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INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter B—Computation of Taxable Income

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PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

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SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) CONTRIBUTIONS TO ARCHER MSAS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any Archer MSA of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

(3) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to an Archer MSA, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the Archer MSAs of such individual or such individual's spouse for such taxable year.

(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

(6) DEFINITIONS.—For purposes of this subsection, the terms "eligible individual" and "Archer MSA" have the respective meanings given to such terms by section 220.

(7) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the Archer MSAs of comparable employees, see section 4980E.

(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—Gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

(d) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account (as defined in section 223(d)) of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

(3) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.

(e) FSA AND HRA TERMINATIONS TO FUND HSAS.—

(1) IN GENERAL.—A plan shall not fail to be treated as a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because such plan provides for a qualified HSA distribution.

[(2) QUALIFIED HSA DISTRIBUTION.—The term "qualified HSA distribution" means a distribution from a health flexible spending arrangement or health reimbursement arrangement to the extent that such distribution—

[(A) does not exceed the lesser of the balance in such arrangement on September 21, 2006, or as of the date of such distribution, and

[(B) is contributed by the employer directly to the health savings account of the employee before January 1, 2012.

Such term shall not include more than 1 distribution with respect to any arrangement.**]**

(2) QUALIFIED HSA DISTRIBUTION.—For purposes of this subsection—

(A) IN GENERAL.—The term "qualified HSA distribution" means, with respect to any employee, a distribution from a health flexible spending arrangement or health reimbursement arrangement of such employee directly to a health savings account of such employee if—

(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) after a significant period of not having such coverage, and

(ii) such arrangement is described in section 223(c)(1)(B)(iii) with respect to the portion of the plan year after such distribution is made.

(B) DOLLAR LIMITATION.—The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).

(3) ADDITIONAL TAX FOR FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(A) IN GENERAL.—If, at any time during the testing period, the employee is not an eligible individual, then the amount of the qualified HSA distribution—

(i) shall be includible in the gross income of the employee for the taxable year in which occurs the first month in the testing period for which such employee is not an eligible individual, and

(ii) the tax imposed by this chapter for such taxable year on the employee shall be increased by 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Clauses (i) and (ii) of subparagraph (A) shall not apply if the employee ceases to be an eligible individual by reason of the death of the employee or the employee becoming disabled (within the meaning of section 72(m)(7)).

(4) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) TESTING PERIOD.—The term "testing period" means the period beginning with the month in which the qualified HSA distribution is contributed to the health savings account and ending on the last day of the 12th month following such month.

(B) ELIGIBLE INDIVIDUAL.—The term "eligible individual" has the meaning given such term by section 223(c)(1).

(C) TREATMENT AS ROLLOVER CONTRIBUTION.—A qualified HSA distribution shall be treated as a rollover contribution described in section 223(f)(5).

(5) TAX TREATMENT RELATING TO DISTRIBUTIONS.—For purposes of this title—

(A) IN GENERAL.—A qualified HSA distribution shall be treated as a payment described in subsection (d).

(B) COMPARABILITY EXCISE TAX.—

(i) IN GENERAL.—Except as provided in clause (ii), section 4980G shall not apply to qualified HSA distributions.

(ii) FAILURE TO OFFER TO ALL EMPLOYEES.—In the case of a qualified HSA distribution to any employee, the failure to offer such distribution to any eligible individual covered under a high deductible health plan of the employer shall (notwithstanding section 4980G(d)) be treated for purposes of section 4980G as a failure to meet the requirements of section 4980G(b).

[(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses 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.]

(f) REIMBURSEMENTS FOR MENSTRUAL CARE PRODUCTS.—For purposes of this section and section 105, expenses incurred for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as incurred for medical care.

(g) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).

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PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

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SEC. 213. MEDICAL, DENTAL, ETC., EXPENSES.

(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the expenses paid during the taxable year, not compensated for by insurance or otherwise, for medical care of the taxpayer, his spouse, or a dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), to the extent that such expenses exceed 10 percent of adjusted gross income.

(b) LIMITATION WITH RESPECT TO MEDICINE AND DRUGS.—An amount paid during the taxable year for medicine or a drug shall be taken into account under subsection (a) only if such medicine or drug is a prescribed drug or is insulin.

(c) SPECIAL RULE FOR DECEDENTS.—

(1) TREATMENT OF EXPENSES PAID AFTER DEATH.—For purposes of subsection (a), expenses for the medical care of the taxpayer which are paid out of his estate during the 1-year period beginning with the day after the date of his death shall be treated as paid by the taxpayer at the time incurred.

