DESCRIPTION OF H.R. 6305, THE "BIPARTISAN HSA IMPROVEMENT ACT OF 2018"

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
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Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

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INTRODUCTION

The House Committee on Ways and Means has scheduled on July 11, 2018 a committee markup of H.R. 6305, the "Bipartisan HSA Improvement Act of 2018," which improves access to health care through modernized health savings accounts. This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the bill.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of H.R. 6305, the "Bipartisan HSA Improvement Act of 2018"* (JCX-45-18), July 10, 2018. This document can also be found on the Joint Committee on Taxation website at www.jct.gov. All section references herein are to the Internal Revenue Code of 1986, as amended, unless otherwise stated.

A. Certain Employment Related Services Not Treated as Disqualifying Coverage for Purposes of Health Savings Accounts

Health Savings Accounts

An individual with a high deductible health plan ("HDHP") and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage)[2] may establish a health savings account ("HSA").[3] Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an "above-the-line" deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.

Distributions from an HSA that are used for qualified medical expenses are excludible from 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 (i.e., age 65).

A high deductible health plan ("HDHP") is a health plan that has an annual deductible that is at least $1,350 for self-only coverage or $2,700 for family coverage for 2018 and that limits the sum of the annual deductible and other payments that the individual must make with

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[2] An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is "permitted insurance" or "permitted coverage."

Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (*e.g.*, auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Also see Notice 2004-50, 2004-33 IRB 1, Q & A-7 and Q & A-8 ("an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP"), but such coverage must be provided through insurance contracts and not on a self-insured basis.

Pursuant to Q & A-10 of Notice 2004-50, coverage under a disease management program does not make an individual ineligible to contribute to an HSA as long as the program does not provide significant benefits in the nature of medical care or treatment so that it is not considered a "health plan" for purposes of Code section 223(c)(1). Where a disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan including monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks it is not considered a "health plan."

Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health FSA is disregarded in determining eligibility for an HSA.

[3] Sec. 223.

respect to covered benefits to no more than $6,650 in the case of self-only coverage and $13,300 in the case of family coverage for 2018.

Qualified medical expenses generally are defined as under Code section 213(d) 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) certain premiums paid for long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for Medigap policies.

Eligible individuals

Eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that (1) is not a high deductible health plan and (2) provides coverage for any benefit which is covered under the high deductible health plan. After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to an HSA.[4]

On-Site Employee Clinics

On-site employer-sponsored health clinics may provide a range of health services to employees for free or at a reduced cost. Under IRS guidance, an otherwise eligible individual who has access to free health care or health care at charges below fair market value from a clinic on an employer's premises will not fail to be an eligible individual merely because of this free or reduced cost care as long as the clinic does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care.

For example, an employer who provides the following free health care for employees does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care: 1) physicals and immunizations, 2) injecting antigens provided by employees, such as performing allergy injections, 3) a variety of aspirin and other nonprescription pain relievers, and 4) treatment for injuries caused by accidents at the plant. However, a hospital that permits its employees to receive care at its facilities for all their medical needs for free (when the employee does not have insurance) or that waives copays and deductibles (when the employee does have health insurance) provides significant benefits in the nature of medical care, and the hospital's employees fail to be eligible individuals for purposes of HSA contributions.[5]

[4] See Sec. 223(b)(7), as interpreted by Notice 2004-2, 2004-2 I.R.B. 269, corrected by Announcement 2004-67, 2004-36 I.R.B. 459.

[5] Notice 2008-59, Q&A-10.

Description of Proposal

Under the proposal, certain employment related services are not treated as coverage under a health plan for purposes of determining eligibility for health savings accounts. An individual is therefore not treated as covered under a health plan, merely because the individual receives, or is eligible to receive qualified items and services in connection with employment at an on-site or retail clinic. These qualified items and services include: physical examinations, immunizations, drugs other than a prescribed drug, and treatment for injuries occurring in the course of employment, drug testing as a condition of employment, hearing or vision screenings, and other similar items and services that do not provide significant benefits in the nature of medical care.

