

PUBLIC LAW 108-173—DEC. 8, 2003

MEDICARE PRESCRIPTION DRUG,
IMPROVEMENT, AND MODERNIZATION ACT
OF 2003

Public Law 108–173
108th Congress

An Act

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes.

Dec. 8, 2003

[H.R. 1]

Medicare
Prescription
Drug,
Improvement,
and
Modernization
Act of 2003.
42 USC 1305
note.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Medicare Prescription Drug, Improvement, and Modernization Act of 2003”.

(b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as otherwise specifically provided, whenever in division A of this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) **BIPA; SECRETARY.**—In this Act:

(1) **BIPA.**—The term “BIPA” means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554.

(2) **SECRETARY.**—The term “Secretary” means the Secretary of Health and Human Services.

(d) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Medicare prescription drug benefit.

Sec. 102. Medicare Advantage conforming amendments.

Sec. 103. Medicaid amendments.

Sec. 104. Medigap amendments.

Sec. 105. Additional provisions relating to medicare prescription drug discount card and transitional assistance program.

Sec. 106. State Pharmaceutical Assistance Transition Commission.

Sec. 107. Studies and reports.

Sec. 108. Grants to physicians to implement electronic prescription drug programs.

Sec. 109. Expanding the work of medicare Quality Improvement Organizations to include parts C and D.

Sec. 110. Conflict of interest study.

Sec. 111. Study on employment-based retiree health coverage.

42 USC 1301
note.

TITLE II—MEDICARE ADVANTAGE**Subtitle A—Implementation of Medicare Advantage Program**

Sec. 201. Implementation of Medicare Advantage program.

Subtitle B—Immediate Improvements

Sec. 211. Immediate improvements.

Subtitle C—Offering of Medicare Advantage (MA) Regional Plans; Medicare Advantage Competition

Sec. 221. Establishment of MA regional plans.
Sec. 222. Competition program beginning in 2006.
Sec. 223. Effective date.

Subtitle D—Additional Reforms

Sec. 231. Specialized MA plans for special needs individuals.
Sec. 232. Avoiding duplicative State regulation.
Sec. 233. Medicare MSAs.
Sec. 234. Extension of reasonable cost contracts.
Sec. 235. Two-year extension of municipal health service demonstration projects.
Sec. 236. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.
Sec. 237. Reimbursement for federally qualified health centers providing services under MA plans.
Sec. 238. Institute of Medicine evaluation and report on health care performance measures.

Subtitle E—Comparative Cost Adjustment (CCA) Program

Sec. 241. Comparative Cost Adjustment (CCA) program.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

Sec. 301. Medicare secondary payor (MSP) provisions.
Sec. 302. Payment for durable medical equipment; competitive acquisition of certain items and services.
Sec. 303. Payment reform for covered outpatient drugs and biologicals.
Sec. 304. Extension of application of payment reform for covered outpatient drugs and biologicals to other physician specialties.
Sec. 305. Payment for inhalation drugs.
Sec. 306. Demonstration project for use of recovery audit contractors.
Sec. 307. Pilot program for national and State background checks on direct patient access employees of long-term care facilities or providers.

TITLE IV—RURAL PROVISIONS**Subtitle A—Provisions Relating to Part A Only**

Sec. 401. Equalizing urban and rural standardized payment amounts under the medicare inpatient hospital prospective payment system.
Sec. 402. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 403. Adjustment to the medicare inpatient hospital prospective payment system wage index to revise the labor-related share of such index.
Sec. 404. More frequent update in weights used in hospital market basket.
Sec. 405. Improvements to critical access hospital program.
Sec. 406. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 407. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 408. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 409. Rural hospice demonstration project.
Sec. 410. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 410A. Rural community hospital demonstration program.

Subtitle B—Provisions Relating to Part B Only

Sec. 411. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under the prospective payment system for hospital outpatient department services.
Sec. 412. Establishment of floor on work geographic adjustment.
Sec. 413. Medicare incentive payment program improvements for physician scarcity.