(2) LIMITATION.—Paragraph (1) shall not apply if the amount paid is allowable under section 2053 as a deduction in computing the taxable estate of the decedent, but this paragraph shall not apply if (within the time and in the manner and form prescribed by the Secretary) there is filed—

(A) a statement that such amount has not been allowed as a deduction under section 2053, and

(B) a waiver of the right to have such amount allowed at any time as a deduction under section 2053.

(d) DEFINITIONS.—For purposes of this section—

(1) The term "medical care" means amounts paid—

(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

(B) for transportation primarily for and essential to medical care referred to in subparagraph (A),

(C) for qualified long-term care services (as defined in section 7702B(c)), **[**or**]**

(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B) or for any qualified long- term care insurance contract (as defined in section 7702B(b))**[**.**]***, or*

In the case of a qualified long-term care insurance contract (as defined in section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).

(E) for qualified sports and fitness expenses.

(2) Amounts paid for certain lodging away from home treated as paid for medical care

Amounts paid for lodging (not lavish or extravagant under the circumstances) while away from home primarily for and essential to medical care referred to in paragraph (1)(A) shall be treated as amounts paid for medical care if—

(A) the medical care referred to in paragraph (1)(A) is provided by a physician in a licensed hospital (or in a medical care facility which is related to, or the equivalent of, a licensed hospital), and

(B) there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

The amount taken into account under the preceding sentence shall not exceed $50 for each night for each individual.

(3) Prescribed drug

The term "prescribed drug" means a drug or biological which requires a prescription of a physician for its use by an individual.

(4) Physician

The term "physician" has the meaning given to such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

(5) Special rule in the case of child of divorced parents, etc.

Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this section.

(6) In the case of an insurance contract under which amounts are payable for other than medical care referred to in subparagraphs (A), (B), and (C) of paragraph (1)—

(A) no amount shall be treated as paid for insurance to which paragraph (1)(D) applies unless the charge for such insurance is either separately stated in the contract, or furnished to the policyholder by the insurance company in a separate statement,

(B) the amount taken into account as the amount paid for such insurance shall not exceed such charge, and

(C) no amount shall be treated as paid for such insurance if the amount specified in the contract (or furnished to the policyholder by the insurance company in a separate statement) as the charge for such insurance is unreasonably large in relation to the total charges under the contract.

(7) Subject to the limitations of paragraph (6), premiums paid during the taxable year by a taxpayer before he attains the age of 65 for insurance covering medical care (within the meaning of subparagraphs (A), (B), and (C) of paragraph (1)) for the taxpayer, his spouse, or a dependent after the taxpayer attains the age of 65 shall be treated as expenses paid during the taxable year for insurance which constitutes medical care if premiums for such insurance are payable (on a level payment basis) under the contract for a period of 10 years or more or until the year in which the taxpayer attains the age of 65 (but in no case for a period of less than 5 years).

(8) The determination of whether an individual is married at any time during the taxable year shall be made in accordance with the provisions of section 6013(d) (relating to determination of status as husband and wife).

(9) COSMETIC SURGERY.—

(A) IN GENERAL.—The term "medical care" does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

(B) COSMETIC SURGERY DEFINED.—For purposes of this paragraph, the term "cosmetic surgery" means any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

(10) ELIGIBLE LONG-TERM CARE PREMIUMS.—

(A) IN GENERAL.—For purposes of this section, the term "eligible long-term care Premiums" means the amount paid during a taxable year for any qualified long-term care insurance contract (as defined in section 7702B(b)) covering an individual, to the extent such amount does not exceed the limitation determined under the following table:

In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	2,000
More than 70	2,500.

(B) INDEXING.—

(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1997, each dollar amount contained in subparagraph (A) shall be increased by the medical care cost adjustment of such amount for such calendar year. If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the nearest multiple of $10.

(ii) MEDICAL CARE COST ADJUSTMENT.—For purposes of clause (i), the medical care cost adjustment for any calendar year is the percentage (if any) by which—

(I) the medical care component of the C-CPI-U (as defined in section 1(f)(6)) for August of the preceding calendar year, exceeds

(II) such component of the CPI (as defined in section 1(f)(4)) for August of 1996, multiplied by the amount determined under section 1(f)(3)(B).

