DESCRIPTION OF THE CHAIRMAN'S AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 2351, THE "HEALTH SAVINGS ACCOUNT AVAILABILITY ACT"

Scheduled for Markup
By the
COMMITTEE ON WAYS AND MEANS
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INTRODUCTION

The House Committee on Ways and Means has scheduled a markup of H.R. 2351, the "Health Savings Account Availability Act" for June 19, 2003. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the Chairman's amendment in the nature of a substitute to H.R. 2351.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of the Chairman's Amendment in the Nature of a Substitute to H.R. 2351, the "Health Savings Account Availability Act"* (JCX-63-03), June 18, 2003.

A. Health Savings Accounts

Present Law

Overview

Under present law, the Federal tax treatment of health expenses and health coverage depends on the individual's circumstances (e.g., whether the individual is covered under an employer-provided health plan).

Employer-provided health coverage

In general, employer contributions to an accident or health plan are excludable from an employee's gross income (and wages for employment tax purposes).[2] This exclusion for employer-provided health coverage generally applies to coverage provided to employees (including former employees) and their spouses, dependents, and survivors. Benefits paid under employer-provided accident or health plans are also generally excludable from income to the extent they are reimbursements for medical care.[3] If certain requirements are satisfied, employer-provided accident or health coverage offered under a cafeteria plan is also excludable from an employee's gross income and wages.[4]

Present law provides for two general arrangements which can be used to pay for or reimburse medical expenses of employees on a tax-favored basis; flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs"). While these arrangements provide similar tax benefits (the amounts paid under the arrangements for medical care are excludable from income and wages), they are subject to different rules. A main distinguishing feature between the two arrangements is that while FSAs are generally part of a cafeteria plan and contributions to FSAs are made on a salary reduction basis, HRAs cannot be part of a cafeteria plan and contributions cannot be made on a salary-reduction basis.[5]

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[2] Sec. 106. All "section," "sec.," and "Code" references are to the Internal Revenue Code of 1986, as amended.

[3] Sec. 105. In the case of a self-insured medical reimbursement arrangement, the exclusion applies to highly compensated employees only if certain nondiscrimination rules are satisfied. Sec. 105(h). Medical care is defined under section 213 and generally includes amounts paid for qualified long-term care insurance and services.

[4] Sec. 125. Long-term care insurance and services may not be provided through a cafeteria plan.

[5] Notice 2002-45, 2002-28 I.R.B. 93 (July 15, 2002); Rev. Rul. 2002-41, 2002-28 I.R.B. 75 (July 15, 2002).

Amounts paid or accrued by an employer within a taxable year for a sickness, accident, hospitalization, medical expense, or similar health plan for its employees are generally deductible as ordinary and necessary business expenses.[6]

Self-employed individuals

The exclusion for employer-provided health coverage does not apply to self-employed individuals. However, under present law, self-employed individuals (i.e., sole proprietors or partners in a partnership)[7] are entitled to deduct 100 percent of the amount paid for health insurance for the self-employed individual and the individual's spouse and dependents.[8]

Itemized deduction for medical expenses

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (to the extent not reimbursed by insurance or otherwise) for medical care of the taxpayer, the taxpayer's spouse, and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income.[9]

Archer medical savings accounts

In general

In general, an Archer medical savings account ("MSA") is a tax-exempt trust or custodial account created exclusively for the benefit of the account holder that is subject to rules similar to those applicable to individual retirement arrangements.[10]

Within limits, contributions to an Archer MSA are deductible in determining adjusted gross income if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. Earnings on amounts in an Archer MSA are not currently includible in income. Distributions from an Archer MSA for qualified medical expenses are not includible in gross income. Distributions not used for qualified medical expenses are includible in gross income and are subject to an additional 15-percent tax unless the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

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[6] Sec. 162.

[7] Self-employed individuals include more than two-percent shareholders of S corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.

[8] Sec. 162(l).

[9] Sec. 213. The adjusted gross income percentage is 10 percent for purposes of the alternative minimum tax.

[10] Sec. 220.

