116TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
116–401

INHALER COVERAGE AND ACCESS NOW ACT

FEBRUARY 21, 2020.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. NEAL, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 4716]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4716) to amend the Internal Revenue Code of 1986 to provide a safe harbor for high deductible health plans without a deductible for certain inhalers, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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99–006

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 "Inhaler Coverage and Access Now Act" or as the "I CAN Act".

SEC. 2. SAFE HARBOR FOR HIGH DEDUCTIBLE HEALTH PLANS WITHOUT DEDUCTIBLE FOR CERTAIN INHALERS.

(a) IN GENERAL.—Section 223(c)(2)(C) of the Internal Revenue Code of 1986 is amended—

(1) by striking "for preventive care" and inserting "for one or more of the following:

"(i) Preventive care", and

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

"(ii) Inhalers for treatment of any chronic lung disease (and any medicine or drug which is delivered through such inhaler for treatment of such disease).".

(b) CONFORMING AMENDMENT.—The heading for section 223(c)(2)(C) of such Code is amended by striking "PREVENTIVE CARE DEDUCTIBLE" and inserting "CERTAIN DEDUCTIBLES".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after the date of the enactment of this Act.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 4716, the "I CAN Act," as amended and ordered reported by the Committee on Ways and Means on October 17, 2019, provides for coverage under a high deductible health plan not requiring a deductible of inhalers for treatment of any chronic lung disease, including asthma (and any medicine or drug which is delivered through such inhalers for treatment of such diseases).

B. BACKGROUND AND NEED FOR LEGISLATION

High Deductible Health Plans (HDHPs) represent a growing percentage of plans offered on the individual and group market. HDHPs have defined minimum deductibles and maximum out-of-pocket limits. HDHPs are often, but not always, paired with a tax-free health savings account (HSA). In general, HSAs provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, an HSA is a tax-exempt account created exclusively to pay for qualified medical expenses. Employers are increasingly offering HSA-eligible HDHPs as a way to lower their health care spending. Proponents argue this benefit design leads to increased consumer engagement in their health care and greater sensitivity to prices in the health care market. However even with HSAs available, greater deductibles lead to greater cost for consumers and an additional barrier to care.

To use an HSA associated with a HDHP, the plan is prohibited from offering coverage below the deductible (i.e., first dollar coverage) of services or benefits meant to treat "an existing illness, injury or condition." However, an HDHP may offer preventive care, such as mammography and immunizations, without a deductible. Recognizing that consumers often delay care because of higher

deductibles, many researchers have recommended offering coverage for chronic conditions below the deductible. While such actions run counter to the original intent of HDHPs, they are helpful to individuals facing rising health care costs, especially those individuals with consistent health care spending, and generally improve health outcomes because individuals have easier access to much needed treatment. Inhalers for treatment of chronic lung disease is one such pre-deductible service that has been identified as providing cost savings and improved health outcomes for individuals with access to such treatments.

C. Legislative History

Background

H.R. 4716, the "Inhaler Coverage and Access Now Act" or "I CAN Act," was introduced on October 17, 2019 and was referred to the Committee on Ways and Means.

Committee hearings

The Committee on Ways and Means Subcommittee on Health held a hearing on Lowering Costs and Expanding Access to Health Care through Consumer-Directed Health Plans on June 6, 2018. The witnesses for this hearing were Roy Ramthun, President and Founder of Ask Mr. HSA Service; Matt Eyles, President and CEO of America's Health Insurance Plans; Jody Dietel, Chief Compliance Officer at WageWorks; and Dr. Sherry Glied, Dean of New York University's Robert F. Wagner Graduate School of Public Service.