The Secretary shall, in consultation with the Secretary of Health and Human Services, prescribe an adjustment which the Secretary determines is more appropriate for purposes of this paragraph than the adjustment described in the preceding sentence, and the adjustment so prescribed shall apply in lieu of the adjustment described in the preceding sentence.

(11) Certain payments to relatives treated as not paid for medical care --An amount paid for a qualified long-term care service (as defined in section 7702B(c)) provided to an individual shall be treated as not paid for medical care if such service is provided—

(A) by the spouse of the individual or by a relative (directly or through a partnership, corporation, or other entity) unless the service is provided by a licensed professional with respect to such service, or

(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term "relative" means an individual bearing a relationship to the individual which is described in any of subparagraphs (A) through (G) of section 152(d)(2). This paragraph shall not apply for purposes of section 105(b) with respect to reimbursements through insurance.

(12) QUALIFIED SPORTS AND FITNESS EXPENSES.—

(A) IN GENERAL.—The term "qualified sports and fitness expenses" means amounts paid for—

(i) membership at a fitness facility,

(ii) participation or instruction in a program of qualified physical activity, or

(iii) safety equipment for use in a program (including a self-directed program) of qualified physical activity.

(B) LIMITATIONS.—

(i) OVERALL DOLLAR LIMITATION.—The aggregate amount treated as qualified sports and fitness expenses with respect to any taxpayer for any taxable year shall not exceed $500 (twice such amount in the case of a joint return or a head of household (as defined in section 2(b))).

(ii) DOLLAR LIMITATION ON SAFETY EQUIPMENT.—The amount treated as qualified sports and fitness expenses with respect to any item of safety equipment described in subparagraph (A)(iii) shall not exceed $250.

(iii) EXCLUSION OF EXERCISE VIDEOS, ETC.—Qualified sports and fitness expenses shall not include videos, books, or similar materials.

(C) QUALIFIED PHYSICAL ACTIVITY.—For purposes of this paragraph—

(i) IN GENERAL.—Except as provided in clause (ii), the term "qualified physical activity" means any physical exercise or physical activity.

(ii) EXCLUSIONS.—The Secretary, after consultation with the Secretary of Health and Human Services, shall issue guidance to determine for purposes of this paragraph what does not constitute a qualified physical activity, including golf, hunting, sailing, horseback riding, and other similar activities.

(D) FITNESS FACILITY DEFINED.—For purposes of subparagraph (A)(i), the term "fitness facility" means a facility—

(i) providing instruction in a program of qualified physical activity or facilities for qualified physical activity,

(ii) which is not a private club owned and operated by its members,

(iii) whose health or fitness facility is not incidental to its overall function and purpose, and

(iv) which is fully compliant with applicable State and Federal anti-discrimination laws.

(E) PROGRAMS WHICH INCLUDE COMPONENTS OTHER QUALIFIED PHYSICAL ACTIVITY.—Rules similar to the rules of paragraph (6) shall apply in the case of any program or facility that includes qualified physical activity (or facilities therefore) and also other components. For purposes of the preceding sentence, travel and accommodations shall be treated as an other component.

(F) INFLATION ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2019, the $500 amount in subparagraph (B)(i) and the $250 amount in subparagraph (B)(ii) shall each be increased by an amount equal to—

(i) such dollar amount, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins, determined by substituting "calendar year 2018" for "calendar year 2016" in subparagraph (A)(ii) thereof.

If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

(e) EXCLUSION OF AMOUNTS ALLOWED FOR CARE OF CERTAIN DEPENDENTS.—Any expense allowed as a credit under section 21 shall not be treated as an expense paid for medical care.

(f) SPECIAL RULES FOR 2013 THROUGH 2018.—In the case of any taxable year—

(1) beginning after December 31, 2012, and ending before January 1, 2017, in the case of a taxpayer if such taxpayer or such taxpayer's spouse has attained age 65 before the close of such taxable year, and

(2) beginning after December 31, 2016, and ending before January 1, 2019, in the case of any taxpayer,

subsection (a) shall be applied with respect to a taxpayer by substituting "7.5 percent" for "10 percent".

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SEC. 220. ARCHER MSAS.

(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 such individual to an Archer MSA 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 the amount equal to 1/12 of—

(A) in the case of an individual who has self-only coverage under the high deductible health plan as of the first day of such month, 65 percent of the annual deductible under such coverage, and

(B) in the case of an individual who has family coverage under the high deductible health plan as of the first day of such month, 75 percent of the annual deductible under such coverage.

