

## COMPARATIVE PRINT

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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.

(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.

(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)).

(h) **CARRYFORWARD OF HEALTH FLEXIBLE SPENDING ARRANGEMENT ACCOUNT BALANCES.**—A plan shall not fail to be treated as a health flexible spending arrangement under this section or section 105 merely because the lesser of—

(1) such arrangement's account balance (or any portion thereof) determined as of the end of any plan year, or

(2) the product of the dollar limitation in effect under section 125(i) for such plan year (determined without regard to paragraph (2) thereof) multiplied by 3, may be carried forward to the succeeding plan year.

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**SEC. 125. CAFETERIA PLANS.**

(a) **GENERAL RULE.**—Except as provided in subsection (b), no amount shall be included in the gross income of a participant in a cafeteria plan solely because, under the plan, the participant may choose among the benefits of the plan.

(b) **EXCEPTION FOR HIGHLY COMPENSATED PARTICIPANTS AND KEY EMPLOYEES.**—

(1) **HIGHLY COMPENSATED PARTICIPANTS.**—In the case of a highly compensated participant, subsection (a) shall not apply to any benefit attributable to a plan year for which the plan discriminates in favor of—

(A) highly compensated individuals as to eligibility to participate, or

(B) highly compensated participants as to contributions and benefits.

(2) **KEY EMPLOYEES.**—In the case of a key employee (within the meaning of section 416(i)(1)), subsection (a) shall not apply to any benefit attributable to a plan for which the qualified benefits provided to key employees exceed 25 percent of the aggregate of such benefits provided for all employees under the plan. For purposes of the preceding sentence, qualified benefits shall be determined without regard to the second sentence of subsection (f).

(3) **YEAR OF INCLUSION.**—For purposes of determining the taxable year of inclusion, any benefit described in paragraph (1) or (2) shall be treated as received or accrued in the taxable year of the participant or key employee in which the plan year ends.

(c) **DISCRIMINATION AS TO BENEFITS OR CONTRIBUTIONS.**—For purposes of subparagraph (B) of subsection (b)(1), a cafeteria plan does not discriminate where qualified benefits and total benefits (or employer contributions allocable to qualified benefits and employer contributions for total benefits) do not discriminate in favor of highly compensated participants.

(d) **CAFETERIA PLAN DEFINED.**—For purposes of this section—

(1) **IN GENERAL.**—The term “cafeteria plan” means a written plan under which—

(A) all participants are employees, and

(B) the participants may choose among 2 or more benefits consisting of cash and qualified benefits.

(2) DEFERRED COMPENSATION PLANS EXCLUDED.—

(A) IN GENERAL.—The term “cafeteria plan” does not include any plan which provides for deferred compensation.

(B) EXCEPTION FOR CASH AND DEFERRED ARRANGEMENTS.—Subparagraph (A) shall not apply to a profit-sharing or stock bonus plan or rural cooperative plan (within the meaning of section 401(k)(7)) which includes a qualified cash or deferred arrangement (as defined in section 401(k)(2)) to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a trust under such plan on behalf of the employee.

(C) EXCEPTION FOR CERTAIN PLANS MAINTAINED BY EDUCATIONAL INSTITUTIONS.—Subparagraph (A) shall not apply to a plan maintained by an educational organization described in section 170(b)(1)(A)(ii) to the extent of amounts which a covered employee may elect to have the employer pay as contributions for post-retirement group life insurance if—

(i) all contributions for such insurance must be made before retirement, and

(ii) such life insurance does not have a cash surrender value at any time.

For purposes of section 79, any life insurance described in the preceding sentence shall be treated as group-term life insurance.

(D) EXCEPTION FOR HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) shall not apply to a plan to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a health savings account established on behalf of the employee.

(E) EXCEPTION FOR HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—Subparagraph (A) shall not apply to a plan to the extent of amounts in a health flexible spending arrangement which may be carried forward as described in section 106(h).

(e) HIGHLY COMPENSATED PARTICIPANT AND INDIVIDUAL DEFINED.—For purposes of this section—

(1) HIGHLY COMPENSATED PARTICIPANT.—The term “highly compensated participant” means a participant who is—

(A) an officer,

(B) a shareholder owning more than 5 percent of the voting power or value of all classes of stock of the employer,

(C) highly compensated, or

(D) a spouse or dependent (within the meaning of section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of an individual described in subparagraph (A), (B), or (C).

(2) HIGHLY COMPENSATED INDIVIDUAL.—The term “highly compensated individual” means an individual who is described in subparagraph (A), (B), (C), or (D) of paragraph (1).