The Committee on Ways and Means held a hearing on The Rising Costs of Prescription Drugs on February 12, 2019. The witnesses for this hearing were Ola Ojewumi, Founder of Project ASCEND and patient; Mark E. Miller, PhD, Executive Vice President of Health Care Arnold Ventures; Rachel Sachs, Associate Professor of Law, Washington University in St. Louis; Alan Reuther, Legislative Consultant, UAW Retiree Medical Benefits Trust; and Joseph R. Antos, PhD, Wilson H. Taylor Scholar In Health Care and Retirement Policy with the American Enterprise Institute.

The Committee on Ways and Means held a hearing on Investing in the U.S. Health System by Lowering Drug Prices, Reducing Out-of-Pocket costs, and Improving Medicare Benefits on October 17, 2019. The witnesses for this hearing were Samantha Reid, a Crohn's Disease patient; Catherine Alicia Georges, National Volunteer President for AARP; Mark E. Miller, PhD, Executive Vice President of Health Care at Arnold Ventures; Judy Feder, PhD, Professor and former Dean of Georgetown University's McCourt School of Public Policy; and Benedic N. Ippolito, PhD, Research Fellow at the American Enterprise Institute.

Committee action

The Committee on Ways and Means marked up H.R. 4716 on October 23, 2019, and ordered the bill, as amended, favorably reported to the House of Representatives by voice vote (with a quorum being present).

II. EXPLANATION OF THE BILL

A. Safe Harbor for High Deductible Health Plans Without Deductible for Certain Inhalers (sec. 2 of the bill and sec. 223 of the Code)

PRESENT LAW

Health savings accounts

An individual may establish a health savings account ("HSA") only if the individual is covered under a plan that meets the requirements for a high deductible health plan, as described below. In general, HSAs provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, an HSA is a tax-exempt trust or custodial account created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents.

Within limits,[1] contributions to an HSA made by or on behalf of an eligible individual are deductible by the individual. Contributions to an HSA are excludible from income and employment taxes if made by the employer. Earnings in HSAs are not taxable. Distributions from an HSA for qualified medical expenses are not includible in gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 20 percent. The 20-percent additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (age 65).

High deductible health plans

A high deductible health plan is a health plan that has an annual deductible which is not less than $1,350 (for 2019) for self-only coverage and twice this amount for family coverage, and for which the sum of the annual deductible and other annual out-of-pocket expenses (other than premiums) for covered benefits does not exceed $6,750 (for 2019) for self-only coverage and twice this amount for family coverage.[2] These dollar thresholds are subject to inflation adjustment, based on chained CPI.[3]

An individual who is covered under a high deductible health plan is eligible to establish an HSA, provided that while such individual is covered under the high deductible health plan, the individual is not covered under any health plan that (1) is not a high deductible health plan and (2) provides coverage for any benefit (subject to certain exceptions) covered under the high deductible health plan.[4]

Various types of coverage are disregarded for this purpose, including coverage of any benefit provided by permitted insurance, coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, as well as cer-

[1] For 2019, the basic limit on annual contributions that can be made to an HSA is $3,500 in the case of self-only coverage and $7,000 in the case of family coverage. The basic annual contributions limits are increased by $1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up" contributions).

[2] Sec. 223(c)(2).

[3] Sec. 223(g).

[4] Sec. 223(c)(1).

tain limited coverage through health flexible savings accounts.[5] Permitted insurance means insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, or such other similar liabilities as specified by the Secretary under regulations. Permitted insurance also means insurance for a specified disease or illness, and insurance paying a fixed amount per day (or other period) of hospitalization.[6]

Under a safe harbor, a high deductible health plan is permitted to provide coverage for preventive care (within the meaning of section 1861 of the Social Security Act, except as otherwise provided by the Secretary) before satisfaction of the minimum deductible.[7] IRS guidance describes the types of coverage that constitute preventive care for this purpose.[8] More recently, Notice 2019–45 [9] provides an appendix with a limited list of preventive care services and items for certain chronic conditions that may be treated as preventive care, and provides that these services and items are treated as preventive only when prescribed to treat an individual diagnosed with the specified chronic condition, and only when prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition. In connection with medicines or drugs delivered through inhalers, Notice 2019–45 limits as preventive care inhaled corticosteroids for individuals diagnosed with asthma; the Notice also permits as preventive care peak flow meters for such diagnosed individuals.