(3) 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) of this paragraph) shall be divided equally between them unless they agree on a different division.

(4) DEDUCTION NOT TO EXCEED COMPENSATION.—

(A) EMPLOYEES.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (I) of subsection (c)(1)(A)(iii) shall not exceed such individual's wages, salaries, tips, and other employee compensation which are attributable to such individual's employment by the employer referred to in such subclause.

(B) SELF-EMPLOYED INDIVIDUALS.—The deduction allowed under subsection (a) for contributions as an eligible individual described in subclause (II) of subsection (c)(1)(A)(iii) shall not exceed such individual's earned income (as defined in section 401(c)(1)) derived by the taxpayer from the trade or business with respect to which the high deductible health plan is established.

(C) COMMUNITY PROPERTY LAWS NOT TO APPLY.—The limitations under this paragraph shall be determined without regard to community property laws.

(5) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—No deduction shall be allowed under this section for any amount paid for any taxable year to an Archer MSA of an individual if—

(A) any amount is contributed to any Archer MSA of such individual for such year which is excludable from gross income under section 106(b), or

(B) if such individual's spouse is covered under the high deductible health plan covering such individual, any amount is contributed for such year to any Archer MSA of such spouse which is so excludable.

(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.

(c) DEFINITIONS.—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,

(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, and

(iii)(I) the high deductible health plan covering such individual is established and maintained by the employer of such individual or of the spouse of such individual and such employer is a small employer, or

(II) such individual is an employee (within the meaning of section 401(c)(1)) or the spouse of such an employee and the high deductible health plan covering such individual is not established or maintained by any employer of such individual or spouse.

(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

(i) coverage for any benefit provided by permitted insurance, and

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(C) CONTINUED ELIGIBILITY OF EMPLOYEE AND SPOUSE ESTABLISHING ARCHER MSAS.—If, while an employer is a small employer—

(i) any amount is contributed to an Archer MSA of an individual who is an employee of such employer or the spouse of such an employee, and

(ii) such amount is excludable from gross income under section 106(b) or allowable as a deduction under this section,

such individual shall not cease to meet the requirement of subparagraph (A)(iii)(I) by reason of such employer ceasing to be a small employer so long as such employee continues to be an employee of such employer.

(D) LIMITATIONS ON ELIGIBILITY.—For limitations on number of taxpayers who are eligible to have Archer MSAs, see subsection (i).

(2) HIGH DEDUCTIBLE HEALTH PLAN.—

(A) IN GENERAL.—The term "high deductible health plan" means a health plan—

(i) in the case of self-only coverage, which has an annual deductible which is not less than $1,500 and not more than $2,250,

(ii) in the case of family coverage, which has an annual deductible which is not less than $3,000 and not more than $4,500, and

(iii) the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

(I) $3,000 for self-only coverage, and

(II) $5,500 for family coverage.

(B) SPECIAL RULES.—

(i) 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).

(ii) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—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 if the absence of a deductible for such care is required by State law.

(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) SMALL EMPLOYER.—

(A) IN GENERAL.—The term "small employer" means, with respect to any calendar year, any employer if such employer employed an average of 50 or fewer employees on business days during either of the 2 preceding calendar years. For purposes of the preceding sentence, a preceding calendar year may be taken into account only if the employer was in existence throughout such year.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the 1st preceding calendar year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) CERTAIN GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—The term "small employer" includes, with respect to any calendar year, any employer if—

(i) such employer met the requirement of subparagraph (A) (determined without regard to subparagraph (B)) for any preceding calendar year after 1996,

(ii) any amount was contributed to the Archer MSA of any employee of such employer with respect to coverage of such employee under a high deductible health plan of such employer during such preceding calendar year and such amount was excludable from gross income under section 106(b) or allowable as a deduction under this section, and

(iii) such employer employed an average of 200 or fewer employees on business days during each preceding calendar year after 1996.

(D) SPECIAL RULES.—

(i) CONTROLLED GROUPS.—For purposes of this paragraph, all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as 1 employer.

(ii) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

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

(d) ARCHER MSA.—For purposes of this section—

(1) ARCHER MSA.—The term "Archer MSA" means a trust created or organized in the United States as a medical savings account exclusively for the purpose of paying the qualified medical expenses of the account holder, 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), 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 75 percent of the highest annual limit deductible permitted under subsection (c)(2)(A)(ii) for such calendar year.