Qualified medical expenses are generally defined as under the itemized deduction for medical expenses, except that qualified medical expenses do not include expenses for health insurance other than long-term care insurance, premiums for health care continuation coverage, and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law.

Eligible individuals

Archer MSAs are available to employees covered under an employer-sponsored high deductible plan of a small employer and to self-employed individuals covered under a high deductible health plan.[11] An employer is a small employer if it employed, on average, no more than 50 employees on business days during either the preceding or the second preceding year. An individual is not eligible for an Archer MSA if he or she is covered under any other health plan in addition to the high deductible plan (other than a plan providing certain limited types of coverage). Individuals entitled to benefits under Medicare are not eligible individuals. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

Treatment of contributions

Individual contributions to an Archer MSA are deductible (within limits) in determining adjusted gross income (i.e., "above-the-line"). In addition, employer contributions are excludable from gross income and wages for employment tax purposes (within the same limits), except that this exclusion does not apply to contributions made through a cafeteria plan. In the case of an employee, contributions can be made to an Archer MSA either by the individual or by the individual's employer, but not by both.

The maximum annual contribution that can be made to an Archer MSA for a year is 65 percent of the annual deductible under the high deductible plan in the case of self-only coverage and 75 percent of the annual deductible in the case of family coverage.

If an employer provides a high deductible health plan coupled with Archer MSAs for employees and makes employer contributions to the Archer MSAs, the employer must make available a comparable contribution on behalf of all employees with comparable coverage during the same period. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the minimum deductible plan. If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to Archer MSAs of the employer for that period.

[11] Self-employed individuals include more than two-percent shareholders of S corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.

Definition of high deductible plan

A high deductible plan is a health plan with an annual deductible of at least $1,700 and no more than $2,500 in the case of self-only coverage and at least $3,350 and no more than $5,050 in the case of family coverage. In addition, the maximum out-of-pocket expenses with respect to allowed costs (including the deductible) must be no more than $3,350 in the case of self-only coverage and no more than $6,150 in the case of family coverage.[12] A plan does not fail to qualify as a high deductible plan merely because it does not have a deductible for preventive care as required by State law. A plan does not qualify as a high deductible health plan if substantially all of the coverage under the plan is certain permitted insurance or is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

Treatment of death of account holder

Upon death, any balance remaining in the decedent's Archer MSA is includible in his or her gross estate. If the account holder's surviving spouse is the named beneficiary of the Archer MSA, then, after the death of the account holder, the Archer MSA becomes the Archer MSA of the surviving spouse and the amount of the Archer MSA balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction.[13] If, upon the account holder's death, the Archer MSA passes to a named beneficiary other than the decedent's surviving spouse, the Archer MSA ceases to be an Archer MSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of the Archer MSA assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includible in income is reduced by the amount in the Archer MSA used, within one year after death, to pay qualified medical expenses incurred prior to the death. If there is no named beneficiary for the decedent's Archer MSA, the Archer MSA ceases to be an Archer MSA as of the date of death, and the fair market value of the assets in the Archer MSA as of such date are includible in the decedent's gross income for the year of the death.

Limit on number of MSAs; termination of MSA availability

The number of taxpayers benefiting annually from an Archer MSA contribution is limited to a threshold level (generally 750,000 taxpayers). The number of Archer MSAs established has not exceeded the threshold level.

After 2003, no new contributions may be made to Archer MSAs except by or on behalf of individuals who previously had Archer MSA contributions and employees who are employed by a participating employer.

[12] These dollar amounts are for 2003. These amounts are indexed for inflation in $50 increments.

[13] Sec. 2056.

Description of Proposal

In general

The proposal creates health savings accounts ("HSAs") which provide for tax-favored savings for health care expenses. In general, an HSA is a tax-exempt trust or custodial account created exclusively for to pay for the qualified medical expenses of the account holder and his or her spouse and dependents and that is subject to rules similar to those applicable to individual retirement arrangements.[14] Within limits, contributions to an HSA are deductible if made by an eligible individual and are excludable if made by the employer of an eligible individual. Family members may also make nondeductible contributions to an HSA on behalf of an eligible individual. Earnings on amounts in an HSA are not includible in gross income. Distributions from an HSA for qualified medical expenses are not includible in income.