REASONS FOR CHANGE

The Committee observes that research shows that exposure to high out-of-pocket costs leads consumers to delay or even forgo treatment for necessary care. In addition, the Committee observes that ensuring access to inhalers for individuals who need them will help prevent costly complications. The Committee released a report that asthma medication is higher priced in the U.S. than other developed countries.[10] For example, Advair Diskus, a common asthma medication costs 1,296 percent higher in the U.S. During Committee hearings on prescription drug costs, the Committee heard testimony about the increasing costs of medications for asthma. The provision will help address the affordability barrier by expanding access to inhalers for the treatment of chronic lung disease for individuals enrolled in high deductible health plans.

EXPLANATION OF PROVISION

The provision permits a high deductible health plan to provide inhalers for treatment of any chronic lung disease, or any medicine or drug which is delivered through such inhaler for treatment of

[5] Sec. 223(c)(1)(B).
[6] Sec. 223(c)(3).
[7] Sec. 223(c)(2)(C).
[8] Notice 2004–23, 2004–15 I.R.B. 725 (April 12, 2004). See also Notice 2004–50, 2004–33 IRB 1 (Aug. 9, 2004); Notice 2008–59, 2008–29 I.R.B. 123 (July 21, 2008); Notice 2013–37, 2013–40 I.R.B. 293 (Sept. 30, 2013).
[9] 2019–32 I.R.B. 593 (August 5, 2019).
[10] *A Painful Pill to Swallow: U.S. vs. International Prescription Drug Prices*, Ways and Means Committee, September 23, 2019. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/U.S.%20vs.%20International%20Prescription%20Drug%20Prices_0.pdf.

such disease, without satisfaction of the plan's minimum deductible. Thus, under the provision, a health plan will not fail to be treated as a high deductible health plan merely by reason of failing to require a deductible for such inhalers or such medicines and drugs, and an individual who is covered under such a plan may contribute to an HSA.

EFFECTIVE DATE

The provision applies to months beginning after the date of enactment.

III. VOTES OF THE COMMITTEE

Pursuant to 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. 4716, the "Inhaler Coverage and Access Now Act," on October 23, 2019.

The amendment in the nature of a substitute to H.R. 4716 was agreed to by voice vote (with a quorum being present).

The bill, H.R. 4716, 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.

The bill is estimated to decrease Federal fiscal year budget receipts by $1.4 billion dollars for the period 2019 through 2029.

ESTIMATED REVENUE EFFECT OF THE PROPOSAL

Item	Fiscal Years [Millions of Dollars]											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020–24	2020–29
Safe Harbor for High Deductible Health Plans Without Deductible for Certain Inhallers [1]	−35	−68	−98	−129	−146	−157	−177	−189	−197	−206	−476	−1,402

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

	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020–24	2020–29
On-buget	−27	−52	−76	−99	−113	−121	−139	−150	−156	−163	−367	−1,095
Off-budget	−8	−16	−22	−30	−33	−36	−38	−39	−41	−43	−109	−307

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

Pursuant to 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 bill involves no new tax expenditure.

C. Cost Estimate Prepared by the Congressional Budget Office

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

U.S. Congress,
Congressional Budget Office,
Washington, DC, October 31, 2019.

Hon. Richard Neal,
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. 4716, the Inhaler Coverage and Access Now Act of 2019.

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

Sincerely,

Phillip Swagel,
Director.

Enclosure.