(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 holder, amounts paid by such holder 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.⟧ *For purposes of this subparagraph, amounts paid for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as paid for medical care.*

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—

(i) IN GENERAL.—Subparagraph (A) shall not apply to any payment for insurance.

(ii) EXCEPTIONS.—Clause (i) 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)), or

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

(C) MEDICAL EXPENSES OF INDIVIDUALS WHO ARE NOT ELIGIBLE INDIVIDUALS.—Subparagraph (A) shall apply to an amount paid by an account holder for medical care of an individual who is not described in clauses (i) and (ii) of subsection (c)(1)(A)for the month in which the expense for such care is incurred only if no amount is contributed (other than a rollover contribution) to any Archer MSA of such account holder for the taxable year which includes such month. This subparagraph shall not apply to any expense for coverage described in subclause (I) or (III) of subparagraph (B)(ii).

(3) ACCOUNT HOLDER.—The term "account holder" means the individual on whose behalf the Archer MSA 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(b), 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.—An Archer MSA is exempt from taxation under this subtitle unless such account has ceased to be an Archer MSA. 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 Archer MSAs, 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 an Archer MSA which is used exclusively to pay qualified medical expenses of any account holder shall not be includible in gross income.

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

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

(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any Archer MSA of an individual, paragraph (2) shall not apply to distributions from the Archer MSAs 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) which is neither excludable from gross income under section 106(b) 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 holder for any taxable year in which there is a payment or distribution from an Archer MSA of such holder

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 holder 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 holder 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 an Archer MSA to the account holder to the extent the amount received is paid into an Archer MSA or a health savings account (as defined in section 223(d)) for the benefit of such holder not later than the 60th day after the day on which the holder receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from an Archer MSA 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 an Archer MSA 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 an Archer MSA 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 an Archer MSA 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 an Archer MSA with respect to which such spouse is the account holder.

(8) TREATMENT AFTER DEATH OF ACCOUNT HOLDER.—

(A) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—If the account holder's surviving spouse acquires such holder's interest in an Archer MSA by reason of being the designated beneficiary of such account at the death of the account holder, such Archer MSA shall be treated as if the spouse were the account holder.

(B) OTHER CASES.—

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

(I) such account shall cease to be an Archer MSA 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 holder, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such holder, in such holder's gross income for the last taxable year of such holder.

(ii) SPECIAL RULES.—

(I) REDUCTION OF INCLUSION FOR PRE-DEATH 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.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

(1) such dollar amount, multiplied by

(2) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting "calendar year 1997" for "calendar year 2016" in subparagraph (A)(ii) thereof.

If any increase under the preceding sentence is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

(h) REPORTS.—The Secretary may require the trustee of an Archer MSA to make such reports regarding such account to the Secretary and to the account holder with respect to contributions, distributions, and such other matters 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.

(i) LIMITATION ON NUMBER OF TAXPAYERS HAVING ARCHER MSAS.—

(1) IN GENERAL.—Except as provided in paragraph (5), no individual shall be treated as an eligible individual for any taxable year beginning after the cut-off year unless—

(A) such individual was an active MSA participant for any taxable year ending on or before the close of the cut-off year, or

(B) such individual first became an active MSA participant for a taxable year ending after the cut-off year by reason of coverage under a high deductible health plan of an MSA-participating employer.

(2) CUT-OFF YEAR.—For purposes of paragraph (1), the term "cut-off year" means the earlier of—

(A) calendar year 2007, or

(B) the first calendar year before 2007 for which the Secretary determines under subsection (j) that the numerical limitation for such year has been exceeded.

(3) ACTIVE MSA PARTICIPANT.—For purposes of this subsection—

(A) IN GENERAL.—The term "active MSA participant" means, with respect to any taxable year, any individual who is the account holder of any Archer MSA into which any contribution was made which was excludable from gross income under section 106(b), or allowable as a deduction under this section, for such taxable year.

(B) SPECIAL RULE FOR CUT-OFF YEARS BEFORE 2007.—In the case of a cut-off year before 2007—

(i) an individual shall not be treated as an eligible individual for any month of such year or an active MSA participant under paragraph (1)(A) unless such individual is, on or before the cut-off date, covered under a high deductible health plan, and

(ii) an employer shall not be treated as an MSA-participating employer unless the employer, on or before the cut-off date, offered coverage under a high deductible health plan to any employee.

