To amend the Internal Revenue Code of 1986 to improve and expand the availability of health savings accounts, and for other purposes.

IN THE SENATE OF THE UNITED STATES

Mr. HATCH introduced the following bill; which was read twice and referred to the Committee on

A BILL

To amend the Internal Revenue Code of 1986 to improve and expand the availability of health savings accounts, and for other purposes.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,

3 SECTION 1. SHORT TITLE; AMENDMENT OF 1986 CODE.

4 (a) SHORT TITLE.—This Act may be cited as the “HSA Improvement and Expansion Act of 2006”.

5 (b) AMENDMENT OF 1986 CODE.—Except as other-
6 wise expressly provided, whenever in this Act an amend-
7 ment or repeal is expressed in terms of an amendment
to, or repeal of, a section or other provision, the reference
shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 2. FINDINGS.

The Congress finds the following:

(1) The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) authorizes health savings accounts (referred to in this section as “HSAs”) into which individuals may make annual contributions of not more than $2,700, and families may make annual contributions of not more than $5,450, to permit spending by individuals for their health care needs.

(2) Federal law provides for obtaining health insurance coverage through a low premium health plan offered with a tax-favored HSA that typically costs substantially less than traditional health insurance.

(3) Giving individuals more direct control over their health care spending will encourage more prudent use of health care services, help make the health care system more responsive to the needs of consumers, and improve access to health coverage for the uninsured.
(4) A broad range of improvements to the Federal laws governing HSAs are necessary to make them more attractive to consumers and employers.

(5) The number of people covered in January 2006 by products combining an HSA with a low premium health plan was 3,168,000, more than triple the 1,031,000 reported in March 2005.

(6) HSAs have become an important option for consumers and employers who have struggled to afford health insurance coverage.

(7) According to a January 2006 census, 31 percent of new enrollees in HSAs and low premium health plans in the individual market were previously uninsured.

(8) HSAs combined with low premium health plans can provide an affordable and accessible health insurance option for individuals of all ages.

(9) 50 percent of all people covered by HSAs and low premium health plans in the individual market, including dependents covered under family plans, are 40 years of age or older.

(10) Many States currently have in effect laws and regulations that require insurers to provide specific benefit coverage in the health insurance plans they offer, preventing individuals and small business
from enrolling in low premium health plans and making them ineligible for HSAs.

**SEC. 3. ACCELERATED FUNDING FOR HSAS THROUGH DISTRIBUTIONS FROM BALANCES IN HEALTH REIMBURSEMENT AND FLEXIBLE SPENDING ARRANGEMENTS AND FROM INDIVIDUAL RETIREMENT PLANS.**

(a) **One-Time FSA and HRA Rollovers to HSAs.**—

(1) **In General.**—A plan shall not fail to be treated as a flexible spending arrangement or health reimbursement arrangement under section 105 or 106 of the Internal Revenue Code of 1986 merely because—

(A) such plan provides for a contribution to the health savings account (as defined in section 223 of such Code) of the employee which meets the requirements of paragraph (2), and

(B) such plan thereafter terminates with respect to such employee.

(2) **Requirements.**—A contribution meets the requirements of this paragraph if—

(A) in the case of a flexible spending arrangement (as defined in section 106(c)(2) of such Code) in existence on June 1, 2006, such
contribution is the remaining balance in such arrangement as of the last day of the plan year ending in or before the taxable year in which such contribution is made,

(B) in the case of a health reimbursement arrangement in existence on June 1, 2006, such contribution is the remaining balance of the amount to be received in reimbursements under such arrangement as of the last day of the plan year ending in or before the taxable year in which such contribution is made, and

(C) such contribution is made by the employer directly to the health savings account of the employee not later than 60 days after the end of the plan year of such flexible spending arrangement or health reimbursement arrangement.

(3) Treatment as rollover contribution.—For purposes of sections 223 and 4973 of such Code, a contribution which meets the requirements of paragraph (2) shall be treated as a rollover contribution described in section 223(f)(5) of such Code.

(4) Tax treatment relating to contributions.—For purposes of this title—
(A) INCOME TAX.—Gross income shall not include the amount of any contribution under this subsection.