- Sec. 414. Payment for rural and urban ambulance services.
- Sec. 415. Providing appropriate coverage of rural air ambulance services.
- Sec. 416. Treatment of certain clinical diagnostic laboratory tests furnished to hospital outpatients in certain rural areas.
- Sec. 417. Extension of telemedicine demonstration project.
- Sec. 418. Report on demonstration project permitting skilled nursing facilities to be originating telehealth sites; authority to implement.

Subtitle C—Provisions Relating to Parts A and B

- Sec. 421. One-year increase for home health services furnished in a rural area.
- Sec. 422. Redistribution of unused resident positions.

Subtitle D—Other Provisions

- Sec. 431. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
- Sec. 432. Office of Rural Health Policy improvements.
- Sec. 433. MedPAC study on rural hospital payment adjustments.
- Sec. 434. Frontier extended stay clinic demonstration project.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

- Sec. 501. Revision of acute care hospital payment updates.
- Sec. 502. Revision of the indirect medical education (IME) adjustment percentage.
- Sec. 503. Recognition of new medical technologies under inpatient hospital prospective payment system.
- Sec. 504. Increase in Federal rate for hospitals in Puerto Rico.
- Sec. 505. Wage index adjustment reclassification reform.
- Sec. 506. Limitation on charges for inpatient hospital contract health services provided to Indians by medicare participating hospitals.
- Sec. 507. Clarifications to certain exceptions to medicare limits on physician referrals.
- Sec. 508. One-time appeals process for hospital wage index classification.

Subtitle B—Other Provisions

- Sec. 511. Payment for covered skilled nursing facility services.
- Sec. 512. Coverage of hospice consultation services.
- Sec. 513. Study on portable diagnostic ultrasound services for beneficiaries in skilled nursing facilities.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Provisions Relating to Physicians' Services

- Sec. 601. Revision of updates for physicians' services.
- Sec. 602. Treatment of physicians' services furnished in Alaska.
- Sec. 603. Inclusion of podiatrists, dentists, and optometrists under private contracting authority.
- Sec. 604. GAO study on access to physicians' services.
- Sec. 605. Collaborative demonstration-based review of physician practice expense geographic adjustment data.
- Sec. 606. MedPAC report on payment for physicians' services.

Subtitle B—Preventive Services

- Sec. 611. Coverage of an initial preventive physical examination.
- Sec. 612. Coverage of cardiovascular screening blood tests.
- Sec. 613. Coverage of diabetes screening tests.
- Sec. 614. Improved payment for certain mammography services.

Subtitle C—Other Provisions

- Sec. 621. Hospital outpatient department (HOPD) payment reform.
- Sec. 622. Limitation of application of functional equivalence standard.
- Sec. 623. Payment for renal dialysis services.
- Sec. 624. Two-year moratorium on therapy caps; provisions relating to reports.
- Sec. 625. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
- Sec. 626. Payment for services furnished in ambulatory surgical centers.
- Sec. 627. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
- Sec. 628. Payment for clinical diagnostic laboratory tests.
- Sec. 629. Indexing part B deductible to inflation.

- Sec. 630. Five-year authorization of reimbursement for all medicare part B services furnished by certain Indian hospitals and clinics.

Subtitle D—Additional Demonstrations, Studies, and Other Provisions

- Sec. 641. Demonstration project for coverage of certain prescription drugs and biologicals.
Sec. 642. Extension of coverage of Intravenous Immune Globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
Sec. 643. MedPAC study of coverage of surgical first assisting services of certified registered nurse first assistants.
Sec. 644. MedPAC study of payment for cardio-thoracic surgeons.
Sec. 645. Studies relating to vision impairments.
Sec. 646. Medicare health care quality demonstration programs.
Sec. 647. MedPAC study on direct access to physical therapy services.
Sec. 648. Demonstration project for consumer-directed chronic outpatient services.
Sec. 649. Medicare care management performance demonstration.
Sec. 650. GAO study and report on the propagation of concierge care.
Sec. 651. Demonstration of coverage of chiropractic services under medicare.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 701. Update in home health services.
Sec. 702. Demonstration project to clarify the definition of homebound.
Sec. 703. Demonstration project for medical adult day care services.
Sec. 704. Temporary suspension of OASIS requirement for collection of data on non-medicare and non-medicaid patients.
Sec. 705. MedPAC study on medicare margins of home health agencies.
Sec. 706. Coverage of religious nonmedical health care institution services furnished in the home.