Effective Date

The provision applies for months beginning after December 31, 2018, in taxable years ending after such date.

B. Contributions Permitted if Spouse Has a Health Flexible Spending Account

Present Law

Health Savings Accounts

An individual with a high deductible health plan ("HDHP") and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage)[6] may establish a health savings account ("HSA").[7] Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an "above-the-line" deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.

HSA contributions for a year are subject to basic dollar limits that are also adjusted annually as needed to reflect annual cost-of-living increases. For 2018, the basic limit on annual contributions that can be made to an HSA is $3,450 in the case of self-only coverage and $6,900 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). Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses

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[6] An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is "permitted insurance" or "permitted coverage."

Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Also see Notice 2004-50, 2004-33 IRB 1, Q & A-7 and Q & A-8 ("an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP"), but such coverage must be provided through insurance contracts and not on a self-insured basis.

Pursuant to Q & A-10 of Notice 2004-50, coverage under a disease management program does not make an individual ineligible to contribute to an HSA as long as the program does not provide significant benefits in the nature of medical care or treatment so that it is not considered a "health plan" for purposes of Code section 223(c)(1). Where a disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan including monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks it is not considered a "health plan."

Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health FSA is disregarded in determining eligibility for an HSA.

[7] Sec. 223.

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 (i.e., age 65).

An HDHP is a health plan that has an annual deductible that is at least $1,350 for self-only coverage or $2,700 for family coverage for 2018 and that limits the sum of the annual deductible and other payments that the individual must make with respect to covered benefits to no more than $6,650 in the case of self-only coverage and $13,300 in the case of family coverage for 2018.

Qualified medical expenses generally are defined as under Code section 213(d) 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) certain premiums paid for long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for Medigap policies.

Eligible individuals

Eligible individuals for HSAs are individuals who are covered by an HDHP and no other health plan that (1) is not an HDHP and (2) provides coverage for any benefit which is covered under the HDHP. After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to an HSA.[8]

If both spouses of a married couple are eligible individuals and either spouse has family coverage, both spouses are treated as having only family coverage, so that the annual contribution limit for family coverage applies. This annual contribution limit (without regard to any catch-up contribution amounts) is reduced by any Archer MSA contributions and then divided equally between the spouses unless they agree on a different division.[9]

If both spouses of a married couple are eligible individuals, each may contribute to an HSA, but are not permitted a joint HSA.[10] Under the rule described above, however, the spouses may divide their annual contribution limit by allocating the entire amount to one spouse to be contributed to that spouse's HSA.[11] This rule does not apply to catch-up contribution amounts.

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[8] See Sec. 223(b)(7), as interpreted by Notice 2004-2, 2004-2 I.R.B. 269, corrected by Announcement 2004-67, 2004-36 I.R.B. 459.

[9] Sec. 223(b)(5).

[10] Notice 2004-50, 2004-2 C.B. 196, Q&A-63.

[11] Notice 2004-50, Q&A-32. Funds from that HSA can be used to pay qualified medical expenses for either spouse on a tax-free basis. Notice 2004-50, Q&A-36.

Health flexible spending accounts

In addition to offering health insurance, employers often agree to reimburse medical expenses of their employees (and their spouses and dependents). These arrangements are commonly used by employers to pay or reimburse employees for medical expenses that are not covered by health insurance. These arrangements include health flexible spending arrangements ("health FSAs").

Health FSAs typically are funded on a salary reduction basis under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses. If the health FSA meets certain requirements, the compensation that is forgone is not includible in gross income or wages for payroll tax purposes.