(f) QUALIFIED BENEFITS DEFINED.—For purposes of this section—

(1) IN GENERAL.—The term “qualified benefit” means any benefit which, with the application of subsection (a), is not includible in the gross income of the employee by reason of an express provision of this chapter (other than section 106(b), 117, 127, or 132). Such term includes any group term life insurance which is includible in gross income only because it exceeds the dollar limitation of section 79 and such term includes any other benefit permitted under regulations.

(2) LONG-TERM CARE INSURANCE NOT QUALIFIED.—The term “qualified benefit” shall not include any product which is advertised, marketed, or offered as long-term care insurance.

(3) CERTAIN EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS NOT QUALIFIED.—

(A) IN GENERAL.—The term “qualified benefit” shall not include any qualified health plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act.

(B) EXCEPTION FOR EXCHANGE-ELIGIBLE EMPLOYERS.—Subparagraph (A) shall not apply with respect to any employee if such employee’s employer is a qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) offering the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market.

(g) SPECIAL RULES.—

(1) COLLECTIVELY BARGAINED PLAN NOT CONSIDERED DISCRIMINATORY.—For purposes of this section, a plan shall not be treated as discriminatory if the plan is maintained under an

agreement which the Secretary finds to be a collective bargaining agreement between employee representatives and one or more employers.

(2) HEALTH BENEFITS.—For purposes of subparagraph (B) of subsection (b)(1), a cafeteria plan which provides health benefits shall not be treated as discriminatory if—

(A) contributions under the plan on behalf of each participant include an amount which—

(i) equals 100 percent of the cost of the health benefit coverage under the plan of the majority of the highly compensated participants similarly situated, or

(ii) equals or exceeds 75 percent of the cost of the health benefit coverage of the participant (similarly situated) having the highest cost health benefit coverage under the plan, and

(B) contributions or benefits under the plan in excess of those described in subparagraph (A) bear a uniform relationship to compensation.

(3) CERTAIN PARTICIPATION ELIGIBILITY RULES NOT TREATED AS DISCRIMINATORY.—For purposes of subparagraph (A) of subsection (b)(1), a classification shall not be treated as discriminatory if the plan—

(A) benefits a group of employees described in section 410(b)(2)(A)(i), and

(B) meets the requirements of clauses (i) and (ii):

(i) No employee is required to complete more than 3 years of employment with the employer or employers maintaining the plan as a condition of participation in the plan, and the employment requirement for each employee is the same.

(ii) Any employee who has satisfied the employment requirement of clause (i) and who is otherwise entitled to participate in the plan commences participation no later than the first day of the first plan year beginning after the date the employment requirement was satisfied unless the employee was separated from service before the first day of that plan year.

(4) CERTAIN CONTROLLED GROUPS, ETC.—All employees who are treated as employed by a single employer under subsection (b), (c), or (m) of section 414 shall be treated as employed by a single employer for purposes of this section.

(h) SPECIAL RULE FOR UNUSED BENEFITS IN HEALTH FLEXIBLE SPENDING ARRANGEMENTS OF INDIVIDUALS CALLED TO ACTIVE DUTY.—

(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan or health flexible spending arrangement (and shall not fail to be treated as an accident or health plan) merely because such arrangement provides for qualified reservist distributions.

(2) QUALIFIED RESERVIST DISTRIBUTION.—For purposes of this subsection, the term “qualified reservist distribution” means any distribution to an individual of all or a portion of the balance in the employee’s account under such arrangement if—

(A) such individual was (by reason of being a member of a reserve component (as defined in section 101 of title 37, United States Code)) ordered or called to active duty for a period in excess of 179 days or for an indefinite period, and

(B) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could otherwise be made under such arrangement for the plan year which includes the date of such order or call.

(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any [taxable year] *plan year* to have salary reduction contributions in excess of \$2,500 made to such arrangement.

(2) COORDINATION WITH CARRYFORWARD OF ACCOUNT BALANCES.—*The dollar amount otherwise in effect under paragraph (1) for any plan year shall be reduced (but not below zero) by the excess (if any) of—*

(A) *the amount of any account balance which is carried forward to such plan year from the preceding plan year, over*

(B) *twice the dollar limitation in effect under paragraph (1) (determined without regard to this paragraph).*

**[(2)] (3) ADJUSTMENT FOR INFLATION.**—In the case of any **[taxable year]** *plan year* beginning after December 31, 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

(A) such amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such **[taxable year]** *plan year* begins by substituting “calendar year 2012” for “calendar year 2016” in subparagraph (A)(ii) thereof.