(B) EMPLOYMENT TAXES.—Amounts contributed to a health savings account under this subsection shall be treated as a payment described in section 106(d) of such Code.

(C) COMPARABILITY EXCISE TAX.—Section 4980G of such Code shall not apply to contributions made under this subsection.

(5) TERMINATION.—This paragraph shall not apply to any taxable year beginning after December 31, 2011.

(b) ONE-TIME DISTRIBUTION FROM INDIVIDUAL RETIREMENT PLANS TO FUND HSAS.—

(1) IN GENERAL.—Section 402 (relating to taxability of beneficiary of employees’ trust) is amended by adding at the end the following new subsection:

“(l) HEALTH SAVINGS ACCOUNT FUNDING DISTRIBUTION FROM INDIVIDUAL RETIREMENT PLANS.—

“(1) IN GENERAL.—In the case of an employee who is an eligible individual and who elects the application of this subsection for a taxable year, gross income of the employee for the taxable year does not include a qualified HSA funding distribution to the
extent such distribution is otherwise includible in gross income (determined after the application of paragraph (4)).

“(2) QUALIFIED HSA FUNDING DISTRIBUTION.—For purposes of this subsection, the term ‘qualified HSA funding distribution’ means a distribution from an individual retirement plan of the employee to the extent that such distribution is contributed to the health savings account of the employee not later than the 60th day after the day on which the employee receives such distribution or in a direct trustee-to-trustee transfer.

“(3) LIMITATIONS.—

“(A) MAXIMUM DOLLAR LIMITATIONS BASED ON OUT-OF POCKET LIMITS IN EFFECT AT TIME OF CONTRIBUTION.—The amount excluded from gross income by paragraph (1) shall not exceed—

“(i) in the case of an individual who has self-only coverage under a high deductible health plan as of the first day of the month in which the qualified HSA funding distribution is contributed to the health savings account of the employee, the amount in effect for the taxable year under
subclause (I) of section 223(c)(2)(A)(ii),

and

“(ii) in the case of an individual who has family coverage under a high deductible health plan as of the first day of the month in which the qualified HSA funding distribution is contributed to the health savings account of the employee, the amount in effect for the taxable year under subclause (II) of section 223(c)(2)(A)(ii).

“(B) ONE-TIME TRANSFER.—

“(i) IN GENERAL.—Except as provided in clause (ii), an individual may make an election under paragraph (1) only for one qualified HSA funding distribution during the lifetime of the individual. Such an election, once made, shall be irrevocable.

“(ii) CONVERSION FROM SELF-ONLY TO FAMILY COVERAGE.—If a qualified HSA funding distribution is made during a month during which an individual has self-only coverage under a high deductible health plan as of the first day of the month, the individual may elect to make
an additional qualified HSA funding distribution during a subsequent month during which the individual has family coverage under a high deductible health plan as of the first day of the subsequent month, except that the limitation otherwise applicable under subparagraph (A)(ii) to the distribution during such subsequent month shall be reduced by the amount of the earlier qualified HSA funding distribution.

“(4) APPLICATION OF SECTION 72.—Notwithstanding section 72, in determining the extent to which an amount is treated as includible in gross income for purposes of paragraph (1), the aggregate amount distributed from an eligible retirement plan in a taxable year shall be treated as includible in gross income to the extent that such amount does not exceed the aggregate amount which would have been so includible if all amounts distributed from all eligible retirement plans were treated as 1 contract for purposes of determining the inclusion of such distribution under section 72. Proper adjustments shall be made in applying section 72 to other dis-
tributions in such taxable year and subsequent taxable years.

“(5) Definitions.—For purposes of this subsection—

“(A) Eligible retirement plan.—The term ‘eligible retirement plan’ means an individual retirement plan (as defined in section 7701(a)(37)), including an individual retirement plan which is designated as a Roth IRA.

“(B) Eligible individual.—The term ‘eligible individual’ has the meaning given such term by section 223(c)(1).

“(6) Related plans treated as 1.—For purposes of this subsection, all eligible retirement plans of an employer shall be treated as a single plan.”.

