114TH CONGRESS
*2d Session*
HOUSE OF REPRESENTATIVES
REPT. 114–809
Part 1

# VETERANS TRICARE CHOICE ACT OF 2016

NOVEMBER 14, 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

## ADDITIONAL VIEWS

[To accompany H.R. 5458]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5458) to provide for coordination between the TRICARE program and eligibility for making contributions to a health savings account, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

CONTENTS



69–006

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

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Veterans TRICARE Choice Act of 2016".

**SEC. 2. COORDINATION BETWEEN TRICARE PROGRAM AND ELIGIBILITY TO MAKE CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.**

(a) IN GENERAL.—Section 223(c)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "and" at the end of clause (ii), by striking the period at the end of clause (iii) and inserting ", and", and by adding at the end the following new clause:

"(iv) coverage under the TRICARE program under chapter 55 of title 10, United States Code, for any period with respect to which an election is in effect under section 1097e of such title providing that the individual is ineligible to be enrolled in (and receive benefits under) such program.".

(b) PROVISIONS RELATING TO ELECTION OF INELIGIBILITY UNDER TRICARE.—

(1) IN GENERAL.—Chapter 55 of title 10, United States Code, is amended by inserting after section 1097d the following new section:

**"§ 1097e. TRICARE program: election of eligibility**

"(a) ELECTION.—Beginning January 1, 2017, a TRICARE-eligible individual may elect at any time to be ineligible to enroll in (and receive any benefits under) the TRICARE program.

"(b) CHANGE OF ELECTION.—(1) If a TRICARE-eligible individual makes an election under subsection (a), the TRICARE-eligible individual may later elect to be eligible to enroll in the TRICARE program. An election made under this subsection may be made only during a special enrollment period.

"(2) The Secretary shall ensure that a TRICARE-eligible individual who makes an election under subsection (a) may efficiently enroll in the TRICARE program pursuant to an election under paragraph (1), including by maintaining the individual, as appropriate, in the health care enrollment system under section 1099 of this title in an inactive manner.

"(c) PERIOD OF ELECTION.—If a TRICARE-eligible individual makes an election under subsection (a), such election shall be in effect beginning on the date of such election and ending on the date that such individual makes an election under subsection (b)(1) to enroll in the TRICARE program.

"(d) HEALTH SAVINGS ACCOUNT PARTICIPATION.—(1) For provisions allowing participation in a health savings account in connection with coverage under a high deductible health plan during the period that the election under subsection (a) is in effect, see section 223(c)(1)(B)(iv) of the Internal Revenue Code of 1986.

"(2) The Secretary shall submit to the Commissioner of Internal Revenue the name of, and any other information that the Commissioner may require with respect to, each TRICARE-eligible individual who makes an election under subsection (a) or (b), not later than 90 days after such election, for purposes of determining the eligibility of such TRICARE-eligible individual for a health savings account described in paragraph (1).

"(e) RECORDS.—The Secretary shall ensure that a TRICARE-eligible individual who makes an election under subsection (a) is maintained on the Defense Enrollment Eligibility Reporting System, or successor system, regardless of whether the individual is eligible for the TRICARE program during the period of such election.

"(f) PROVISION OF INFORMATION.—The Secretary shall provide to each TRICARE-eligible individual who seeks to make an election under subsection (a) information regarding—

"(1) health savings accounts in connection with coverage under a high deductible health plan described in subsection (d)(1), including a comparison of such

health saving accounts and the health care benefits the individual is eligible to receive under the TRICARE program; and

"(2) changing such an election under subsection (b)(1).

"(g) ANNUAL REPORT.—Not later than 60 days after the end of each fiscal year, the Secretary shall submit to the congressional defense committees a report on elections by TRICARE-eligible individuals under this section that includes the following:

"(1) The number of TRICARE-eligible individuals, as of the date of the submittal of the report, who are ineligible to enroll in (and receive any benefits under) the TRICARE program pursuant to an election under subsection (a).

"(2) The number of TRICARE-eligible individuals who made an election described under subsection (a) but, as of the date of the submittal of the report, are enrolled in the TRICARE program pursuant to a change of election under subsection (b).