(C) CUT-OFF DATE.—For purposes of subparagraph (B)—

(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the cut-off date is October 1 of the cut-off year.

(ii) EMPLOYEES WITH ENROLLMENT PERIODS AFTER OCTOBER 1.—In the case of an individual described in subclause (I) of subsection (c)(1)(A)(iii), if the regularly scheduled enrollment period for health plans of the individual's employer occurs during the last 3 months of the cut-off year, the cut-off date is December 31 of the cut-off year.

(iii) SELF-EMPLOYED INDIVIDUALS.—In the case of an individual described in subclause (II) of subsection (c)(1)(A)(iii), the cut-off date is November 1 of the cut-off year.

(iv) SPECIAL RULES FOR 1997.—If 1997 is a cut-off year by reason of subsection (j)(1)(A)—

(I) each of the cut-off dates under clauses (i) and (iii) shall be 1 month earlier than the date determined without regard to this clause, and

(II) clause (ii) shall be applied by substituting "4 months" for "3 months".

(4) MSA-PARTICIPATING EMPLOYER.—For purposes of this subsection, the term "MSA-participating employer" means any small employer if—

(A) such employer made any contribution to the Archer MSA of any employee during the cut-off year or any preceding calendar year which was excludable from gross income under section 106(b), or

(B) at least 20 percent of the employees of such employer who are eligible individuals for any month of the cut-off year by reason of coverage under a high deductible health plan of such employer each made a contribution of at least $100 to their Archer MSAs

for any taxable year ending with or within the cut-off year which was allowable as a deduction under this section.

(5) ADDITIONAL ELIGIBILITY AFTER CUT-OFF YEAR.—If the Secretary determines under subsection (j)(2)(A) that the numerical limit for the calendar year following a cut-off year described in paragraph (2)(B) has not been exceeded—

(A) this subsection shall not apply to any otherwise eligible individual who is covered under a high deductible health plan during the first 6 months of the second calendar year following the cut-off year (and such individual shall be treated as an active MSA participant for purposes of this subsection if a contribution is made to any Archer MSA with respect to such coverage), and

(B) any employer who offers coverage under a high deductible health plan to any employee during such 6-month period shall be treated as an MSA-participating employer for purposes of this subsection if the requirements of paragraph (4) are met with respect to such coverage.

For purposes of this paragraph, subsection (j)(2)(A) shall be applied for 1998 by substituting "750,000" for "600,000".

(j) DETERMINATION OF WHETHER NUMERICAL LIMITS ARE EXCEEDED.—

(1) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1997.—The numerical limitation for 1997 is exceeded if, based on the reports required under paragraph (4), the number of Archer MSAs established as of—

(A) April 30, 1997, exceeds 375,000, or

(B) June 30, 1997, exceeds 525,000.

(2) DETERMINATION OF WHETHER LIMIT EXCEEDED FOR 1998, 1999, 2001, 2002, 2004, 2005, OR 2006.—

(A) IN GENERAL.—The numerical limitation for 1998, 1999, 2001, 2002, 2004, 2005, or 2006 is exceeded if the sum of—

(i) the number of MSA returns filed on or before April 15 of such calendar year for taxable years ending with or within the preceding calendar year, plus

(ii) the Secretary's estimate (determined on the basis of the returns described in clause (i)) of the number of MSA returns for such taxable years which will be filed after such date,

exceeds 750,000 (600,000 in the case of 1998). For purposes of the preceding sentence, the term "MSA return" means any return on which any exclusion is claimed under section 106(b) or any deduction is claimed under this section.

(B) ALTERNATIVE COMPUTATION OF LIMITATION.—The numerical limitation for 1998, 1999, 2001, 2002, 2004, 2005, or 2006 is also exceeded if the sum of—

(i) 90 percent of the sum determined under subparagraph (A) for such calendar year, plus

(ii) the product of 2.5 and the number of Archer MSAs established during the portion of such year preceding July 1 (based on the reports required under paragraph (4)) for taxable years beginning in such year,

exceeds 750,000.

(C) NO LIMITATION FOR 2000 OR 2003.—The numerical limitation shall not apply for 2000 or 2003.

(3) PREVIOUSLY UNINSURED INDIVIDUALS NOT INCLUDED IN DETERMINATION.—

(A) IN GENERAL.—The determination of whether any calendar year is a cut-off year shall be made by not counting the Archer MSA of any previously uninsured individual.