At a Glance

H.R. 4716, Inhaler Coverage and Access Now Act of 2019
As ordered reported by the House Committee on Ways and Means on October 23, 2019

By Fiscal Year, Millions of Dollars	2020	2020-2024	2020-2029
Direct Spending (Outlays)	0	0	0
Revenues	-35	-476	-1,402
Increase or Decrease (-) in the Deficit	35	476	1,402
Spending Subject to Appropriation (Outlays)	0	0	0

		Mandate Effects	
Statutory pay-as-you-go procedures apply?	Yes		
Increases on-budget deficits in any of the four consecutive 10-year periods beginning in 2030?	< $5 billion	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	No

The bill would:

- H.R. 4716 would amend the Internal Revenue Code to allow a high deductible plan to provide inhalers for treatment of any chronic lung disease, or any medicine or drug which is delivered through such inhaler for treatment of such disease, without a deductible and without affecting a beneficiary's eligibility to participate in a Health Savings Account (HSA).

Estimated budgetary effects would primarily stem from:

- An increase in contributions to HSAs, which are excluded from income and employment taxes.

The Congressional Budget Act of 1974, as amended, stipulates that revenue estimates provided by the staff of the Joint Committee on Taxation (JCT) will be the official estimates for all tax legislation considered by Congress. As such, CBO incorporates those estimates into its cost estimates of the effects of legislation. All of the estimates for the provisions of H.R. 4716 were provided by JCT.

Bill summary: H.R. 4716 would amend the Internal Revenue Code by expanding the range of services a high deductible health plan can cover before the plan's minimum deductible is satisfied. Under current law, individuals are generally eligible to participate in a Health Savings Account (HSA) if they are covered by a high deductible health plan and no other health care plan, except for certain types of coverage specifically disregarded by law. Currently, high-deductible health plans are allowed to provide "first dollar" (before the minimum deductible is satisfied) coverage for preventative care, including inhalers for individuals diagnosed with asthma. H.R. 4716 would allow a high deductible plan to also provide inhalers for treatment of any chronic lung disease, or any medicine or drug which is delivered through such inhaler for treatment of such disease, without a deductible and without affecting a beneficiary's eligibility to participate in an HSA.

Estimated Federal cost: The estimated budgetary effect of H.R. 4716 is shown in Table 1.

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF H.R. 4716

	By fiscal year, millions of dollars—											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2020–2024	2020–2029
Decreases (−) in Revenues												
Estimated Revenues	−35	−68	−98	−129	−146	−157	−177	−189	−197	−206	−476	−1,402
On-Budget	−27	−52	−76	−99	−113	−121	−139	−150	−156	−163	−367	−1,095
Off-Budget [a]	−8	−16	−22	−30	−33	−36	−38	−39	−41	−43	−109	−307
Increase in the Deficit From Changes in Revenues												
Effect on the Deficit	35	68	98	129	146	157	177	189	197	206	476	1,402
On-Budget Deficit	27	52	76	99	113	121	139	150	156	163	367	1,095
Off-Budget Deficit	8	16	22	30	33	36	38	39	41	43	109	307

Source: Staff of the Joint Committee on Taxation.
Components may not sum to totals because of rounding.
[a] Off-budget revenues result from changes in Social Security payroll tax receipts.

Basis of estimate: The Congressional Budget Act of 1974, as amended, stipulates that revenue estimates provided by the staff of the Joint Committee on Taxation (JCT) are the official estimates for all tax legislation considered by the Congress. CBO therefore incorporates those estimates into its cost estimates of the effects of legislation. All of the estimates for the provisions of H.R. 4716 were provided by JCT.[1]

Revenues: JCT estimates that the bill would decrease revenues by $1.4 billion over the 2020–2029 period. The change in revenues includes a reduction of $307 million that would result from changes in off-budget revenues (from Social Security payroll taxes).

Uncertainty: These budgetary estimates are uncertain because they rely on underlying projections and other estimates that are uncertain. Specifically, they are based in part on CBO's economic projections for the next decade under current law, and on estimates of changes in taxpayers' behavior in response to changes in tax rules.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The changes in revenues that are subject to those pay-as-you-go procedures are shown in Table 1. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

Increase in long-term deficits: JCT estimates that enacting H.R. 4716 would increase on-budget deficits by less than $5 billion in each of the four consecutive 10-year periods beginning in 2030.