Eligible individuals

Eligible individuals are individuals who (1) are covered under a health plan meeting minimum deductible requirements and no other health plan, or (2) are uninsured. Individuals entitled to benefits under Medicare are not eligible individuals. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

An individual with other coverage in addition to a plan with minimum deductible requirements is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage. In addition, an individual is treated as uninsured if their only coverage is permitted insurance or coverage. Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations, (2) insurance for a specified disease or illness, and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

A plan meets the minimum deductible requirements if the plan is a health plan with an annual deductible of at least $500 in the case of self-only coverage and at least $1,000 in the case of family coverage. These dollar amounts are indexed for inflation. Under the proposal, there are no maximum deductible requirements and no limits on out-of-pocket expenses. A plan is not a minimum deductible plan if it is certain permitted insurance or is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

[14] The provision provides that the present-law requirement applicable to insurance companies that certain policy acquisition expenses must be capitalized and amortized (sec. 848) does not apply in the case of any contract that is a health savings account.

Tax treatment of and limits on contributions

Contributions to an HSA made by an eligible individual are deductible (within limits) in determining adjusted gross income (i.e., "above-the-line"). Nondeductible contributions can be made by a family member of an eligible individual. In addition, employer contributions to an HSA (including salary reduction contributions made through a cafeteria plan) are excludable from gross income and wages for employment tax purposes (within the same limits). In the case of an employee, contributions can be made to an HSA by both the individual (and family member) and the individual's employer. Individual, employer, and family contributions are aggregated for purposes of the maximum annual contribution limit.

The maximum aggregate annual contribution that can be made to an HSA (for all contributions) for a year is $2,000 for persons with self-only coverage and uninsured unmarried individuals with no dependents[15] and $4,000 for individuals with family coverage and uninsured individuals with a spouse or dependents.[16] In the case of individuals age 55 and older, the $2,000 and $4,000 contribution limits would be increased to the following amounts respectively: $2,500 in 2004, $2,600 in 2005, $2,700 in 2006, $2,800 in 2007, $2,900 in 2008, and $3,000 in 2009 and thereafter; $4,500 in 2004, $4,600 in 2005, $4,700 in 2006, $4,800 in 2007, $4,900 in 2008, and $5,000 in 2009 and thereafter.

The maximum allowable contribution is phased out for taxpayers with adjusted gross income[17] above certain levels. In the case of single individuals, the phase-out range is $45,000 to $50,000 for 2004, and $50,000 to $60,000 for 2005 and thereafter. For married taxpayers filing a joint return, the phase-out range is $65,000 to $75,000 for 2004, $70,000 to $80,000 for 2005, $75,000 to $85,000 for 2006, and $80,000 to $100,000 for 2007 and thereafter.[18]

An excise tax applies to contributions in excess of the maximum deductible amount. The excise tax is generally equal to six percent of the cumulative amount of excess contributions that are not distributed from the HSA.[19]

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[15] Written declarations releasing claim to a dependency exemption are disregarded in determining whether an individual has dependents.

[16] The annual contribution limit is the sum of the limits determined separately for each month, based on the individual's status and health plan coverage as of the first day of the month.

[17] Adjusted gross income is defined generally as under the rules relating to individual retirement arrangements ("IRAs"), and is computed after the deduction for contributions to IRAs and before the deduction provided by the proposal.

[18] In the case of married taxpayers filing separate returns, the phase-out range is $0 to $10,000. These phase-out ranges are the same as those that apply to deductible contributions to IRAs.

[19] Ordering rules apply to determine the nature of any distributed excess contributions (e.g., nondeductible family contributions or employer contributions).

Amounts can be rolled over into an HSA from another HSA, an Archer MSA, or a health FSA on a tax-free basis. Rollovers from a flexible spending account are limited to up to $500 annually under the following section of the bill. Amounts transferred from another HSA or from an Archer MSA are not taken into account under the annual contribution limit.