"(h) DEFINITIONS.—In this section:

"(1) The term 'TRICARE-eligible individual' means an individual who is—

"(A) eligible to be a covered beneficiary entitled to health care benefits under the TRICARE program (determined without regard to this section); and

"(B) not serving on active duty in the uniformed services.

"(2) The term 'special enrollment period' means the period in which a beneficiary under the Federal Employees Health Benefits program under chapter 89 of title 5 may enroll in or change a plan under such program by reason of a qualifying event or during an open enrollment season. For purposes of this section, such qualifying events shall also include events determined appropriate by the Secretary of Defense, including events relating to a member of the armed forces being ordered to active duty.".

(2) CONFORMING AMENDMENT.—The table of sections at the beginning of chapter 55 of such title is amended by inserting after the item relating to section 1097d the following new item:

"1097e. TRICARE program: election of eligibility.".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to months beginning after December 31, 2016.

## I. SUMMARY AND BACKGROUND

### A. PURPOSE AND SUMMARY

The bill, H.R. 5458, as reported from the Committee on Ways and Means, allows eligible individuals covered by TRICARE to elect out of that coverage and thus, during that period, be eligible to make contributions to their Health Savings Account ("HSA").

### B. BACKGROUND AND NEED FOR LEGISLATION

Those who enroll in qualified high-deductible health plans ("HDHP") are permitted to open an HSA. These accounts allow for pre-tax contributions, tax-free investment earnings, and tax-free distributions for future qualified medical expenses.

TRICARE is the primary program by which the military health system provides active and retired members of the armed forces and their families with medical coverage. An individual who is covered by an HDHP for a month and also covered under TRICARE for the month is not eligible to make HSA contributions for the month.

According to a 2015 census conducted by America's Health Insurance Plans (AHIP), as of January 2015, 19.7 million people were covered by an HDHP/HSA, a 2.3 million-person increase from 2014 levels. HDHPs/HSAs are an increasingly popular option for workers—only four percent of workers were enrolled in such coverage in 2005 compared to 24 percent in 2015. The current inability for certain non-active duty, TRICARE-eligible individuals to contribute to their HSAs limits their choices and ability to save in a tax-pre-

ferred way for their health care. The Committee believes those who have served this country should have expanded options when it comes to financing their health insurance.

### C. Legislative History

*Background*

H.R. 5458 was introduced on June 13, 2016, and was referred to the Committee on Ways and Means.

*Committee action*

The Committee on Ways and Means marked up H.R. 5458, the Veterans TRICARE Choice Act of 2016, on June 15, 2016, and ordered the bill, as amended, favorably reported (with a quorum being present).

*Committee hearings*

The policy issues surrounding access to consumer-directed health care accounts, like HSAs, 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); and
- Subcommittee on Health Member Day Hearing on Tax-Related Proposals to Improve Health Care (May 17, 2016).

## II. EXPLANATION OF THE BILL

### A. Coordination Between TRICARE Program and Eligibility To Make Contributions to Health Savings Accounts (Sec. 2 of the Bill and Sec. 223 of the Code)

#### PRESENT LAW

*Health savings accounts*

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage) is generally eligible to make deductible contributions to a health savings account ("HSA"), subject to certain limits (an "eligible individual"). HSA contributions made on behalf of an eligible individual by an employer are excludible from income and wages for employment tax purposes. Eligibility for HSA contributions is generally determined monthly, based on the individual's status and health plan coverage as of the first day of the month.

An individual with other coverage in addition to a high deductible health plan is still eligible to make HSA contributions if such other coverage is permitted insurance or permitted coverage. Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary of the Treasury may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment per day (or other period) for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for ac-

cidents, disability, dental care, vision care, or long-term care. Coverage under certain health flexible spending arrangements or health reimbursement arrangements is also permitted.

*TRICARE program*

The Military Health System provides active duty and retired members of the armed forces and their families (including certain survivors and former spouses) with medical coverage, primarily through the TRICARE program.[1] The TRICARE program offers various health plans, including a managed care option and fee-for-service options. An individual may be covered by TRICARE automatically without having to enroll in TRICARE. An individual who is covered by a high deductible health plan for a month and also covered under TRICARE for the month is not eligible to make HSA contributions for the month.