Subtitle B—Graduate Medical Education

- Sec. 711. Extension of update limitation on high cost programs.
Sec. 712. Exception to initial residency period for geriatric residency or fellowship programs.
Sec. 713. Treatment of volunteer supervision.

Subtitle C—Chronic Care Improvement

- Sec. 721. Voluntary chronic care improvement under traditional fee-for-service.
Sec. 722. Medicare Advantage quality improvement programs.
Sec. 723. Chronically ill medicare beneficiary research, data, demonstration strategy.

Subtitle D—Other Provisions

- Sec. 731. Improvements in national and local coverage determination process to respond to changes in technology.
Sec. 732. Extension of treatment of certain physician pathology services under medicare.
Sec. 733. Payment for pancreatic islet cell investigational transplants for medicare beneficiaries in clinical trials.
Sec. 734. Restoration of medicare trust funds.
Sec. 735. Modifications to Medicare Payment Advisory Commission (MedPAC).
Sec. 736. Technical amendments.

TITLE VIII—COST CONTAINMENT

Subtitle A—Cost Containment

- Sec. 801. Inclusion in annual report of medicare trustees of information on status of medicare trust funds.
Sec. 802. Presidential submission of legislation.
Sec. 803. Procedures in the House of Representatives.
Sec. 804. Procedures in the Senate.

Subtitle B—Income-Related Reduction in Part B Premium Subsidy

- Sec. 811. Income-related reduction in part B premium subsidy.

TITLE IX—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

- Sec. 900. Administrative improvements within the Centers for Medicare & Medicaid Services (CMS).

Subtitle A—Regulatory Reform

- Sec. 901. Construction; definition of supplier.
- Sec. 902. Issuance of regulations.
- Sec. 903. Compliance with changes in regulations and policies.
- Sec. 904. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

- Sec. 911. Increased flexibility in medicare administration.
- Sec. 912. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

- Sec. 921. Provider education and technical assistance.
- Sec. 922. Small provider technical assistance demonstration program.
- Sec. 923. Medicare Beneficiary Ombudsman.
- Sec. 924. Beneficiary outreach demonstration program.
- Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
- Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

- Sec. 931. Transfer of responsibility for medicare appeals.
- Sec. 932. Process for expedited access to review.
- Sec. 933. Revisions to medicare appeals process.
- Sec. 934. Prepayment review.
- Sec. 935. Recovery of overpayments.
- Sec. 936. Provider enrollment process; right of appeal.
- Sec. 937. Process for correction of minor errors and omissions without pursuing appeals process.
- Sec. 938. Prior determination process for certain items and services; advance beneficiary notices.
- Sec. 939. Appeals by providers when there is no other party available.
- Sec. 940. Revisions to appeals timeframes and amounts.
- Sec. 940A. Mediation process for local coverage determinations.

Subtitle E—Miscellaneous Provisions

- Sec. 941. Policy development regarding evaluation and management (E & M) documentation guidelines.
- Sec. 942. Improvement in oversight of technology and coverage.
- Sec. 943. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
- Sec. 944. EMTALA improvements.
- Sec. 945. Emergency Medical Treatment and Labor Act (EMTALA) Technical Advisory Group.
- Sec. 946. Authorizing use of arrangements to provide core hospice services in certain circumstances.
- Sec. 947. Application of OSHA bloodborne pathogens standard to certain hospitals.
- Sec. 948. BIPA-related technical amendments and corrections.
- Sec. 949. Conforming authority to waive a program exclusion.
- Sec. 950. Treatment of certain dental claims.
- Sec. 951. Furnishing hospitals with information to compute DSH formula.
- Sec. 952. Revisions to reassignment provisions.
- Sec. 953. Other provisions.