Under IRS guidance, an individual who is covered by an HDHP and a health FSA that pays or reimburses certain medical expenses that are not limited to the exceptions for permitted insurance, permitted coverage, or preventive care is generally not an eligible individual for the purpose of making deductible contributions to an HSA. Similarly, if the individual is covered by a health FSA sponsored by the employer of the individual's spouse, the individual is not an eligible individual.[12]

Description of Proposal

Under the proposal, an individual's eligibility for HSAs is determined without regard to whether or not the spouse of the individual has coverage under a health FSA for any taxable year as long as the aggregate reimbursements under the arrangement for the year do not exceed the total expenses which would be eligible for reimbursement if determined without regard to the individual's expenses paid or incurred.

Effective Date

The provision applies to plan years beginning after December 31, 2018.

[12] Rev. Rul. 2004-45.

C. FSA and HRA Terminations or Conversions to Fund HSAs

Present Law

Health savings accounts

An individual with a high deductible health plan and no other health plan (other than a plan that provides certain permitted insurance or permitted coverage)[13] may establish a health savings account ("HSA").[14] Subject to limits, contributions to an HSA made by or on behalf of an eligible individual are deductible in determining adjusted gross income of the individual (that is, an "above-the-line" deduction). Contributions to an HSA by an employer for an employee (including salary reduction contributions made through a cafeteria plan) are excludible from income and from wages for employment tax purposes.

HSA contributions for a year are subject to basic dollar limits that are also adjusted annually as needed to reflect annual cost-of-living increases. For 2018, the basic limit on annual contributions that can be made to an HSA is $3,450 in the case of self-only coverage and $6,900 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). Contributions, including catch-up contributions, cannot be made once an individual is enrolled in Medicare.

Distributions from an HSA that are used for qualified medical expenses are excludible from gross income. Distributions from an HSA that are not used for qualified medical expenses

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[13] An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is "permitted insurance" or "permitted coverage."

Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Also see Notice 2004-50, 2004-33 IRB 1, Q & A-7 and Q & A-8 ("an eligible individual may be covered by an HDHP and also by permitted insurance for one or more specific diseases, such as cancer, diabetes, asthma or congestive heart failure, as long as the principal health coverage is provided by the HDHP"), but such coverage must be provided through insurance contracts and not on a self-insured basis.

Pursuant to Q & A-10 of Notice 2004-50, coverage under a disease management program does not make an individual ineligible to contribute to an HSA as long as the program does not provide significant benefits in the nature of medical care or treatment so that it is not considered a "health plan" for purposes of Code section 223(c)(1). Where a disease management program provides evidence-based information, disease specific support, case monitoring and coordination of the care and treatment provided by a health plan including monitoring laboratory or other test results, telephone contacts or web-based reminders of health care schedules, and providing information to minimize health risks it is not considered a "health plan."

Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. With respect to coverage for years beginning after December 31, 2006, certain coverage under a Health FSA is disregarded in determining eligibility for an HSA.

[14] Sec. 223.

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 (i.e., age 65).

A high deductible health plan is a health plan that has an annual deductible that is at least $1,350 for self-only coverage or $2,700 for family coverage for 2018 and that limits the sum of the annual deductible and other payments that the individual must make with respect to covered benefits to no more than $6,650 in the case of self-only coverage and $13,300 in the case of family coverage for 2018.

Qualified medical expenses generally are defined as under Code section 213(d) 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) certain premiums paid for long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law, and (4) premiums for individuals who have attained the age of Medicare eligibility, other than premiums for Medigap policies.

Eligible individuals

Eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that (1) is not a high deductible health plan and (2) provides coverage for any benefit which is covered under the high deductible health plan. After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to an HSA.[15]

Health flexible spending accounts and health reimbursement arrangements

In addition to offering health insurance, employers often agree to reimburse medical expenses of their employees (and their spouses and dependents). These arrangements are commonly used by employers to pay or reimburse employees for medical expenses that are not covered by health insurance. These arrangements include health flexible spending arrangements ("health FSAs") and health reimbursement arrangements ("HRAs").

