The Health Savings Act of 2016

United States Senator Orrin Hatch & Congressman Erik Paulsen

This bill simplifies and enhances Health Savings Accounts (HSAs) and Health Flexible Spending Accounts (FSAs) by addressing some of the questions and concerns that have been raised since HSAs were first enacted in 2003 but were not addressed by the HOPE Act of 2006.

TITLE I – RENAMING HIGH DEDUCTIBLE HEALTH PLANS

Section 101—High deductible health plans renamed HSA eligible health plans

Current law uses the term "high deductible health plan" rather than the more appropriate "HSA-eligible health plan". This section changes that in the Internal Revenue Code.

TITLE II – ENHANCING ACCESS TO TAX-PREFERRED HEALTH ACCOUNTS

Section 201 — Allow spouses to make catch-up contributions to same HSA account

Current law allows HSA-eligible individuals age 55 or older to make additional catch-up contributions each year. However, the contributions must be deposited into separate HSA accounts even if both spouses are eligible to make catch-up contributions. This section would allow the spouse who is the HSA account holder to double their catch-up contribution to account for their eligible spouse.

Section 202 — Provisions relating to Medicare

(1) HSA-eligible seniors enrolled in Medicare Part A only may continue to contribute to their Health Savings Accounts

Current law restricts HSA participation by Medicare beneficiaries, which means that once a person turns 65 they usually may no longer contribute to their HSA (although they may continue to spend money from an existing HSA). For most seniors, enrollment in Medicare Part A is automatic when receiving Social Security and is difficult to delay or decline enrollment. However, the current deductible for hospital coverage under Medicare Part A is very high, over $1,000 per admission, nearly equal to the minimum deductible required for HSA-qualified plans. Section 102(a) allows Medicare beneficiaries enrolled only in Part A to continue to contribute to their HSA accounts after turning 65 if they are otherwise eligible to contribute to an HSA.

(2) Medicare beneficiaries participating in Medicare Advantage MSA may contribute their own money to their Medicare Medical Savings Accounts (MSAs)

Current law prohibits Medicare beneficiaries enrolled in Medicare Medical Savings Accounts (MSA) from contributing their own money to their MSAs. Although created in the 1997 Balanced Budget Act, Medicare MSAs are a relatively new type of plan under the Medicare Advantage program. MSA plans allow seniors to enroll in a high-deductible plan and receive tax-free contributions from the federal government to HSA-like accounts. However, the government contribution is significantly lower than the plan deductible, and the beneficiary may not contribute any of their own money to fill in the gap. Section 102(b) allows Medicare beneficiaries participating in a Medicare MSA plan to contribute their own tax-deductible money to their MSAs to cover the annual shortfall.

Section 203 — Individuals eligible for Indian Health Service Assistance

Current law prohibits Native Americans from contributing to their HSAs if they have utilized medical services of the Indian Health Service (IHS) or a tribal organization. The bill would remove those restrictions and allow Native Americans to contribute to their HSAs regardless of utilization of IHS or tribal medical services.

Section 204 — Individuals eligible for TRICARE coverage

Current law prohibits individuals who are eligible to receive hospital care, medical services, or prescription drugs under TRICARE Extra or TRICARE Standard from contributing to their HSA. This bill would remove this restriction.

Section 205 — Members of health care sharing ministries eligible to establish health savings accounts.

Amends current law by stipulating that membership in a health care sharing ministry will be treated as coverage under an HAS eligible health plan.

Section 206 — Treatment of Direct Primary Care Service Arrangements

Amends current law by designating treatment of direct primary care service arrangements, arrangements under which an individual is provided coverage restricted to primary care services in exchange for a fixed periodic fee or payment for primary care services, shall not be treated as a health plan or as insurance.

Section 207 — Individuals Eligible for On-Site Medical Clinic Coverage

An individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual is eligible to receive health care benefits from an onsite medical clinic of employer of the individual or the individual's spouse if such health care benefits are not significant benefits. The Bill defines the following health care benefits to be considered benefits which are not significant: Physicals and immunizations, injecting antigens provided by employees, medications available with out a prescription such as pain relievers and antihistamines, treatment for injuries

occurring at the employer's place of employment or otherwise in the course of employment, tests for infectious conditions such as streptococcal sore throat, monitoring of chronic conditions such as diabetes, drug testing, hearing or vision screenings and related services and other similar treatments and services.

Section 208 — Treatment of Embedded Deductibles

Stipulates that a health plan providing family coverage that has an annual deductible for all covered individuals under the plan of at least the amount described will not fail to be treated as an HAS eligible health plan solely because it covers expenses with respect to an individual under that plan that exceed an embedded deductible which is equal to or in excess of the amount described by the legislation.