TITLE X—MEDICAID AND MISCELLANEOUS PROVISIONS**Subtitle A—Medicaid Provisions**

- Sec. 1001. Medicaid disproportionate share hospital (DSH) payments.
- Sec. 1002. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.
- Sec. 1003. Extension of moratorium.

Subtitle B—Miscellaneous Provisions

- Sec. 1011. Federal reimbursement of emergency health services furnished to undocumented aliens.
- Sec. 1012. Commission on Systemic Interoperability.
- Sec. 1013. Research on outcomes of health care items and services.
- Sec. 1014. Health care that works for all Americans: Citizens Health Care Working Group.

- Sec. 1015. Funding start-up administrative costs for medicare reform.
- Sec. 1016. Health care infrastructure improvement program.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Subtitle A—Access to Affordable Pharmaceuticals

- Sec. 1101. Thirty-month stay-of-effectiveness period.
- Sec. 1102. Forfeiture of 180-day exclusivity period.
- Sec. 1103. Bioavailability and bioequivalence.
- Sec. 1104. Conforming amendments.

Subtitle B—Federal Trade Commission Review

- Sec. 1111. Definitions.
- Sec. 1112. Notification of agreements.
- Sec. 1113. Filing deadlines.
- Sec. 1114. Disclosure exemption.
- Sec. 1115. Enforcement.
- Sec. 1116. Rulemaking.
- Sec. 1117. Savings clause.
- Sec. 1118. Effective date.

Subtitle C—Importation of Prescription Drugs

- Sec. 1121. Importation of prescription drugs.
- Sec. 1122. Study and report on importation of drugs.
- Sec. 1123. Study and report on trade in pharmaceuticals.

TITLE XII—TAX INCENTIVES FOR HEALTH AND RETIREMENT SECURITY

- Sec. 1201. Health savings accounts.
- Sec. 1202. Exclusion from gross income of certain Federal subsidies for prescription drug plans.
- Sec. 1203. Exception to information reporting requirements related to certain health arrangements.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. MEDICARE PRESCRIPTION DRUG BENEFIT.

- (a) IN GENERAL.—Title XVIII is amended—
 - (1) by redesignating part D as part E; and
 - (2) by inserting after part C the following new part:

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

“Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits

“ELIGIBILITY, ENROLLMENT, AND INFORMATION

“SEC. 1860D–1. (a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—

42 USC
1395w–101.

“(1) IN GENERAL.—Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1860D–2(a)) as follows:

“(A) FEE-FOR-SERVICE ENROLLEES MAY RECEIVE COVERAGE THROUGH A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is not enrolled in an MA plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1860D–41(a)(14)).

“(B) MEDICARE ADVANTAGE ENROLLEES.—

“(iii)(I) compares in specific terms the detriment identified under clause (i) with the benefits identified under clause (ii); and

“(II) determines that the benefits do not outweigh the detriment.

“(m) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.”.

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking “covered product in violation of section 804” and inserting “prescription drug in violation of section 804”; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6)), by striking “covered product pursuant to section 804(a)” and inserting “prescription drug under section 804(b)”.

SEC. 1122. STUDY AND REPORT ON IMPORTATION OF DRUGS.

21 USC 384 note.

The Secretary, in consultation with appropriate government agencies, shall conduct a study on the importation of drugs into the United States pursuant to section 804 of the Federal Food, Drug, and Cosmetic Act (as added by section 1121 of this Act). Not later than 12 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of the Congress a report providing the findings of such study.

SEC. 1123. STUDY AND REPORT ON TRADE IN PHARMACEUTICALS.

21 USC 381 note.

The President’s designees shall conduct a study and report on issues related to trade and pharmaceuticals.

TITLE XII—TAX INCENTIVES FOR HEALTH AND RETIREMENT SECURITY

SEC. 1201. HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 223 as section 224 and by inserting after section 222 the following new section:

26 USC 223, 224.

“SEC. 223. HEALTH SAVINGS ACCOUNTS.