Health FSAs typically are funded on a salary reduction basis under a cafeteria plan, meaning that employees are given the option to reduce their current cash compensation and instead have the amount made available for use in reimbursing the employee for his or her medical expenses. If the health FSA meets certain requirements, the compensation that is forgone is not includible in gross income or wages for payroll tax purposes.

[15] See Sec. 223(b)(7), as interpreted by Notice 2004-2, 2004-2 I.R.B. 269, corrected by Announcement 2004-67, 2004-36 I.R.B. 459.

Health FSAs that are funded on a salary reduction basis are subject to the requirements for cafeteria plans, including a requirement that amounts remaining in a health FSA at the end of a plan year must be forfeited by the employee (referred to as the "use-it-or-lose-it rule"). [16]

Health reimbursement arrangements ("HRAs") operate in a manner similar to health FSAs, in that they are an employer-maintained arrangement that reimburses employees and their dependents[17] for medical expenses. Some of the rules applicable to HRAs and health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or-lose-it rule does not apply. Thus, amounts remaining at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[18] Unlike a health FSA, an HRA is permitted to reimburse an employee for health insurance premiums.

Interactions of health savings accounts with other health arrangements

In general, an individual with an HDHP and no other health plan (other than a plan that provides certain permitted insurance, or permitted coverage) may establish an HSA. Permitted insurance is coverage 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, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. Permitted coverage is coverage for accidents, disability, dental care, vision care, or long-term care.[19]

Under IRS guidance, a health FSA and an HRA are (with some exceptions) considered health plans under this definition and therefore, an individual who is covered by an HDHP and a general purpose health FSA or general purpose HRA that pays or reimburses qualified medical expenses,[20] is not an eligible individual for the purpose of making contributions to an HSA.[21] However, an individual does not fail to be an eligible individual for the purpose of making contributions to an HSA if the individual is covered under the following arrangements (or some combination of the following arrangements): 1) a limited-purpose health FSA that pays or reimburses only permitted coverage or preventive care services, 2) a limited-purpose HRA that pays or reimburses benefits for permitted insurance, permitted coverage or preventive care services, 3) a suspended HRA that does not pay or reimburse any medical expense incurred

[16] Sec. 125(d)(2).

[17] As defined in Sec. 152.

[18] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in IRS Notice 2002-45, 2002-2 C.B. 93.

[19] Notice 2004-23.

[20] Defined in Sec. 213(d).

[21] Rev. Rul. 2004-45.

during the suspension period except permitted insurance, permitted coverage, or preventive care services, 4) a post-deductible health FSA or HRA, which does not pay or reimburse any medical expense incurred before the minimum annual deductible for a plan to be an HDHP.[22]

If a general purpose health FSA allows reimbursement for expenses incurred during a grace period following the end of the plan year, an otherwise eligible individual participating in the health FSA is generally not eligible to make contributions to an HSA until the first day of the first month following the end of the grace period.[23] However, if an individual has a zero balance in a general purpose health FSA, as determined on a cash basis,[24] on the last day of the health FSA plan year, the individual does not fail to be an eligible individual as of the first day of the immediately following health FSA plan year solely because of coverage during a health FSA grace period. Similarly, an individual with a zero balance in a general purpose HRA, determined on a cash basis, on the last day of the HRA plan year, does not fail to be an eligible individual on the first day of the immediately following HRA plan year, as long as certain requirements are satisfied.[25]

Coverage by an HSA-compatible health FSA or HRA (these include, limited-purpose health FSA or HRA, post-deductible health FSA or HRA, retirement HRA, or suspended HRA), does not affect an employee's eligibility to contribute to an HSA, including during a health FSA grace period.[26] In addition, IRS guidance holds that an individual covered by an HDHP that does not provide prescription drug coverage, along with a separate prescription drug plan or rider that provides benefits before the minimum annual deductible of the HDHP has been satisfied is not eligible to contribute to HSAs.[27]

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[22] As defined in Sec. 223(c)(2)(A)(i).

[23] Notice 2005-42, 2005-1, C.B. 1204.

