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 3. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(D) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to coverage beginning after December 31, 2016.

SEC. 4. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

(a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A) of the Internal Revenue Code of 1986 is amended by striking "$2,250" and inserting "the amount in effect under subsection (c)(2)(A)(ii)(I)".

(b) FAMILY COVERAGE.—Section 223(b)(2)(B) of such Code is amended by striking "$4,500" and inserting "the amount in effect under subsection (c)(2)(A)(ii)(II)".

(c) CONFORMING AMENDMENTS.—Section 223(g)(1) of such Code is amended—

(1) by striking "subsections (b)(2) and" both places it appears and inserting "subsection", and

(2) by striking "determined by" in subparagraph (B) thereof and all that follows through "'calendar year 2003'." and inserting "determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2016.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill H.R. 5445, as reported by the Committee on Ways and Means, provides for various improvements to Health Savings Accounts ("HSAs") in order to make them more attractive to various populations of consumers.

B. BACKGROUND AND NEED FOR LEGISLATION

According to a 2015 census conducted by America's Health Insurance Plans (AHIP), as of January 2015, 19.7 million people were covered by a high deductible health plan (HDHP) with an HSA, a 2.3 million-person increase from 2014 levels. These pairings are an increasingly popular option for workers—only 4 percent of worker were enrolled in such coverage in 2005 compared to 24 percent in 2015—and show no signs of slowing. According to a survey conducted by PricewaterhouseCoopers, "the percentage of employers offering only high-deductible plans for employees has nearly doubled since 2012."

HSAs and other consumer-directed health products encourage good health and health care policy. By encouraging individuals to plan, shop, and save for their own health care needs, patients have more control over their own health care.

C. LEGISLATIVE HISTORY

Background

H.R. 5445 was introduced on June 10, 2016, and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up H.R. 5445, the Health Care Security Act of 2016, on June 15, 2016, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

Both the policy issues surrounding HSAs and their impact on health care have been discussed at two Ways and Means hearings during the 114th 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).

II. EXPLANATION OF THE BILL

A. Allow Both Spouses to Make Catch-Up Contributions to the Same Health Savings Account (sec. 2 of the bill and sec. 223 of the Code)

PRESENT LAW

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) may establish a health savings account ("HSA"). 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 for qualified medical expenses are not includible in gross income.

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 2016, the basic limit on contributions that can be made to an HSA for a year is $3,350 in the case of self-only coverage and $6,750 in the case of family coverage.[1] For 2017, the amount is $3,400 in the case of self-only coverage and $6,750 (the same as 2016) in the case of family coverage. The basic contribution limits are increased by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year (referred to as "catch-up contributions").[2] All HSA contributions are aggregated for purposes of the contribution limits.[3] The annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (that is, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month.[4]

If eligible individuals are married to each other and either spouse has family coverage, both spouses are treated as having only family coverage, so that the contribution limit for family coverage applies. The contribution limit (without regard to any catch-up contribution amounts) is divided equally between the spouses unless they agree on a different division.

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[1] Under section 4973, an excise tax applies to contributions in excess of the maximum contribution amount for the HSA. The excise tax generally is equal to six percent of the cumulative amount of excess contributions that are not distributed from the HSA.

[2] Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

[3] In addition, contributions to Archer MSAs under section 220 reduce the annual HSA contribution limit.

[4] Under a special rule, an individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual for every month in the taxable year for purposes of computing the annual limit. Thus, the individual may contribute the maximum annual amount. However, if the individual ceases to be an eligible individual within a certain period, contributions that could not otherwise have been made are generally includible in income and are subject to a 10-percent additional tax.

If both spouses of a married couple are eligible individuals, each may contribute to an HSA, but they cannot have a joint HSA.[5] Under the rule described above, however, the spouses may divide their basic contribution limit for the year by allocating the entire amount to one spouse to be contributed to that spouse's HSA.[6] This rule does not apply to catch-up contribution amounts. Thus, if both spouses are at least age 55 and eligible to make catch-up contributions, each must make the catch-up contribution to his or her own HSA.[7]

REASONS FOR CHANGE

The Committee continues to believe that high deductible health plans and the related HSAs will help reduce health care costs. The Committee has identified certain cases where it believes that the operation of HSAs can be improved. One such case involves the present-law obstacle that prevents both otherwise eligible spouses from making catch-up contributions if they have only one HSA account. The Committee believes the efficiency of HSAs could be improved by allowing both eligible spouses to make catch up contributions to a single HSA, rather than the present law requirement that they each must have their own HSA in order to make catch-up contributions.