If any increase determined under this paragraph is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(j) **SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.**—

(1) **IN GENERAL.**—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.

(2) **SIMPLE CAFETERIA PLAN.**—For purposes of this subsection, the term “simple cafeteria plan” means a cafeteria plan—

(A) which is established and maintained by an eligible employer, and

(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

(3) **CONTRIBUTION REQUIREMENTS.**—

(A) **IN GENERAL.**—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

(i) a uniform percentage (not less than 2 percent) of the employee’s compensation for the plan year, or

(ii) an amount which is not less than the lesser of—

(I) 6 percent of the employee’s compensation for the plan year, or

(II) twice the amount of the salary reduction contributions of each qualified employee.

(B) **MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.**—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

(C) **ADDITIONAL CONTRIBUTIONS.**—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

(D) **DEFINITIONS.**—For purposes of this paragraph—

(i) **SALARY REDUCTION CONTRIBUTION.**—The term “salary reduction contribution” means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

(ii) **QUALIFIED EMPLOYEE.**—The term “qualified employee” means, with respect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

(iii) **HIGHLY COMPENSATED EMPLOYEE.**—The term “highly compensated employee” has the meaning given such term by section 414(q).

(iv) **KEY EMPLOYEE.**—The term “key employee” has the meaning given such term by section 416(i).

(4) **MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.**—

(A) **IN GENERAL.**—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

(B) **CERTAIN EMPLOYEES MAY BE EXCLUDED.**—For purposes of subparagraph (A)(i), an employer may elect to exclude under the plan employees—

- (i) who have not attained the age of 21 before the close of a plan year,
- (ii) who have less than 1 year of service with the employer as of any day during the plan year,
- (iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or
- (iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

(A) IN GENERAL.—The term “eligible employer” means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding 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 year.

(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

(i) IN GENERAL.—If—

(I) an employer was an eligible employer for any year (a “qualified year”), and

(II) such employer establishes a simple cafeteria plan for its employees for such year,

then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

(D) SPECIAL RULES.—

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

(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term “applicable nondiscrimination requirement” means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).

(7) COMPENSATION.—The term “compensation” has the meaning given such term by section 414(s).

(k) CROSS REFERENCE.—For reporting and recordkeeping requirements, see section 6039D.

(l) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

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**PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS**

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**SEC. 223. HEALTH SAVINGS ACCOUNTS.**

(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by or on behalf of such individual to a health savings account of such individual.

(b) LIMITATIONS.—

(1) **IN GENERAL.**—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

(2) **MONTHLY LIMITATION.**—The monthly limitation for any month is  $\frac{1}{12}$  of—

(A) in the case of an eligible individual who has self- only coverage under a high deductible health plan as of the first day of such month, **[\$2,250]** *the amount in effect under subsection (c)(2)(A)(i)(I).*

(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]** *the amount in effect under subsection (c)(2)(A)(i)(II).*

(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)).

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.]

**(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.**—

(A) **IN GENERAL.**—*In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—*

*(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),*



(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.

(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 (other than an entitlement to benefits described in subsection (c)(1)(B)(v)) 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~~[\.]~~, *and*
  - (iv) *entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act by reason of section 226(a) of such Act.*

(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR CERTAIN VETERANS BENEFITS.—An individual shall not fail to be treated as an eligible individual for any period merely because the individual receives hospital care or medical services under any law administered by the Secretary of Veterans Affairs for a service-connected disability (within the meaning of section 101(16) of title 38, United States Code).

(2) HIGH DEDUCTIBLE HEALTH PLAN.—

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

- (i) which has an annual deductible which is not less than—
  - (I) \$1,000 for self-only coverage, and
  - (II) twice the dollar amount in subclause (I) for family coverage, and
- (ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—
  - (I) \$5,000 for self-only coverage, and
  - (II) twice the dollar amount in subclause (I) for family coverage.