[24] "Cash basis" means the balance as of any date, without taking into account expenses incurred that have not been reimbursed as of that date. Thus, pending claims, claims submitted, claims received or claims under review that have not been paid as of a date are not taken into account for purposes of determining the account balance as of that date.

[25] These requirements are: 1) effective on the first of the immediately following HRA plan year, the employee elects to waive participation in the HRA, or 2) effective on or before the first day of the following HRA plan year, the employer terminates the general purpose HRA with respect to all employees, or 3) effective on or before the first day of the following HRA plan year, with respect to all employees, the employer converts the general purpose HRA to an HSA-compatible HRA. See Rev. Rul. 2004-45.

[26] Rev. Rul. 2004-45.

[27] See Rev. Rul. 2004-38, 2004-15.

FSA and HRA terminations to fund HSAs

The Health Opportunity Empowerment Act of 2006[28] amended the Code to allow for certain amounts in a health FSA or HRA to be rolled over into an HSA with favorable tax treatment. To allow this, the plan must be amended in writing, the employee must elect the rollover, and the year-end balance must be frozen. In addition, funds must be transferred by the employer within two and a half months after the end of the plan year and result in a zero balance in the health FSA or HRA.[29] The Act provides for distributions of an amount from a health FSA or HRA to an HSA ("qualified HSA distribution") before January 1, 2012. The distribution must not exceed the lesser of the balance in the health FSA or HRA on September 21, 2006, or as of the date of distribution.

Under these rules, a qualified HSA distribution must be contributed directly to the HSA trustee by the employer. Only one qualified health distribution is allowed with respect to each health FSA or HRA of an individual. Qualified HSA distributions are not taken into account in applying the annual limit for HSA contributions. Qualified HSA distributions are treated as rollovers, and thus are not deductible.

If an employee fails to remain HSA-eligible for 12 months ("the testing period"[30]) following the distribution, the employee is not eligible directly following the distribution, and the amount of the rollover is included in gross income and is subject to an additional 20 percent tax unless the individual dies or becomes disabled. Failure to remain an eligible individual does not require the withdrawal of the qualified HSA distribution, and the amount is not an excess contribution.

Description of Proposal

The proposal defines "qualified HSA distribution" as a distribution from an employee's health FSA or HRA directly to an employee's HSA if such distribution is made in connection with the employee establishing coverage under an HDHP after a significant period of not having such coverage.

The aggregate amount of qualified HSA distributions may not exceed the total annual limit on FSA contributions ($2,650 in 2018)[31] or twice this amount in the case of an eligible individual who has family coverage under an HDHP.

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[28] The Health Opportunity Patient Empowerment Act of 2006, included in the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, sec. 302, December 20, 2006.

[29] The IRS provided guidance on special transition relief for amounts remaining at the end of 2006. See Notice 2007-22.

[30] The testing period is defined to be the period beginning with the month in which the qualified HSA distribution is contributed to the HSA and ending on the last day of the 12th month following that month.

[31] Sec. 125(i).

The statutory annual contribution limits to an HSA are $2,250 for an individual with single coverage or $4,500 for an individual with family coverage, and indexed for cost-of-living adjustments. The contribution limits for 2018 are $3,450 for self-only HDHP coverage, and $6,900 for an individual with family coverage. The proposal allows deductible HSA contributions up to these limits for a given year, reduced by the amount of the qualified HSA distribution attributable to that year.

The proposal also specifies that if a general purpose health FSA or HRA is converted to an HSA-compatible FSA or HRA, coverage under this health FSA or HRA for the portion of the plan year after a qualified HSA distribution is made is disregarded in determining whether the individual is eligible to make deductible contributions to an HSA.

Finally, the proposal provides that the amount of any qualified HSA distribution is to be included on the information to be reported on Form W-2.[32]

Effective Date

The proposal is effective for distributions made after December 31, 2018, in taxable years ending after such date.

[32] Sec. 6051(a)