26 USC 223.

“(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, the lesser of—

“(i) the annual deductible under such coverage,

or

“(ii) \$2,250, or

“(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, the lesser of—

“(i) the annual deductible under such coverage,

or

“(ii) \$4,500.

“(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—

“(A) IN GENERAL.—In the case of an individual who has attained age 55 before the close of the taxable year, the applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by the additional contribution amount.

“(B) ADDITIONAL CONTRIBUTION AMOUNT.—For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

“For taxable years beginning in:

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

“(4) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to an individual for any taxable year shall be reduced (but not below zero) by the sum of—

“(A) the aggregate amount paid for such taxable year to Archer MSAs of such individual, and

“(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)).

Subparagraph (A) shall not apply with respect to any individual to whom paragraph (5) applies.

“(5) SPECIAL RULE FOR MARRIED INDIVIDUALS.—In the case of individuals who are married to each other, if either spouse has family coverage—

“(A) both spouses shall be treated as having only such family coverage (and if such spouses each have family coverage under different plans, as having the family coverage with the lowest annual deductible), and

“(B) the limitation under paragraph (1) (after the application of subparagraph (A) and without regard to any additional contribution amount under paragraph (3))—

“(i) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

“(ii) after such reduction, shall be divided equally between them unless they agree on a different division.

“(6) DENIAL OF DEDUCTION TO DEPENDENTS.—No deduction shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

“(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.

“(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, and

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

“(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 1871 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).

“(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)(ii), 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) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise.

“(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).

“(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 roll-overs).

“(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 10 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 subparagraph (A) of section 71(b)(2) 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 (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 1992’ in subparagraph (B) 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’.

“(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.”.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (18) the following new paragraph:

“(19) HEALTH SAVINGS ACCOUNTS.—The deduction allowed by section 223.”.

(c) ROLLOVERS FROM ARCHER MSAs PERMITTED.—Subparagraph (A) of section 220(f)(5) of such Code (relating to rollover contribution) is amended by inserting “or a health savings account (as defined in section 223(d))” after “paid into an Archer MSA”.

(d) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

26 USC 62.

26 USC 220.

(1) EXCLUSION FROM INCOME TAX.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection: 26 USC 106.

“(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.”.

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph: 26 USC 3231.

“(11) HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—The term ‘compensation’ shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d).”.

(B) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking “or” at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting “; or”, and by inserting after paragraph (17) the following new paragraph: 26 USC 3306.

“(18) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d).”.

(C) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking “or” at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting “; or”, and by inserting after paragraph (21) the following new paragraph: 26 USC 3401.

“(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(d).”.

(3) EMPLOYER CONTRIBUTIONS REQUIRED TO BE SHOWN ON W-2.—Subsection (a) of section 6051 of such Code is amended by striking “and” at the end of paragraph (10), by striking the period at the end of paragraph (11) and inserting “, and”, and by inserting after paragraph (11) the following new paragraph: 26 USC 6051.

“(12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee’s spouse.”.

(4) PENALTY FOR FAILURE OF EMPLOYER TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—

(A) IN GENERAL.—Chapter 43 of such Code is amended by adding after section 4980F the following new section:

26 USC 4980G. **“SEC. 4980G. FAILURE OF EMPLOYER TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.**

“(a) GENERAL RULE.—In the case of an employer who makes a contribution to the health savings account of any employee during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (b) for such calendar year.

“(b) RULES AND REQUIREMENTS.—Rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

“(c) REGULATIONS.—The Secretary shall issue regulations to carry out the purposes of this section, including regulations providing special rules for employers who make contributions to Archer MSAs and health savings accounts during the calendar year.”.

(B) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding after the item relating to section 4980F the following new item:

“Sec. 4980G. Failure of employer to make comparable health savings account contributions.”.