(B) PREVIOUSLY UNINSURED INDIVIDUAL.—For purposes of this subsection, the term "previously uninsured individual" means, with respect to any Archer MSA, any individual who had no health plan coverage (other than coverage referred to in subsection (c)(1)(B)) at any time during the 6-month period before the date such individual's coverage under the high deductible health plan commences.

(4) REPORTING BY MSA TRUSTEES.—

(A) IN GENERAL.—Not later than August 1 of 1997, 1998, 1999, 2001, 2002, 2004, 2005, and 2006, each person who is the trustee of an Archer MSA established before July 1 of such calendar year shall make a report to the Secretary (in such form and manner as the Secretary shall specify) which specifies—

(i) the number of Archer MSAs established before such July 1 (for taxable years beginning in such calendar year) of which such person is the trustee,

(ii) the name and TIN of the account holder of each such account, and

(iii) the number of such accounts which are accounts of previously uninsured individuals.

(B) ADDITIONAL REPORT FOR 1997.—Not later than June 1, 1997, each person who is the trustee of an Archer MSA established before May 1, 1997, shall make an additional report described in subparagraph (A) but only with respect to accounts established before May 1, 1997.

(C) PENALTY FOR FAILURE TO FILE REPORT.—The penalty provided in section 6693(a) shall apply to any report required by this paragraph, except that—

(i) such section shall be applied by substituting "$25" for "$50", and

(ii) the maximum penalty imposed on any trustee shall not exceed $5,000.

(D) AGGREGATION OF ACCOUNTS.—To the extent practicable, in determining the number of Archer MSAs on the basis of the reports under this paragraph, all Archer MSAs of an individual shall be treated as 1 account and all accounts of individuals who are married to each other shall be treated as 1 account.

(5) DATE OF MAKING DETERMINATIONS.—Any determination under this subsection that a calendar year is a cut-off year shall be made by the Secretary and shall be published not later than October 1 of such year.

* * * * * * *

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 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:

For taxable years beginning in:	The additional contribution amount is:
2004	$500
2005	$600
2006	$700
2007	$800
2008	$900
2009 and thereafter	$1,000.

(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))**[**.**]**, *and*

(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).

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.**]**

(iii) coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2) determined without regard to subparagraph (A)(ii) thereof) is made, if the terms of such arrangement which apply for such portion of the plan year are such that, if such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year, and

(iv) coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reimbursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual.

(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).

(D) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—

(i) IN GENERAL.—A direct primary care service arrangement shall not be treated as a health plan for purposes of subparagraph (A)(ii).

(ii) DIRECT PRIMARY CARE SERVICE ARRANGEMENT.—For purposes of this paragraph—

(I) IN GENERAL.—The term "direct primary care service arrangement" means, with respect to any individual, an arrangement under which such individual is provided medical care (as defined in section 213(d)) consisting solely of primary care services provided by primary care practitioners (as defined in section 1833(x)(2)(A) of the Social Security Act, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee.

(II) LIMITATION.—With respect to any individual for any month, such term shall not include any arrangement if the aggregate fees for all direct primary care service arrangements (determined without regard to this subclause) with respect to such individual for such month exceed $150 (twice such dollar amount in the case of an individual with any direct primary care service arrangement (as so determined) that covers more than one individual).

(iii) CERTAIN SERVICES SPECIFICALLY EXCLUDED FROM TREATMENT AS PRIMARY CARE SERVICES.—For purposes of this paragraph, the term "primary care services" shall not include—

(I) procedures that require the use of general anesthesia,

(II) prescription drugs (other than vaccines), and

(III) laboratory services not typically administered in an ambulatory primary care setting.

The Secretary, after consultation with the Secretary of Health and Human Services, shall issue regulations or other guidance regarding the application of this clause.

(E) SPECIAL RULE FOR QUALIFIED ITEMS AND SERVICES.—

(i) IN GENERAL.—An individual shall not be treated as covered under a health plan for purposes of subparagraph (A)(ii) merely because the individual, in connection with the employment of the individual or the individual's spouse, receives (or is eligible to receive) qualified items and services at—

(I) a healthcare facility located at a facility owned or leased by the employer of the individual (or of the individual's spouse), or operated primarily for the benefit of such employer's employees, or

(II) a healthcare facility located within a supermarket, pharmacy, or similar retail establishment.