REASONS FOR CHANGE

The Committee continues to believe that high deductible health plans and the related HSAs will help reduce health care costs. In some cases, an individual covered by a high deductible health plan may become covered by TRICARE automatically, ending his or her eligibility to make HSA contributions. The individual may prefer to decline TRICARE coverage in order to continue to make HSA contributions; however, declining TRICARE coverage is not an option under present law. The Committee wishes to provide individuals with that option.

EXPLANATION OF PROVISION

*HSA eligibility*

Under the provision, for any period with respect to which an individual has made an election of TRICARE ineligibility, as described below, TRICARE coverage is disregarded in determining whether the individual is eligible to make HSA contributions for the period.

*TRICARE program*

The provision amends the provisions of the TRICARE program to allow a TRICARE-eligible individual to elect to be ineligible to enroll in and receive benefits under the TRICARE program (referred to herein as an "election of TRICARE ineligibility"). For this purpose, a TRICARE-eligible individual is an individual who is eligible to be a covered beneficiary entitled to health care benefits under the TRICARE program (determined without regard to an election of TRICARE ineligibility) and is not serving on active duty. An election of TRICARE ineligibility is in effect for the period beginning on the date of the election and ending on the date the individual makes an election to be eligible to enroll in the TRICARE program, as described below.

If a TRICARE-eligible individual makes an election of TRICARE ineligibility, the individual may later elect to be eligible to enroll in the TRICARE program, but only during a special enrollment period. A special enrollment period is defined as the period in which

[1] 10 U.S.C. chapter 55.

a beneficiary under the Federal Employees Health Benefits program [2] may enroll in or change plans by reason of a qualifying event or during an open enrollment season. The Secretary of Defense is directed to ensure that a TRICARE-eligible individual who makes an election of TRICARE ineligibility may later efficiently enroll in the TRICARE program, including by maintaining the individual, as appropriate, in the TRICARE enrollment system in inactive status.

The Secretary of Defense is directed also to ensure that a TRICARE-eligible individual who makes an election of TRICARE ineligibility is maintained on the Defense Enrollment Eligibility Reporting System (or a successor system), regardless of whether the individual is eligible for the TRICARE program during the period of the election.

Under the provision, the Secretary of Defense is required to provide certain information to the Commissioner of Internal Revenue (the "Commissioner") and to a TRICARE-eligible individual seeking to make an election of TRICARE ineligibility. Specifically, not later than 90 days after an election of TRICARE ineligibility, there must be provided to the Commissioner the name of the TRICARE-eligible individual who makes the election and any other information that the Commissioner may require with respect to the individual for purposes of determining the individual's eligibility for an HSA. There must be provided to each TRICARE-eligible individual seeking to make an election of TRICARE ineligibility information regarding (1) HSAs in connection with coverage under a high deductible health plan, including a comparison of HSAs and the health care benefits the individual is eligible to receive under the TRICARE program, and (2) changing an election of TRICARE ineligibility later in order to be eligible to enroll in the TRICARE program, as described above.

In addition, not later than 60 days after the end of each fiscal year, the Secretary of Defense is required to submit to the congressional defense committees a report on elections of TRICARE ineligibility and subsequent elections to be eligible to enroll in the TRICARE program, which includes (1) the number of TRICARE-eligible individuals, as of the date of the submission of the report, who are ineligible to enroll in and receive any benefits under the TRICARE program pursuant to an election of TRICARE ineligibility, and (2) the number of TRICARE-eligible individuals who made an election of TRICARE ineligibility and, as of the date of the submission of the report, are enrolled in the TRICARE program pursuant to a later election to be eligible to enroll in the TRICARE program.

EFFECTIVE DATE

The provision applies to months beginning after December 31, 2016.

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[2] Provisions governing the Federal Employees Health Benefits program are contained in 5 U.S.C. chapter 89 and provide special enrollment periods in the case of certain events, such as marriage or the birth of a child. The provision allows the Secretary of Defense to include additional events, including events relating to a member of the armed forces being ordered to active duty.

## III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 5458, the "Veterans TRICARE Choice Act of 2016," on June 15, 2016.

The bill, H.R. 5458, as amended, was ordered favorably reported to the House of Representatives by a voice vote (with a quorum being present).