TITLE III – IMPROVING COVERAGE UNDER TAX-PREFERRED HEALTH ACCOUNTS

Section 301 — Allowance of Distributions for Prescription and Over-the-Counter Medicines and Drugs

Amends Section 223 (d)(2)(A) and Section 220 (d)(2)(A) by changing the language of the last sentences of the aforementioned sections to read: "such term shall include an amount paid for any prescription or over-the-counter medicine or drug". The Bill also stipulates that for purposes of this section and section 105, reimbursement for expenses incurred for any prescription or over-the-counter medicine or drug shall be treated as a reimbursement for medical expenses.

Section 302 — Purchase of Health Insurance from HSA Account

Amends the language in Section 152 by striking "and any dependent of such individual" in subparagraph A and inserting "any dependent of such individual, and any child of such individual who has not attained the age of 27 before the end of such individual's taxable year". The Bill also strikes subparagraph (B) and inserts the following: "Health insurance may not be purchased from account, except as provided in subparagraph (C), subparagraph (A) shall not apply to any payment for insurance".

Section 303 — Special Rule for Certain Medical Expenses Incurred Before Establishment of Account

Adds a clause to the end of paragraph (2) of Section 223(d) regarding the treatment of certain medical expenses incurred before the establishment of an account that allows for health savings accounts established during the 60-day period beginning on the date that coverage of the account beneficiary under an HAS eligible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.

Section 304 – Preventative Care Prescription Drug Clarification

Clarifies the use of drugs in preventative care by amending subparagraph (C) of section 223(c)(2) to add the following: "Preventative care shall include prescription and over-the-counter drugs and medicines which have the primary purpose of preventing the onset of, further deterioration from, or complications associated with chronic conditions, illnesses, or diseases".

TITLE IV – PROTECTING ACCESS TO LOW-COST HEALTH PLANS BY REDUCING BURDENSOME MANDATES

Section 401 – HSA Eligible Health Plans Qualify as Providing Minimum Value

Amends clause (ii) of section 36B(c)(2)(C) by inserting ", in the case of a plan other than an HSA eligible health plan" after "an eligible employer-sponsored plan (as defined in section 5000A (f)(2)) and".

TITLE V – MISCELLANEOUS PROVISIONS RELATING TO TAX PREFERRED HEALTH ACCOUNTS

Section 501 – FSA and HRA Interaction with HSAs.

The HOPE Act of 2006 (H.R. 6111) allowed employers that offered Flexible Spending Arrangements (FSAs) or Health Reimbursement Arrangements (HRAs) to roll over unused funds to an HSA as employees transitioned to an HSA for the first time. However, the unused FSA funds may not be rolled over to HSAs unless the employer offers a "grace period" that allows medical expenses to be reimbursed from an FSA through March 15 of the following year (instead of the usual "use or lose" by December 31). In addition, the amount that may be rolled over to the HSA cannot exceed the amount in such an account as of September 21, 2006. This provision effectively limits most employees from ever being able to use unused funds in an FSA or an HRA to help fund their HSAs. This section clarifies current law to provide employers greater opportunity to roll-over of funds from employees' FSAs or HRAs to their HSAs in a future year in order to ease the transition from FSAs and HRAs to HSAs.

Section 502 – Equivalent Bankruptcy Protections for Health Savings Accounts as Retirement Funds

Amends current law by allowing HSAs to be treated in the same manner as an individual retirement account.

Section 503 – Administrative Error Correction Before Due Date of Return

Amends current law by allowing for error correction on filings so that individuals are not subjected to the penalties of the Cadillac tax for administrative errors.

Section 504 – Reauthorization of Medicaid Health Opportunity Accounts

Amends current law to reauthorize health opportunity accounts in Medicaid as a demonstration program. This section also allows for health opportunity accounts to be maintained for 3 years after a person becomes ineligible for Medicaid benefits so that they have access to those funds for their health care.

Section 505 – Exclusion of Certain Health Arrangements from Employer-Sponsored Excise Tax

Defines what constitutes "applicable employer-sponsored coverage" for the Cadillac tax and exempts employee contributions from the tax calculation. Employer salary reduction contributions would be treated as employee contributions because they are employee-directed.

TITLE VI- OTHER PROVISIONS

Section 601 – Certain Exercise Equipment and Physical Fitness Programs Treated as Medical Care

Amends the current definition of "medical care" to include equipment for physical exercise or health coaching. Payment specifications and equipment and facility limitations are outlined. HSAs are not subject to the same limitations of "medical care".

Section 602 – Certain Nutritional and Dietary Supplements to be Treated as Medical Care

Amends the current definition of "medical care" to include dietary and nutritional supplements.

Section 603 – Certain Provider Fees to be Treated as Medical Care

Amends the current definition of "medical care" to include periodic fees paid for specific medical services or the right to receive medical services on an as-needed basis. Health FSAs are not considered insurance.