The Family and Retirement Health Investment Act of 2013

United States Senator Orrin Hatch & Congressman Erik Paulsen

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

TITLE I – PROVISIONS RELATING TO TAX-PREFERED HEALTH ACCOUNTS

Section 101 — Allow spouses to make catch-up contributions to same HSA account

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

Section 102 — Provisions relating to Medicare

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

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

(2) Medicare enrollees may contribute their own money to their Medicare Medical Savings Accounts (MSAs)

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

Section 102(b) allows Medicare beneficiaries participating in a Medicare MSA plan to contribute their own tax-deductible money to their MSAs to cover the annual shortfall.

Section 103 — Individuals eligible for veterans' benefits for a service-connected disability

Current law prohibits veterans from contributing to their HSAs if they have utilized VA medical services in the past three months. The bill would remove those restrictions and allow veterans with a service-connected disability to contribute to their HSAs regardless of utilization of VA medical services.

Section 104 — Individuals eligible for Indian Health Service assistance

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

Section 105 — Individuals eligible for TRICARE coverage

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

Section 106 — FSA and HRA interactions with HSAs

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

Section 107 — Allowance of distributions for prescription and over-the-counter medicines and drugs

Under PPACA, effective January 1, 2011, funds in an FSA, HSA, or HRA may not be used to purchase over-the-counter medications without a prescription (insulin is exempt from the requirement). This

section restores over the counter drug purchases as a qualified medical expense without a prescription for FSAs, HSAs, HRAs, and Archer MSAs.

Section 108 — Purchase of health insurance from HSA account

Under current law, people can only use their HSA account to pay for health insurance premiums when they are receiving federal or state unemployment benefits or are covered by a COBRA continuation policy from a former employer. In addition, HSA funds may not be used to pay for a spouse's Medicare premiums unless the HSA account holder is age 65 or older. This section allows HSA account funds to be used to pay premiums for long-term care insurance, COBRA coverage, and HSA-qualified policies regardless of their circumstances. This section also clarifies that Medicare premiums for a spouse on Medicare are reimbursable from an HSA even though the HSA account holder is not age 65. The bill also allows an employer to offer a stand-alone HRA which an employee could use to purchase health insurance in the exchange

Section 109 — Special rule for certain medical expenses incurred before establishment of account

When people enroll in an HSA-qualified plan, some let a few months elapse between the time when their coverage starts (e.g., January) and when the health savings bank account is set up and becomes operational (e.g., March). However, the IRS does not allow for medical expenses incurred in that gap (between January and March) to be reimbursed with HSA funds. Section 8 allows all "qualified medical expenses" (as defined under the tax code) incurred after HSA-qualified coverage begins to be reimbursed from an HSA account as long as the account is established by April 15 of the following year.

Section 110 — Preventive care prescription drug clarification

Current law allows "preventive care" services to be paid by HSA-qualified plans without being subject to the policy deductible. Although IRS guidance allowed certain types of prescription drugs to be considered "preventive care," the guidance generally does not permit plans to include drugs that prevent complications resulting from chronic conditions. Section 111 expands the definition of "preventive care" to include medications that prevent worsening of or complications from chronic conditions. This will provide additional flexibility to health plans that want to provide coverage for these medications and remove a perceived barrier to HSAs for people with chronic conditions.

Section 111 — Equivalent bankruptcy protections for health savings accounts as retirement funds

Funds in an HSA account are not considered part of the protected estate in a bankruptcy and, as a result, the money is available to creditors. This lack of protection may result in the seizure of funds that were

specifically set aside to pay for medical costs for the individual and/or their family. The change clarifies that bankruptcy proceedings should not result in the loss of health care savings.

Section 112 — Administrative error correction before due date of return

HSA contribution errors are infrequent, but they are problematic for employees who are responsible for taxes and penalties if the error is corrected. This provision allows for limited corrective distributions, without penalty, in the event of contribution errors.

Section 113 — Reauthorization of Medicaid health opportunity accounts

The bill permits states to once again offer accounts similar to HSAs for Medicaid recipients. A previous law terminated this option for states.

Section 114 – Members of health care sharing ministries

To promote all forms for consumer directed health care programs the bill will allow members of health care sharing ministries to establish Health Savings Accounts.

Section 115 – HSA Qualified Health Plans

The bill changes the name "high deductible health plan" to "HSA qualified health plan."

Section 116 – Primary Care Service Arrangements

The bill allows HSA dollars to be used to cover the fees associated with primary care service arrangements.

Section 117 – Deeming HSA Plans to meet QHP requirements

The bill deems HSA qualified health plans as meeting the requirement for Qualified Health Plans (QHP) under the Patient Protection and Affordable Care Act (PPACA) to meet the 60% actuarial value standard.

Section 118 – Allow for Stand-Alone HRAs

PPACA prohibits the use of annual dollar limits on group health plans, which includes HRAs. This section will allow for stand-alone HRAs for employers to provide to employees to purchase insurance through an exchange notwithstanding the prohibition on annual dollar limits.

TITLE II – OTHER PROVISIONS

Sections 201-203 — Expanded definition of "qualified medical expenses"

With the increasing need to encourage Americans to take better care of their health and reduce the prevalence of obesity, Sections 10 and 11 modify the definition of "qualified medical expenses" in Section 213(d) of the Internal Revenue Code to include the cost of:

- Exercise and physical fitness programs, up to $1,000 per year (Sec. 121);
- Nutritional and dietary supplements, including meal replacement products, up to $1,000 per year (Sec. 122); and
- Periodic fees paid to medical practitioners for access to medical care (Sec. 123).

The modifications made by these sections would affect all health care programs using the definition, including HSAs, HRAs, FSAs, and the medical expense deduction when taxpayers itemize.

Section 204 — Repeal of annual limitations on deductibles for employer-sponsored plans offered in small group market

Section 1302(c)(2) of PPACA imposes a new limit on deductibles for health insurance plans sold to small employers. The limit is $2,000 for single coverage and $4,000 for family coverage. The limits prohibit small employers from purchasing plans for the employees with higher deductibles unless the employer offers a flexible spending arrangement to reimburse the difference above the limits. This section repeals this provision of the health reform law so small employers can continue to offer more affordable plans to their employees.