EXPLANATION OF PROVISION

Under the provision, if both spouses of a married couple are eligible for catch-up contributions and either has family coverage, the annual contribution limit that can be divided between them includes catch-up contribution amounts of both spouses. Thus, for example, the spouses can agree that their combined basic and catch-up contribution amounts are allocated to one spouse to be contributed to that spouse's HSA. In other cases, as under present law, a spouse's catch-up contribution amount is not eligible for division between the spouses; the catch-up contribution must be made to the HSA of that spouse.

EFFECTIVE DATE

The provision applies for taxable years beginning after December 31, 2016.

B. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT (SEC. 3 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

Distributions from an HSA for qualified medical expenses are not includible in 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

[5] Notice 2004–50, 2004–2 C.B. 196, Q&A–63.
[6] 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.
[7] Notice 2008–59, 2008–2 C.B. 123, Q&A–22.

death, disability, or the individual attains the age of Medicare eligibility (that is, age 65).

In order for a distribution from an HSA to be excludible as a payment for a qualified medical expense, the medical expense must be incurred on or after the date that the HSA is established.[8] Thus, a distribution from an HSA is not excludible as a payment for a qualified medical expense if the medical expense is incurred after a taxpayer enrolls in a high deductible health plan but before the taxpayer establishes an HSA.

REASONS FOR CHANGE

The Committee has identified certain cases where it believes that the operation of HSAs can be improved. One such case involves the typical lag between obtaining coverage under a high deductible health plan and the establishment of an HSA. Recognizing this lag, the Committee believes it is appropriate to allow medical expenses incurred after coverage is obtained under a high deductible health plan but prior to the establishment of the HSA to be paid for from the HSA and to be excludible from income, provided the HSA is established within 60 days of obtaining coverage under a high deductible health plan.

EXPLANATION OF PROVISION

Under the provision, if an HSA is established during the 60-day period beginning on the date that an individual's coverage under a high deductible health plan begins, then the HSA is treated as having been established on the date coverage under the high deductible health plan begins for purposes of determining if an expense incurred is a qualified medical expense. Thus, if a taxpayer establishes an HSA within 60 days of the date that the taxpayer's coverage under a high deductible health plan begins, any distribution from an HSA used as a payment for a medical expense incurred during that 60-day period after the high deductible health plan coverage began is excludible from gross income as a payment for a qualified medical expense even though the expense was incurred before the date that the HSA was established.

EFFECTIVE DATE

The provision applies with respect to coverage beginning after December 31, 2016.

C. MAXIMUM CONTRIBUTION LIMIT TO HSA INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION (SEC. 4 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

HSA contributions for a year are subject to basic dollar limits that are adjusted annually as needed to reflect annual cost-of-living increases. For 2016, the basic limit on contributions that can be made to an HSA for a year is $3,350 in the case of self-only cov-

[8] Q&A–26 of Notice 2004–2, 2004–1 C.B. 269.

erage and $6,750 in the case of family coverage.[9] For 2017, the amount is $3,400 in the case of self-only coverage and $6,750 (the same as 2016) in the case of family coverage. The basic contribution limits are increased by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year (referred to as "catch-up contributions").[10] All HSA contributions are aggregated for purposes of the contribution limits.[11] The annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (that is, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month.[12]

A minimum annual deductible amount and a maximum on the sum of the annual deductible and out-of-pocket expenses (such as co-pays) apply to high deductible health plans, which are adjusted annually as needed to reflect cost-of-living increases. For 2016, the minimum deductible is $1,300 in the case of self-only coverage and $2,600 in the case of family coverage. In addition, for 2016, the sum of the deductible and out-of-pocket expenses must be no more than $6,550 in the case of self-only coverage and no more than $13,100 in the case of family coverage. The same amounts apply for 2017.

REASONS FOR CHANGE

The Committee continues to believe that high deductible health plans and the related HSAs will help reduce health care costs. In furtherance of that goal, increasing the limits on HSA contributions will encourage more people to enroll in high deductible health plans and contribute to HSAs.

EXPLANATION OF PROVISION

The provision increases the basic limit on aggregate HSA contributions for a year to equal the maximum on the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan. Thus, for 2017, the basic limit is $6,550 in the case of self-only coverage and $13,100 in the case of family coverage. As under present law, basic contribution limits are increased by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year. In addition, as under present law, the annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (that is, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month.

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[9] Under section 4973, an excise tax applies to contributions in excess of the maximum contribution amount for the HSA. The excise tax generally is equal to six percent of the cumulative amount of excess contributions that are not distributed from the HSA.

[10] Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

[11] In addition, contributions to Archer MSAs under section 220 reduce the annual HSA contribution limit.

[12] Under a special rule, an individual who is an eligible individual during the last month of a taxable year is treated as having been an eligible individual for every month in the taxable year for purposes of computing the annual limit. Thus, the individual may contribute the maximum annual amount. However, if the individual ceases to be an eligible individual within a certain period, contributions that could not otherwise have been made are generally includible in income and are subject to a 10-percent additional tax.