## IV. BUDGET EFFECTS OF THE BILL

### A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 5458, as reported.

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

FISCAL YEARS

[Millions of dollars]

| 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017–21 | 2017–26 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| −1 | −8 | −9 | −9 | −10 | −11 | −11 | −12 | −13 | −13 | −37 | −97 |

[1] Estimate includes the following off-budget effects:

| 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2017–21 | 2017–26 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| −1 | −3 | −4 | −4 | −4 | −5 | −5 | −5 | −5 | −6 | −16 | −41 |

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.

JUNE 20, 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. 5458, the Veterans TRICARE Choice 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. 5458—Veterans TRICARE Choice Act of 2016*

H.R. 5458 would allow certain individuals who are automatically eligible for TRICARE, which is the health benefits program of the Department of Defense, to elect to be temporarily ineligible for that benefit. Making that election would allow those individuals to contribute to health savings accounts (HSAs), which are tax-advantaged accounts used to pay health expenses. Under current law, individuals eligible for TRICARE cannot make contributions to HSAs. The new election allowed under H.R. 5458 would not apply to individuals serving on active duty.

The staff of the Joint Committee on Taxation estimates that the legislation would reduce revenues by $97 million over the 2017–2026 period. That change in revenues includes a reduction of $41 million that would result from changes in off-budget revenues (from Social Security payroll taxes). CHO estimates that effects on direct spending and spending subject to appropriation would be insignificant in any year and in total over the 2017–2026 period.

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

JCT and CHO estimate that enacting the bill would not increase net direct spending or on-budget deficits by more than $5 billion in any of the four consecutive 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 Mark Booth, Unit Chief, Revenue Estimating.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR HR 5458, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON JUNE 15, 2016

| | By fiscal year, in millions of dollars— | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2016–2021 | 2016–2026 |
| NET INCREASE IN THE ON-BUDGET DEFICIT | | | | | | | | | | | | | |
| Statutory Pay-As-You-Go Effects | 0 | 0 | 5 | 5 | 5 | 6 | 6 | 6 | 7 | 8 | 7 | 21 | 56 |
| Memorandum: | | | | | | | | | | | | | |
| *Change in Off-Budget Revenues*[a] | 0 | −1 | −3 | −4 | −4 | −4 | −5 | −5 | −5 | −5 | −6 | −16 | −41 |

Source: Staff of the Joint Committee on Taxation.
Note: Components may not sum to total because of rounding
a. A negative sign for revenues indicates a reduction in revenues.

## 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. 5458 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 legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code of 1986 and has widespread applicability to individuals or small businesses.

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

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

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

## G. Duplication of Federal Programs

In compliance with Sec. 3(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 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 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 exclud-

able 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 MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in 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

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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 sec-

tion 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[.], *and*

*(iv) coverage under the TRICARE program under chapter 55 of title 10, United States Code, for any period with respect to which an election is in effect under section 1097e of such title providing that the individual is ineligible to be enrolled in (and receive benefits under) such program.*

(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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## TITLE 10, UNITED STATES CODE

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# SUBTITLE A—GENERAL MILITARY LAW

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# PART II—PERSONNEL

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## CHAPTER 55—MEDICAL AND DENTAL CARE



### *§ 1097e. TRICARE program: election of eligibility*

*(a) ELECTION.—Beginning January 1, 2017, a TRICARE-eligible individual may elect at any time to be ineligible to enroll in (and receive any benefits under) the TRICARE program.*

*(b) CHANGE OF ELECTION.—(1) If a TRICARE-eligible individual makes an election under subsection (a), the TRICARE-eligible individual may later elect to be eligible to enroll in the TRICARE program. An election made under this subsection may be made only during a special enrollment period.*

*(2) The Secretary shall ensure that a TRICARE-eligible individual who makes an election under subsection (a) may efficiently enroll in the TRICARE program pursuant to an election under paragraph (1), including by maintaining the individual, as appropriate, in the health care enrollment system under section 1099 of this title in an inactive manner.*

*(c) PERIOD OF ELECTION.—If a TRICARE-eligible individual makes an election under subsection (a), such election shall be in effect beginning on the date of such election and ending on the date that such individual makes an election under subsection (b)(1) to enroll in the TRICARE program.*

*(d) HEALTH SAVINGS ACCOUNT PARTICIPATION.—(1) For provisions allowing participation in a health savings account in connection with coverage under a high deductible health plan during the period that the election under subsection (a) is in effect, see section 223(c)(1)(B)(iv) of the Internal Revenue Code of 1986.*