(2) Coordination with limitation on contributions to HSAs.—Section 223(b)(4) (relating to coordination with other contributions) is amended by striking “and” at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting “, and”, and by inserting after subparagraph (B) the following new subparagraph:

“(C) the aggregate amount contributed to health savings accounts of such individual for
such taxable year under section 402(l) (and such amount shall not be allowed as a deduction under subsection (a)).”.

(3) 10-PERCENT PENALTY ON EARLY DISTRIBUTIONS NOT TO APPLY.—Section 72(t)(2)(A) of such Code (relating to subsection not to apply to certain distributions) is amended by striking “or” at the end of clause (vi), by striking the period at the end of clause (vii) and inserting “, or”, and by inserting after clause (vii) the following new clause:

“(viii) a qualified HSA funding distribution (as defined by section 402(l)).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.

SEC. 4. PROVISIONS RELATING TO ELIGIBILITY TO CONTRIBUTE TO HSAS.

(a) INDIVIDUALS ELIGIBLE FOR REIMBURSEMENT UNDER SPOUSE’S FLEXIBLE SPENDING ARRANGEMENT.—Section 223(c)(1) (defining eligible individual) is amended by adding at the end the following new subparagraph:

“(C) SPECIAL RULE FOR CERTAIN FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of subparagraph (A)(ii), an individual shall not
be treated as covered under a health plan described in such subparagraph merely because the individual is covered under a flexible spending arrangement (within the meaning of section 106(c)(2)) which is maintained by an employer of the spouse of the individual, but only if—

“(i) the employer is not also the employer of the individual, and

“(ii) the individual certifies to the employer and to the Secretary (in such form and manner as the Secretary may prescribe) that the individual and the individual’s spouse will not accept reimbursement under the arrangement for any expenses for medical care provided to the individual.”.

(b) INDIVIDUALS OVER AGE 65 AUTOMATICALLY ENROLLED IN MEDICARE PART A.—Section 223(b)(7) (relating to contribution limitation on medicare eligible individuals) is amended by adding at the end the following new sentence: “This paragraph shall not apply to any individual during any period the individual’s only entitlement to such benefits is an entitlement to hospital insurance benefits under part A of title XVIII of such Act pursuant to an automatic enrollment for such hospital insurance
benefits under the regulations under section 226(a)(1) of such Act.”

(c) INDIVIDUALS ELIGIBLE FOR CERTAIN VETERANS BENEFITS.—Section 223(c)(1) (defining eligible individual), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

“(D) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR CERTAIN VETERANS BENEFITS.—
For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives periodic hospital care or medical services for a service-connected disability under any law administered by the Secretary of Veterans Affairs but only if the individual is not eligible to receive such care or services for any condition other than a service-connected disability.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.

SEC. 5. PROVISIONS RELATING TO CONTRIBUTION AND LOW PREMIUM HEALTH PLAN LIMITS.

(a) INCREASE IN CONTRIBUTION LIMITS FOR HSAs.—
(1) **INCREASE IN MONTHLY LIMIT.**—

(A) IN GENERAL.—Paragraph (2) of section 223(b) (relating to monthly limitation) is amended to read as follows:

“(2) MONTHLY LIMITATION.—In the case of an eligible individual who has coverage under a high deductible health plan, the monthly limitation for any month of such coverage is $2,700, and

“(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, $2,700, and

“(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, $5,450.”.

(B) **CONFORMING AMENDMENTS.**—

(i) Section 223(d)(1)(A)(ii)(I) is amended by striking “subsection (b)(2)(B)(ii)” and inserting “subsection (b)(2)(B)”.

(ii) Section 223(c)(2)(D) is amended to read as follows:

“(D) SPECIAL RULE FOR NETWORK PLANS.—In the case of a plan using a network
of providers, 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).”.

(2) INCREASE IN LIMIT FOR INDIVIDUALS BECOMING ELIGIBLE INDIVIDUALS AFTER THE BEGINNING OF THE YEAR.—Section 223(b) (relating to limitations) is amended by adding at the end the following new paragraph:

“(8) INCREASE IN LIMIT FOR INDIVIDUALS BECOMING ELIGIBLE INDIVIDUALS AFTER THE BEGINNING OF THE YEAR.—An individual who first becomes an eligible individual during a calendar year in a month after January of the calendar year shall, for purposes of computing the limitation under paragraph (1) for any taxable year, be treated as having been an eligible individual during each of the months in such calendar year preceding such first month (and as having been enrolled in each of those months in the same high deductible health plan the individual was enrolled in for such first month).”.