EFFECTIVE DATE

The provision applies for taxable years beginning after December 31, 2016.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 5445, "To amend the Internal Revenue Code of 1986 to improve the rules with respect to health savings accounts," on June 15, 2016.

The bill, H.R. 5445, was ordered favorably reported to the House of Representatives as amended by a roll call vote of 23 yeas to 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Levin		X	
Mr. Johnson	X			Mr. Rangel		X	
Mr. Nunes				Mr. McDermott		X	
Mr. Tiberi	X			Mr. Lewis		X	
Mr. Reichert	X			Mr. Neal		X	
Mr. Boustany	X			Mr. Becerra		X	
Mr. Roskam	X			Mr. Doggett		X	
Mr. Price	X			Mr. Thompson		X	
Mr. Buchanan	X			Mr. Larson		X	
Mr. Smith (NE)	X			Mr. Blumenauer		X	
Ms. Jenkins	X			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. Young	X						
Mr. Kelly	X						
Mr. Renacci	X						
Mr. Meehan	X						
Ms. Noem	X						
Mr. Holding	X						
Mr. Smith (MO)	X						
Mr. Dold	X						
Mr. Rice	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. 5445, as reported.

The bill, as reported, is estimated to have the following effect on Federal fiscal year budget receipts for the period 2017–2026:

ESTIMATED REVENUE EFFECTS OF H.R. 5445, THE "HEALTH CARE SECURITY ACT OF 2016," AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—FISCAL YEARS 2017–2016

[Millions of dollars]

Provison	Effective	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
1. Allow both spouse to make catch-up contributions to the same health savings account ("HSA") [1].	tyba 12/31/16	−15	−32	−35	−38	−41	−44	−47	−50	−53	−56	−162	−410
2. Special rule for certain medical expenses incurred before establishment of HSA [1].	cba 12/31/16	−6	−16	−18	−20	−21	−23	−24	−26	−27	−28	−81	−210
3. Maximum contribution limit to HSA increased to amount of deductible and out-of-pocket limitation [1].	tyba 12/31/16	−900	−1373	−1550	−1734	−1923	−2112	−2298	−2477	−2663	−2863	−7,480	−19,894
Net Total		−922	−1,421	−1,603	−1,792	−1,985	−2,179	−2,369	−2,552	−2,743	−2,948	−7,724	−20,514

Joint Committee on taxation:
Note: Details may not add to totals due to rounding.
Legend for "Effective" column: cba = coverage beginning after; tyba = taxable years beginning after.

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–21	2017–26
[1] Estimate includes the following off-budget budget effects:												
Allow both spouses to make catch-up contributions to the same HSA	−5	−11	−12	−13	−14	−14	−15	−16	−17	−18	−53	−135
Special rule for certain medical expenses incurred before establishment of HSA	−2	−6	−6	−7	−7	−8	−8	−9	−9	−10	−28	−72
Maximum contribution limit to HSA increased to amount of deductible and out-of-pocket limitation	−206	−315	−355	−397	−441	−484	−527	−568	−610	−656	−1,714	−4,559

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 provisions of the bill involve increased tax expenditures. See amounts shown in the table in Part IV.A above.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, June 17, 2016.

Hon. Kevin Brady,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5445, the Health Care Security Act of 2016.

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

Sincerely,

Keith Hall.

Enclosure.

H.R. 5445—Health Care Security Act of 2016

H.R. 5445 would amend the Internal Revenue code to modify the rules regarding contributions to and treatment of distributions from Health Savings Accounts (HSAs), which are tax-favored accounts that individuals with high-deductible health plans can use to fund certain health expenses. The bill would raise the maximum basic contribution limit to an HSA to equal the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan–almost doubling the limit allowed under current law. Also, under current law, spouses must allocate the entire amount of their catch-up contributions to their own HSA, but the bill would allow spouses to divide up their combined catch-up contributions between both of their HSAs. Lastly, under current law,

distributions from HSAs for qualified medical expenses are only excluded from gross income if the expense was incurred after the establishment of the HSA. The bill would allow distributions to be excluded from gross income if the associated medical expenses were incurred within a 60-day period between the individual gaining coverage under a high deductible plan and establishing the HSA.

The staff of the Joint Committee on Taxation (JCT) estimates that enacting H.R. 5445 would reduce revenues by about $20.5 billion over the 2017–2026 period. Of that reduction, about $4.8 billion would result from changes in off-budget revenues (from Social Security payroll taxes).