Mandates: None.

JCT has reviewed H.R. 4716 and determined that it contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

Estimate prepared by: Revenues: Staff of the Joint Committee on Taxation and Nathaniel Frentz; Mandates: Staff of the Joint Committee on Taxation.

Estimate reviewed by: Joshua Shakin, Chief, Revenue Estimating Unit; Joseph Rosenberg, Deputy Assistant Director for Tax Analysis; John McClelland, Assistant Director for Tax Analysis.

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

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee made findings and recommendations that are reflected in this report.

B. Statement of General Performance Goals and Objectives

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill con-

[1] For JCT's estimates of the provisions, which include detail beyond the summary presented below, see Joint Committee on Taxation, Description of H.R. 4716, Description Of H.R. 4716, The "Inhaler Coverage and Access Now Act", JCX–45–19 (October 21, 2019) https://go.usa.gov/xpajj

tains no measure that authorizes funding, so no statement of general performance goals and objectives 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, Clause 5(b)

Clause 5(b) of rule XXI of the Rules of the House of Representatives provides, in part, that "It shall not be in order to consider a bill, joint resolution, amendment, or conference report carrying a retroactive Federal income tax rate increase." The Committee, after careful review, states that the bill does not involve any retroactive Federal income tax rate increase within the meaning of the rule.

E. Tax Complexity Analysis

Section 4022(b) of Pub. L. No. 105–266, the Internal Revenue Service Restructuring and Reform Act of 1998 (the "RRA"), 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 RRA because the bill contains no provision that amends the Internal Revenue Code of 1986 and has "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 clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report to Congress pursuant to section 21 of Pub. L. No. 111–139; or (3) a program related to a pro-

gram identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. HEARINGS

In compliance with Sec. 103(i) of H. Res. 6 (116th Congress) (1) the following hearing was used to develop or consider H.R. 4716:

On February 12, 2019, the Committee held a hearing on the Rising Costs of Prescription Drugs, held.

(2) The following related hearing was held:

On October 17th, 2019. the Committee held a hearing on Investing in the U.S. Health System by Lowering Drug Prices, Reducing Out-of-Pocket Costs, and Improving Medicare Benefits.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

INTERNAL REVENUE CODE OF 1986

* * * * * * *

Subtitle A—Income Taxes

* * * * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

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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 $\frac{1}{12}$ of—

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

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

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

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

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

(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] *CERTAIN DEDUCTIBLES*.—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] *for one or more of the following:*

(i) Preventive care (within the meaning of section 1861 of the Social Security Act, except as otherwise provided by the Secretary).

(ii) Inhalers for treatment of any chronic lung disease (and any medicine or drug which is delivered through such inhaler for treatment of such disease).

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

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

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

(3) PERMITTED INSURANCE.—The term "permitted insurance" means—

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

(i) liabilities incurred under workers' compensation laws,

(ii) tort liabilities,

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

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

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

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

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

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

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

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

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

(i) unless it is in cash, or

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

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

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

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

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

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

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

(2) QUALIFIED MEDICAL EXPENSES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) TAX TREATMENT OF ACCOUNTS.—

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

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

(f) TAX TREATMENT OF DISTRIBUTIONS.—

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

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

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

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

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

(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

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

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

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

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

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

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

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

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

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

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

(8) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—

(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account beneficiary's surviving spouse acquires such beneficiary's interest in a health savings account by reason of being the designated beneficiary of such account at the death of the account beneficiary, such health savings ac-

count shall be treated as if the spouse were the account beneficiary.

(B) OTHER CASES.—

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

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

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

(ii) SPECIAL RULES.—

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

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

(g) COST-OF-LIVING ADJUSTMENT.—

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

(A) such dollar amount, multiplied by

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

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

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

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

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

(h) REPORTS.—The Secretary may require—

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

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

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

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