(3) APPLICATION OF SPECIAL RULES FOR MARRIED INDIVIDUALS.—Paragraph (5) of section
223(b) (relating to special rule for married individuals) is amended to read as follows:

“(5) SPECIAL RULES FOR MARRIED INDIVIDUALS.—

“(A) IN GENERAL.—In the case of individuals who are married to each other and who are both eligible individuals, the limitation under paragraph (1) for each spouse shall be equal to the spouse’s applicable share of the excess (if any) of—

“(i) the dollar amount in effect under paragraph (2)(B) (without regard to any additional contribution amounts under paragraph (3)), over

“(ii) the aggregate amount paid to Archer MSAs of such spouses for the taxable year.

“(B) APPLICABLE SHARE.—For purposes of subparagraph (A), a spouse’s applicable share is one-half of the limitation under subparagraph (A) unless both spouses agree on a different division.”

(4) SELF-ONLY COVERAGE.—Section 223(c)(4) (defining family coverage) is amended to read as follows:
“(4) COVERAGE.—

“(A) FAMILY COVERAGE.—The term ‘family coverage’ means any coverage other than self-only coverage.

“(B) SELF-ONLY COVERAGE.—If more than 1 individual is covered by a high deductible health plan but only 1 of the individuals is an eligible individual, the coverage shall be treated as self-only coverage.”.

(b) FAMILY PLAN MAY HAVE INDIVIDUAL ANNUAL DEDUCTIBLE LIMIT.—Section 223(c)(2) (defining high deductible health plan) is amended by adding at the end the following new subparagraph:

“(E) SPECIAL RULE FOR FAMILY COVERAGE.—A health plan providing family coverage shall not fail to meet the requirements of subparagraph (A)(i)(II) merely because the plan elects to provide both—

“(i) an aggregate annual deductible limit for all individuals covered by the plan which is not less than the amount in effect under subparagraph (A)(i)(II), and

“(ii) an annual deductible limit for each individual covered by the plan which
is not less than the amount in effect under subparagraph (A)(i)(I).”.

(c) **Cost-of-Living Adjustments Computed Earlier in the Calendar Year.**—Paragraph (1) of section 223(g) (relating to cost-of-living adjustment) is amended by adding at the end the following new flush sentence:

“In the case of any taxable year beginning after 2006, 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.”.

(d) **Effective Date.**—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.

**SEC. 6. Definition of Qualified Medical Expenses.**

(a) **Premiums for Low Premium Health Plans Treated as Qualified Medical Expenses.**—Subparagraph (C) of section 223(d)(2) is amended by striking “or” at the end of clause (iii), by striking the period at the end of clause (iv) and inserting “, or”, and by adding at the end the following new clause:

“(v) a high deductible health plan, but only if the expenses are for coverage for a
month with respect to which the account beneficiary is an eligible individual by reason of the coverage under the plan.”.

(b) Special Rule for Certain Medical Expenses Incurred Before Establishment of Account.—Paragraph (2) of section 223(d) is amended by adding at the end the following new subparagraph:

“(D) Certain medical expenses incurred before establishment of account treated as qualified.—An expense shall not fail to be treated as a qualified medical expense solely because such expense was incurred before the establishment of the health savings account if such expense was incurred—

“(i) during either—

“(I) the taxable year in which the health savings account was established, or

“(II) the preceding taxable year in the case of a health savings account established after the taxable year in which such expense was incurred but before the time prescribed by law for filing the return for such
taxable year (not including extensions thereof), and

“(ii) for medical care of an individual during a period that such individual was an eligible individual.

For purposes of clause (ii), an individual shall be treated as an eligible individual for any portion of a month the individual is described in subsection (e)(1), determined without regard to whether the individual is covered under a high deductible health plan on the 1st day of such month.”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2006.