(ii) QUALIFIED ITEMS AND SERVICES DEFINED.—For purposes of this subparagraph, the term "qualified items and services" means the following:

(I) Physical examinations.

(II) Immunizations, including injections of antigens provided by employees.

(III) Drugs other than a prescribed drug (as such term is defined in section 213(d)(3)).

(IV) Treatment for injuries occurring in the course of employment.

(V) Drug testing, if required as a condition of employment.

(VI) Hearing or vision screenings.

(VII) Other similar items and services that do not provide significant benefits in the nature of medical care.

(iii) AGGREGATION.—For purposes of clause (i)(I), all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

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

(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).

(E) FIRST DOLLAR COVERAGE FLEXIBILITY.—

(i) IN GENERAL.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for not more than $250 of specified services for self-only coverage (twice such amount in the case of family coverage) during a plan year.

(ii) SPECIFIED SERVICES.—For purposes of this subparagraph, the term "specified services" means, with respect to a plan, services other than preventive care (within the meaning of subparagraph (C)) identified under the terms of the plan as being services to which clause (i) applies.

(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.❳ *For purposes of this subparagraph, amounts paid for menstrual care products shall be treated as paid for medical care.*

(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)**[**.**]**, *or*

(v) any direct primary care service arrangement.

(D) MENSTRUAL CARE PRODUCT.—For purposes of this paragraph, the term "menstrual care product" means a tampon, pad, liner, cup, sponge, or similar product used by women with respect to menstruation or other genital-tract secretions.

(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 account 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), *(c)(1)(D)(ii)(II),* **[**and (c)(2)(A)**]**, *(c)(2)(A), and (c)(2)(E)* 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**]** *the taxable year (plan year in the case of the dollar amount*

in subsection (c)(2)(E)) begins determined by substituting for "calendar year 2016" in subparagraph (A)(ii) thereof—

(i) except as provided in ⟦clause (ii)⟧ *clauses (ii), (iii) and (iv)*, "calendar year 1997", ⟦and⟧

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

(iii) in the case of the dollar amount in subsection (c)(2)(E) for plan years beginning in calendar years after 2019, "calendar year 2018", and

(iv) in the case of the dollar amount in subsection (c)(1)(D)(ii)(II) for taxable years beginning in calendar years after 2019, "calendar year 2018".

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), *(c)(1)(D)(ii)(II),* ⟦and (c)(2)(A)⟧, *(c)(2)(A), and (c)(2)(E)* 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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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart C—Information Regarding Wages Paid Employees

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SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year,

within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

(1) the name of such person,

(2) the name of the employee (and an identifying number for the employee if wages as defined in section 3121(a) have been paid),

(3) the total amount of wages as defined in section 3401(a),

(4) the total amount deducted and withheld as tax under section 3402,

(5) the total amount of wages as defined in section 3121(a),

(6) the total amount deducted and withheld as tax under section 3101,

(8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),

(9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),

(10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned income as determined for purposes of section 32 (relating to earned income credit),

(11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,

(12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse *(other than any qualified HSA distribution, as defined in section 106(e)(2))*,

(13) the total amount of deferrals for the year under a nonqualified deferred compensation plan (within the meaning of section 409A(d)),

(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

(A) coverage to which paragraphs (11) and (12) apply, or

(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125),

(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee,

(16) the amount includible in gross income under subparagraph (A) of section 83(i)(1) with respect to an event described in subparagraph (B) of such section which occurs in such calendar year, **[**and**]**

(17) the aggregate amount of income which is being deferred pursuant to elections under section 83(i), determined as of the close of the calendar year**[**.**]**,

(18) in the case of a direct primary care service arrangement (as defined in section 223(c)(1)(D)(ii)) which is provided in connection with employment, the aggregate fees for such arrangement for such employee, and

(19) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if

any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) ADDITIONAL REQUIREMENTS.—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) STATEMENTS TO CONSTITUTE INFORMATION RETURNS.—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) RAILROAD EMPLOYEES.—

(1) ADDITIONAL REQUIREMENT.—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) INFORMATION TO BE SUPPLIED TO EMPLOYEES.—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.—

(1) STATEMENTS REQUIRED FROM PAYOR.—

(A) IN GENERAL.—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

(i) the name and, if there is withholding under section 3402(o), the social security number of such employee,

(ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and

(iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term "third-party sick pay" means any sick pay (as defined in section 3402(o)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(o)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

(A) the information shown on the statement furnished under paragraph (1)(A), and

(B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable. To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

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