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

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 5445, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON JUNE 15, 2016

	By fiscal year, in millions of dollars—											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2017–2021	2017–2026
NET INCREASE IN THE ON-BUDGET DEFICIT												
Statutory Pay-As-You-Go Effects	709	1,089	1,230	1,375	1,523	1,673	1,819	1,959	2,107	2,264	5,929	15,748
Memorandum:												
Change in Off-Budget Revenues [a]	−213	−332	−373	−417	−462	−506	−550	−593	−636	−684	−1,795	−4,766

Source: Staff of the Joint Committee on Taxation.
Note: Components may not sum to total because of rounding.
[a] Negative numbers indicate a reduction in revenues.

CBO and JCT estimate that enacting the bill would increase on-budget deficits by more than $5 billion in at least one of the four 10-year periods beginning in 2027.

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

The CBO staff contact for this estimate is Peter Huether. The estimate was approved by David Weiner, Assistant Director for Tax Analysis.

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

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of H.R. 5445 that the Committee concluded that it is appropriate to report the bill, as amended, favorably to the House of Representatives with the recommendation that the bill do pass.

B. Statement of General Performance Goals and Objectives

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

C. Information Relating to Unfunded Mandates

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

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

D. Applicability of House Rule 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 leg-

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

H. Disclosure of Directed Rule Makings

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

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

A. Text of Existing Law Amended or Repealed by the Bill, as Reported

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

Changes in Existing Law Made by the Bill, as Reported

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

INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter B—Computation of Taxable Income

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PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

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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 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 indi-

vidual 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 1871 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 subparagraph (A) of section 71(b)(2) 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 1992" in subparagraph (B) 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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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 italics, existing law in which no change is proposed is shown in roman):

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 (new matter is printed in italics and existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter B—Computation of Taxable Income

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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 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] *the amount in effect under subsection (c)(2)(A)(ii)(I)*.

(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] *the amount in effect under subsection (c)(2)(A)(ii)(II)*.

(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.]

(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

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

(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.

(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 1871 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 pre-

scribed 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).

(D) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.

(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 subparagraph (A) of section 71(b)(2) 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] *subsection* (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 1992" in subparagraph (B) 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".] *determined by substituting "calendar year 2003" for "calendar year 1992" in subparagraph (B) thereof.*

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] *subsection* (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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VII. DISSENTING VIEWS

We strongly object to H.R. 5445, which would double the annual contribution limit for Health Savings Accounts (HSAs). Taxpayers are generally eligible to make contributions to HSAs if they are covered by a high deductible health plan (HDHP). For 2016, the HSA contribution limits are $3,350 for self-only coverage and $6,750 for family coverage, with taxpayers age 55 plus eligible to make $1,000 catch-up contributions. H.R. 5445 would increase the contribution limits to $6,550 for self-only coverage and $13,100 for family coverage (with no change to the catch-up contribution limit).

This bill is primarily a tax cut for higher income taxpayers. Statistical data from the Internal Revenue Service shows that in 2013, only 22% of households that claimed a deduction for HSA contributions had adjusted gross incomes of $50,000 or less, with an average HSA contribution of $2,076. In contrast, 48% of taxpayers claiming the deduction had adjusted gross incomes of $100,000 or more, with an average HSA contribution of $3,971. Furthermore, 21% of taxpayers claiming the deduction had adjusted gross income of $200,000 or more, with an average HSA contribution of $4,743. The percentage of taxpayers within an income bracket who claim the deduction also increases significantly with income; for example, in 2013, only 0.3% of taxpayers with adjusted gross income of $50,000 or less claimed the deduction, but 3.8% of returns with incomes of $200,000 or more claimed the deduction—a rate that is over 10 times higher.

The statistical data on income and HSA contributions are not a surprise. This is because higher income households can afford to make contributions to HSAs because their discretionary income is higher, while lower income households cannot afford to do so. In 2013, an insurance trade association (AHIP) estimated that there were 15.5 million covered lives under HDHPs, but only 1.194 million tax returns made HSA contributions in 2013. Similarly, a 2008 GAO report found that between 2005 and 2007, 42 to 49% of enrollees in HDHPs did not have access to an HSA.

We also object to H.R. 5445 because this legislation costs over $20 billion and its cost is not offset. It is shameful that in this Republican-controlled Congress, tax breaks that often benefit higher income families and corporations do not need to be paid for and add to our record high deficits, while the Majority proposes cutting programs for low and middle class Americans. As a result of the Majority's skewed priorities, we are unable to combat public health crises such as the Zika virus and removal of the lead in the public water system of Flint, Michigan.

We are also concerned that expansion of HSAs is a centerpiece of the Republican efforts to destroy the Affordable Care Act (ACA). For example, enhancements to HSAs would be provided under the ACA replacement plan drafted by Senators Hatch (R–UT) and Burr

(R–NC) and Chairman Upton (Energy and Commerce Committee), as well as the plan drafted by the House's Republican Study Committee.

For these reasons we strongly oppose H.R. 5445.

SANDER M. LEVIN.

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