If an employer makes contributions to employees' HSAs, the employer must make available a comparable contribution on behalf of all employees with comparable coverage during the same period. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the minimum deductible plan. The comparability rule is applied separately to part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week). The comparability rule does not apply to amounts transferred from an employee's health FSA, Archer MSA, or another HSA.

If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to HSAs of the employer for that period. The excise tax is designed as a proxy for the denial of the deduction for employer contributions. In the case of a failure to comply with the comparability rule which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed to the extent that the payment of the tax would be excessive relative to the failure involved. For purposes of the comparability rule, employers under common control are aggregated.

Taxation of distributions

Distributions from an HSA for qualified medical expenses of the individual and his or her spouse or dependents generally are excludable from income. Amounts in an HSA can be used for qualified medical expenses even if the individual is not currently eligible for contributions to the HSA.

Qualified medical expenses generally are defined as under the itemized deduction for medical expenses and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) long-term care insurance, (2) premiums for health care continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, (4) health insurance meeting the minimum deductible requirements if no portion of the cost of the insurance is paid by the employer or former employer of the individual or the individual's spouse,[20] and (5) retiree health insurance for individuals who are older than age 65 (including Medicare Part B premiums).

Distributions that are not for medical expenses are includible in income (except to the extent that the distribution is attributable to a return of nondeductible family contributions).[21]

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[20] Amounts paid by the employer include salary reduction contributions.

[21] Ordering rules apply to determine the extent to which distributions are attributable to nondeductible contributions.

Distributions includible in income are also subject to an additional 15-percent tax unless made after the individual attains the age in which eligible for Medicare (i.e., age 65), death, or disability.

Tax treatment of HSAs after death

Upon death, any balance remaining in the decedent's HSA is includible in his or her gross estate.

If the account holder's surviving spouse is the named beneficiary of the HSA, then, after the death of the account holder, the HSA becomes the HSA of the surviving spouse and the amount of the HSA balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction provided in Code section 2056. The surviving spouse is not required to include any amount in income as a result of the death; the general rules applicable to HSAs apply to the surviving spouse's HSA (e.g., the surviving spouse is subject to income tax only on distributions from the HSA for nonmedical purposes). The surviving spouse can exclude from income amounts withdrawn from the HSA for expenses incurred by the decedent prior to death, to the extent they otherwise are qualified medical expenses.

If, upon death, the HSA passes to a named beneficiary other than the decedent's surviving spouse, the HSA ceases to be an HSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of HSA assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includible in income is reduced by the amount in the HSA used, within one year after death, to pay qualified medical expenses incurred prior to the death. As is the case with other HSA distributions, whether the expenses are qualified medical expenses is determined as of the time the expenses were incurred. In computing taxable income, the beneficiary may claim a deduction for that portion of the Federal estate tax on the decedent's estate that was attributable to the amount of the HSA balance (calculated in accordance with the present-law rules relating to income in respect of a decedent set forth in sec. 691(c)).

If there is no named beneficiary for the decedent's HSA, the HSA ceases to be an HSA as of the date of death, and the fair market value of the assets in the HSA as of such date are includible in the decedent's gross income for the year of the death. This rule applies in all cases in which there is no named beneficiary, even if the surviving spouse ultimately obtains the right to HSA assets (e.g., if the surviving spouse is the sole beneficiary of the decedent's estate).

Effective Date

The proposal is effective for taxable years beginning after December 31, 2003.

B. Disposition of Unused Health Benefits in Flexible Spending Arrangements

Present Law

A health flexible spending arrangement ("FSA") is a reimbursement account or other arrangement under which an employee is reimbursed for medical expenses.[22] A flexible spending arrangement is defined under the Code as a benefit which provides employees with coverage under which specified incurred expenses may be reimbursed and the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.[23] Health FSAs are typically part of a cafeteria plan and may be funded through salary reduction.[24] Health FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance. There is no special exclusion for benefits provided under an FSA. Thus, health benefits provided under an FSA are excludable from income only if there is a specific exclusion for the benefits in the Code (e.g., the exclusion for employer-provided health care (other than long-term care) or dependent care assistance coverage).

FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement.[25] Under proposed Treasury regulations, a cafeteria plan is considered to permit the deferral of compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.[26] Thus, amounts in an employee's account that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the "use it or lose it" rule.

Description of Proposal

The proposal allows up to $500 of unused health benefits in an employee's health FSA to be carried forward to the employee's account for the next plan year of the health FSA or transferred to a health savings account ("HSA") maintained for the benefit of the employee.[27] Under the proposal, if an individual is not eligible to contribute to an HSA for the taxable year, the individual may transfer up to $500 of unused health benefits in the employee's health FSA to

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[22] FSAs may also be used to provide certain other nontaxable benefits, such as dependent care.

[23] Sec. 106(c).

[24] Long-term care insurance cannot be offered through a cafeteria plan. Sec. 125(f).

[25] Sec. 401(k).

[26] Prop. Treas. Reg. 1.125-2 Q&A-5(a).

[27] The previous section of the bill provides the eligibility rules for contributions to an HSA.

a tax-qualified retirement plan, a tax-sheltered annuity (section 403(b)), an individual retirement arrangement (IRA), or an eligible deferred compensation plan of a State or local government (section 457). An employee's unused health benefit is the excess of the maximum amount of reimbursement allowable to the employee over the actual amount of reimbursement during the year. Amounts transferred are subject to the rules and limits on contributions that would otherwise apply.

Effective Date

The proposal applies to taxable years beginning after December 31, 2003.

C. Exception to Information Reporting Requirements for Certain Health Arrangements

Present Law

Any person in a trade or business who, in the course of that trade or business, makes specified payments to another person totaling $600 or more in a year, must provide an information report to the IRS (as well as a copy to the recipient) on the payments.[28] Reporting is required to be done on Form 1099. In general, these information reports remind taxpayers of amounts of income that should be reflected on their tax returns and assist the IRS in verifying that taxpayers have reported these amounts correctly.

Treasury regulations specify that fees for professional services, including the services of physicians, must be reported.[29] Treasury regulations also provide a general exception from these information reporting requirements for payments made to corporations, except that this exception is inapplicable if the corporation is "engaged in providing medical and health care services."[30]

Earlier this year, the IRS issued a revenue ruling describing whether employer-provided expense reimbursements made through debit or credit cards or other electronic media are excludible from gross income.[31] In the course of this ruling, the IRS stated that "payments made to medical service providers through the use of debit, credit, and stored value cards are reportable by the employer on Form 1099-MISC under section 6041."[32]

Present law provides for two general arrangements which can be used to pay for or reimburse medical expenses of employees on a tax-favored basis; flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs"). While these arrangements provide similar tax benefits (the amounts paid under the arrangements for medical care are excludable from income and wages), they are subject to different rules. A main distinguishing feature between the two arrangements is that while FSAs are generally part of a cafeteria plan and contributions to FSAs are made on a salary reduction basis, HRAs cannot be part of a cafeteria plan and contributions cannot be made on a salary-reduction basis.[33]

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[28] Section 6041. This is one of the oldest information reporting provisions in the Code. It was originally enacted as section 147 of the Revenue Act of 1938 (Public No. 554, 75th Congress).

[29] Treas. Reg. sec. 1.6041-1(d)(2).

[30] Treas. Reg. sec. 1.6041-3(p)(1). These regulations provide an exception from these information reporting requirements if the payment is made to a hospital that is tax-exempt or that is owned and operated by a governmental entity.

[31] Rev. Rul. 2003-43, 2003-21 I.R.B. 935 (May 27, 2003).

[32] *Id.*

[33] Notice 2002-45, 2002-28 I.R.B. 93 (July 15, 2002); Rev. Rul. 2002-41, 2002-28 I.R.B. 75 (July 15, 2002).

Description of Proposal

The proposal provides an exception from the generally applicable information reporting provisions for payments for medical care made under either: (1) a flexible spending arrangement;[34] or (2) a health reimbursement arrangement that is treated as employer-provided coverage.

Effective Date

The proposal applies to payments made after December 31, 2002.

[34] This term is defined in section 106(c)(2).