26 USC 4973.

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to certain tax-favored accounts and annuities) is amended—

(1) by striking “or” at the end of subsection (a)(3), by inserting “or” at the end of subsection (a)(4), and by inserting after subsection (a)(4) the following new paragraph:

“(5) a health savings account (within the meaning of section 223(d)),” and

(2) by adding at the end the following new subsection:

“(g) EXCESS CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—For purposes of this section, in the case of health savings accounts (within the meaning of section 223(d)), the term ‘excess contributions’ means the sum of—

“(1) the aggregate amount contributed for the taxable year to the accounts (other than a rollover contribution described in section 220(f)(5) or 223(f)(5)) which is neither excludable from gross income under section 106(d) nor allowable as a deduction under section 223 for such year, and

“(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

“(A) the distributions out of the accounts which were included in gross income under section 223(f)(2), and

“(B) the excess (if any) of—

“(i) the maximum amount allowable as a deduction under section 223(b) (determined without regard to section 106(d)) for the taxable year, over

“(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the health savings account in a distribution to which section 223(f)(3) applies shall be treated as an amount not contributed.”.

(f) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph: 26 USC 4975.

“(6) SPECIAL RULE FOR HEALTH SAVINGS ACCOUNTS.—An individual for whose benefit a health savings account (within the meaning of section 223(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health savings account by reason of the application of section 223(e)(2) to such account.”.

(2) Paragraph (1) of section 4975(e) of such Code is amended by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), respectively, and by inserting after subparagraph (D) the following new subparagraph:

“(E) a health savings account described in section 223(d).”.

(g) FAILURE TO PROVIDE REPORTS ON HEALTH SAVINGS ACCOUNTS.—Paragraph (2) of section 6693(a) of such Code (relating to reports) is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph: 26 USC 6693.

“(C) section 223(h) (relating to health savings accounts).”.

(h) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) of such Code (defining specified insurance contract) is amended by striking “and” at the end of clause (iii), by striking the period at the end of clause (iv) and inserting “, and”, and by adding at the end the following new clause: 26 USC 848.

“(v) any contract which is a health savings account (as defined in section 223(d)).”.

(i) HEALTH SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Paragraph (2) of section 125(d) (relating to cafeteria plan defined) is amended by adding at the end the following new subparagraph: 26 USC 125.

“(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.”.

(j) CLERICAL AMENDMENT.—The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

“Sec. 223. Health savings accounts.

“Sec. 224. Cross reference.”.

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003. 26 USC 62 note.

SEC. 1202. EXCLUSION FROM GROSS INCOME OF CERTAIN FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139 the following new section:

26 USC 139A. **“SEC. 139A. FEDERAL SUBSIDIES FOR PRESCRIPTION DRUG PLANS.**

“Gross income shall not include any special subsidy payment received under section 1860D–22 of the Social Security Act. This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.”.

26 USC 56. (b) ALTERNATIVE MINIMUM TAX RELIEF.—Section 56(g)(4)(B) of such Code is amended by inserting “or 139A” after “section 114”.

(c) CONFORMING AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of such Code is amended by inserting after the item relating to section 139 the following new item:

“Sec. 139A. Federal subsidies for prescription drug plans.”.

26 USC 56 note. (d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after the date of the enactment of this Act.

SEC. 1203. EXCEPTION TO INFORMATION REPORTING REQUIREMENTS RELATED TO CERTAIN HEALTH ARRANGEMENTS.

26 USC 6041. (a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 (relating to information at source) is amended by adding at the end the following new subsection:

“(f) SECTION DOES NOT APPLY TO CERTAIN HEALTH ARRANGEMENTS.—This section shall not apply to any payment for medical care (as defined in section 213(d)) made under—

“(1) a flexible spending arrangement (as defined in section 106(c)(2)), or

“(2) a health reimbursement arrangement which is treated as employer-provided coverage under an accident or health plan for purposes of section 106.”.

26 USC 6041 note. (b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after December 31, 2002.

Approved December 8, 2003.

LEGISLATIVE HISTORY—H.R. 1 (S. 1):

HOUSE REPORTS: No. 108–391 (Comm. of Conference).
CONGRESSIONAL RECORD, Vol. 149 (2003):

June 26, considered and passed House.

July 7, considered and passed Senate, amended, in lieu of S. 1.

Nov. 21, House agreed to conference report.

Nov. 25, Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 39 (2003):

Dec. 8, Presidential remarks and statement.