(B) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—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) BRONZE AND CATASTROPHIC PLANS TREATED AS HIGH DEDUCTIBLE HEALTH PLANS.—

(i) IN GENERAL.—*The term “high deductible health plan” shall include any plan described in subsection (d)(1)(A) or (e) of section 1302 of the Patient Protection and Affordable Care Act.*

(ii) CERTAIN RULES NOT APPLICABLE.—*Subparagraphs (C) and (D) shall not apply with respect to any plan described in clause (i).*

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

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

- (i) liabilities incurred under workers’ compensation laws,
- (ii) tort liabilities,
- (iii) liabilities relating to ownership or use of property, or
- (iv) such other similar liabilities as the Secretary may specify by regulations,

- (B) insurance for a specified disease or illness, and  
(C) insurance paying a fixed amount per day (or other period) of hospitalization.
- (4) FAMILY COVERAGE.—The term “family coverage” means any coverage other than self-only coverage.
- (5) ARCHER MSA.—The term “Archer MSA” has the meaning given such term in section 220(d).
- (d) HEALTH SAVINGS ACCOUNT.—For purposes of this section—
- (1) IN GENERAL.—The term “health savings account” means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:
- (A) Except in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5), no contribution will be accepted—
- (i) unless it is in cash, or
- (ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—
- (I) the dollar amount in effect under subsection (b)(2)(B), and
- (II) the dollar amount in effect under subsection (b)(3)(B).
- (B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.
- (C) No part of the trust assets will be invested in life insurance contracts.
- (D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.
- (E) The interest of an individual in the balance in his account is nonforfeitable.
- (2) QUALIFIED MEDICAL EXPENSES.—
- (A) IN GENERAL.—The term “qualified medical expenses” means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise. Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.
- (B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A) shall not apply to any payment for insurance.
- (C) EXCEPTIONS.—Subparagraph (B) shall not apply to any expense for coverage under—
- (i) a health plan during any period of continuation coverage required under any Federal law,
- (ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),
- (iii) a health plan during a period in which the individual is receiving unemployment compensation under any Federal or State law, or
- (iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act, any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act).
- (D) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—*If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.*
- (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) and] *subsection (c)(2)(A)* shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins [determined by substituting for “calendar year 2016” in subparagraph (A)(ii) thereof—] *determined by substituting “calendar year 2003” for “calendar year 2016” in subparagraph (A)(ii) thereof.*

[(i) except as provided in clause (ii), “calendar year 1997”, and

[(ii) in the case of each dollar amount in subsection (c)(2)(A), “calendar year 2003”.]

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

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

(h) **REPORTS.**—The Secretary may require—

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

(2) any person who provides an individual with a high deductible health plan to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.  
The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

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**PATIENT PROTECTION AND AFFORDABLE CARE ACT**

\* \* \* \* \*

**TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS**

\* \* \* \* \*

**Subtitle D—Available Coverage Choices for All Americans**

**PART 1—ESTABLISHMENT OF QUALIFIED HEALTH PLANS**

\* \* \* \* \*

**SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.**

(a) **ESSENTIAL HEALTH BENEFITS PACKAGE.**—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

- (1) provides for the essential health benefits defined by the Secretary under subsection (b);
- (2) limits cost-sharing for such coverage in accordance with subsection (c); and
- (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) **ESSENTIAL HEALTH BENEFITS.**—

(1) **IN GENERAL.**—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.

(2) **LIMITATION.**—

(A) **IN GENERAL.**—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) **CERTIFICATION.**—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(3) COST-SHARING.—In this title—

(A) IN GENERAL.—The term “cost-sharing” includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—

(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) EMPLOYER CONTRIBUTIONS.—The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any [plan year if—]



[(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

[(B) the plan provides—] *plan year if the plan provides—*

[(i)] (A) except as provided in [clause (ii)] *subparagraph (B)*, the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

[(ii)] (B) coverage for at least three primary care visits.

[(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

[(A) has not attained the age of 30 before the beginning of the plan year; or

[(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

[(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

[(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

[(3)] (2) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

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## PART 2—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

\* \* \* \* \*

### SEC. 1312. CONSUMER CHOICE.

(a) CHOICE.—

(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

(2) QUALIFIED EMPLOYERS.—

(A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) SINGLE RISK POOL.—

(1) INDIVIDUAL MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange *and enrollees in catastrophic plans described in section 1302(e)*, to be members of a single risk pool.

(2) **SMALL GROUP MARKET.**—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) **MERGER OF MARKETS.**—A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) **STATE LAW.**—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) **EMPOWERING CONSUMER CHOICE.**—

(1) **CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.**—Nothing in this title shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) **CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.**—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) **VOLUNTARY NATURE OF AN EXCHANGE.**—

(A) **CHOICE TO ENROLL OR NOT TO ENROLL.**—Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) **PROHIBITION AGAINST COMPELLED ENROLLMENT.**—Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) **INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.**—A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) **MEMBERS OF CONGRESS IN THE EXCHANGE.**—

(i) **REQUIREMENT.**—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) **DEFINITIONS.**—In this section:

(I) **MEMBER OF CONGRESS.**—The term “Member of Congress” means any member of the House of Representatives or the Senate.