*(2) The Secretary shall submit to the Commissioner of Internal Revenue the name of, and any other information that the Commissioner may require with respect to, each TRICARE-eligible individual who makes an election under subsection (a) or (b), not later than 90 days after such election, for purposes of determining the eligibility of such TRICARE-eligible individual for a health savings account described in paragraph (1).*

*(e) RECORDS.—The Secretary shall ensure that a TRICARE-eligible individual who makes an election under subsection (a) is maintained on the Defense Enrollment Eligibility Reporting System, or successor system, regardless of whether the individual is eligible for the TRICARE program during the period of such election.*

*(f) PROVISION OF INFORMATION.—The Secretary shall provide to each TRICARE-eligible individual who seeks to make an election under subsection (a) information regarding—*

*(1) health savings accounts in connection with coverage under a high deductible health plan described in subsection (d)(1), in-*

*cluding a comparison of such health saving accounts and the health care benefits the individual is eligible to receive under the TRICARE program; and*

*(2) changing such an election under subsection (b)(1).*

*(g) ANNUAL REPORT.—Not later than 60 days after the end of each fiscal year, the Secretary shall submit to the congressional defense committees a report on elections by TRICARE-eligible individuals under this section that includes the following:*

*(1) The number of TRICARE-eligible individuals, as of the date of the submittal of the report, who are ineligible to enroll in (and receive any benefits under) the TRICARE program pursuant to an election under subsection (a).*

*(2) The number of TRICARE-eligible individuals who made an election described under subsection (a) but, as of the date of the submittal of the report, are enrolled in the TRICARE program pursuant to a change of election under subsection (b).*

*(h) DEFINITIONS.—In this section:*

*(1) The term "TRICARE-eligible individual" means an individual who is—*

*(A) eligible to be a covered beneficiary entitled to health care benefits under the TRICARE program (determined without regard to this section); and*

*(B) not serving on active duty in the uniformed services.*

*(2) The term "special enrollment period" means the period in which a beneficiary under the Federal Employees Health Benefits program under chapter 89 of title 5 may enroll in or change a plan under such program by reason of a qualifying event or during an open enrollment season. For purposes of this section, such qualifying events shall also include events determined appropriate by the Secretary of Defense, including events relating to a member of the armed forces being ordered to active duty.*

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## VII. ADDITIONAL VIEWS

Many veterans, after completing their service to the country, enter the civilian workforce and may receive health coverage though this private employer. Some employers choose to offer health savings accounts (HSAs) coupled with a high deductible health plan. For veterans also receiving coverage though Tricare, this can cause a problem. Contributions to a health savings account may only be made while the account owner is enrolled in a high deductible health plan. Further, the account owner may not be eligible for coverage that is not a high deductible health plan. Under present law, eligibility for Tricare coverage disqualifies a retiree from HSA eligibility because the Tricare program is not a high deductible health plan. While there is a difference of opinion in the committee on tax-preferred health accounts, the legislation recognizes that some veterans may have that coverage, and could run afoul of current law because of enrollment in Tricare. This is an issue that we should fix.

H.R. 5458 would provide that military retirees may disclaim their eligibility for the Tricare Program—the military's retiree medical insurance program. This would allow a retiree who is enrolled in a high deductible health plan to receive or make HSA contributions. Under the bill, retirees would be permitted to revoke their disclaimer upon a change of status event and enroll in Tricare coverage—such as if they terminate employment with a civilian employer who offers the high deductible health plan.

The Department of Defense as well as the House Armed Services Committee have some concerns with the approach in this bill, in particular that TRICARE eligibility is a statutory entitlement that cannot be waived. Changes in this legislation may also lead to a number of unintended consequences. Disclaimer of eligibility is not contingent upon enrollment in a HDHP so beneficiaries who do not obtain minimum essential coverage elsewhere, or who incur a gap in coverage, may be liable for the individual coverage penalty at the end of the tax year. We must also make sure that the Department of Defense and veterans' organizations properly educate beneficiaries about the very narrow circumstances by which this proposed language would apply and the potential impact on family readiness such an election could have should a beneficiary suffer a catastrophic illness or injury. We hope these issues will be addressed before the bill is brought to the House floor.

SANDER M. LEVIN,
*Ranking Member.*

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