(II) **CONGRESSIONAL STAFF.**—The term “congressional staff” means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) **NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.**—An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) **ENROLLMENT THROUGH AGENTS OR BROKERS.**—The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals and employers in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

(f) **QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.**—

(1) **QUALIFIED INDIVIDUALS.**—In this title:

(A) **IN GENERAL.**—The term “qualified individual” means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange.

(B) **INCARCERATED INDIVIDUALS EXCLUDED.**—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) **QUALIFIED EMPLOYER.**—In this title:

(A) **IN GENERAL.**—The term “qualified employer” means a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) **EXTENSION TO LARGE GROUPS.**—

(i) **IN GENERAL.**—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) **LARGE EMPLOYERS ELIGIBLE.**—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term “qualified employer” shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) **ACCESS LIMITED TO LAWFUL RESIDENTS.**—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

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## **TITLE IX—REVENUE PROVISIONS**

### **Subtitle A—Revenue Offset Provisions**

\* \* \* \* \*

#### **SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.**

(a) **IMPOSITION OF FEE.**—

(1) **IN GENERAL.**—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2013 a fee in an amount determined under subsection (b).

(2) **ANNUAL PAYMENT DATE.**—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) **DETERMINATION OF FEE AMOUNT.**—

(1) **IN GENERAL.**—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

(2) **AMOUNTS TAKEN INTO ACCOUNT.**—For purposes of paragraph (1)—

(A) **IN GENERAL.**—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

Not more than \$25,000,000 .....	0 percent
More than \$25,000,000 but not more than \$50,000,000 .....	50 percent
More than \$50,000,000 .....	100 percent.

(B) PARTIAL EXCLUSION FOR CERTAIN EXEMPT ACTIVITIES.—After the application of subparagraph (A), only 50 percent of the remaining net premiums written with respect to health insurance for any United States health risk that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513 of the Internal Revenue Code of 1986) of any covered entity qualifying under paragraph (3), (4), (26), or (29) of section 501(c) of such Code and exempt from tax under section 501(a) of such Code shall be taken into account.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks,

(B) any governmental entity,

(C) any entity—

(i) which is incorporated as a nonprofit corporation under a State law,

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and

(iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act, and

(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

If any entity described in subparagraph (C) or (D) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section.

(4) JOINT AND SEVERAL LIABILITY.—If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (3), all such persons shall be jointly and severally liable for payment of such fee.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term “United States health risk” means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.  
(e) APPLICABLE AMOUNT.—For purposes of subsection (b)(1)—

(1) YEARS BEFORE 2019.—In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

<b>Calendar year</b>	<b>Applicable amount</b>
2014 .....	\$8,000,000,000
2015 .....	\$11,300,000,000
2016 .....	\$11,300,000,000
2017 .....	\$13,900,000,000
2018 .....	\$14,300,000,000.

(2) YEARS AFTER 2018.—In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written with respect to health insurance for any United States health risk for such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

(i) \$10,000, plus

(ii) the lesser of—

(I) an amount equal to \$1,000, multiplied by the number of days during which such failure continues, or

(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(3) ACCURACY-RELATED PENALTY.—

(A) IN GENERAL.—In the case of any understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year, there shall be paid by the covered entity making such understatement, an amount equal to the excess of—

(i) the amount of the covered entity's fee under this section for the calendar year the Secretary determines should have been paid in the absence of any such understatement, over

(ii) the amount of such fee the Secretary determined based on such understatement.

(B) UNDERSTATEMENT.—For purposes of this paragraph, an understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year is the difference between the amount of such net pre-

miums written as reported on the return filed by the covered entity under paragraph (1) and the amount of such net premiums written that should have been reported on such return.

(C) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A) shall be subject to the provisions of subtitle F of the Internal Revenue Code of 1986 that apply to assessable penalties imposed under chapter 68 of such Code.

(4) TREATMENT OF INFORMATION.—Section 6103 of the Internal Revenue Code of 1986 shall not apply to any information reported under this subsection.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term “Secretary” means the Secretary of the Treasury or the Secretary’s delegate.

(2) UNITED STATES.—The term “United States” means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—The term “health insurance” shall not include—

(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

(B) any insurance for long-term care, or

(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2).

(j) EFFECTIVE DATE.—This section shall apply to calendar years—

(1) beginning after December 31, 2013, and ending before January 1, 2017,

(2) beginning after December 31, 2017, and ending before January 1, 2019, and

(3) beginning after **[December 31, 2019]** *December 31, 2021*.

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