TECHNICAL EXPLANATION OF H.R. 2596, THE "HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003," AS PASSED BY THE HOUSE OF REPRESENTATIVES ON JUNE 26, 2003

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of the
JOINT COMMITTEE ON TAXATION

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INTRODUCTION

This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a technical explanation of H.R. 2596, the "Health Savings and Affordability Act of 2003," as passed by the House of Representatives on June 26, 2003.[2]

[1] This document may be cited as follows: Joint Committee on Taxation, *Technical Explanation of H.R. 2596, the "Health Savings and Affordability Act of 2003,"* as passed by the House of Representatives on June 26, 2003 (JCX-66-03), June 30, 2003.

[2] The House Committee on Ways and Means reported out another bill, H.R. 2351, relating to health savings accounts on June 25, 2003. H.R. REP. NO. 108-177 (2003).

I. EXPLANATION OF THE BILL

A. Health Savings Accounts and Health Savings Security Accounts (sec. 2 of the bill and new secs. 223 and 224 of the Code)

Present Law

Overview

Present law contains a number of provisions dealing with the Federal tax treatment of health expenses and health insurance coverage.

Employer-provided health coverage

In general, employer contributions to an accident or health plan are excludable from an employee's gross income (and wages for employment tax purposes).[3] This exclusion generally applies to coverage provided to employees (including former employees) and their spouses, dependents, and survivors. Benefits paid under employer-provided accident or health plans are also generally excludable from income to the extent they are reimbursements for medical care.[4] If certain requirements are satisfied, employer-provided accident or health coverage offered under a cafeteria plan is also excludable from an employee's gross income and wages.[5]

Present law provides for two general employer-provided arrangements that can be used to pay for or reimburse medical expenses of employees on a tax-favored basis: flexible spending arrangements ("FSAs") and health reimbursement arrangements ("HRAs"). While these arrangements provide similar tax benefits (i.e., the amounts paid under the arrangements for medical care are excludable from gross income and wages for employment tax purposes), they are subject to different rules. A main distinguishing feature between the two arrangements is that while FSAs are generally part of a cafeteria plan and contributions to FSAs are made on a salary reduction basis, HRAs cannot be part of a cafeteria plan and contributions cannot be made on a salary-reduction basis.[6]

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[3] Secs. 106, 3121(a)(2), and 3306(b)(2). All "section," "sec.," and "Code" references are to the Internal Revenue Code of 1986, as amended.

[4] Sec. 105. In the case of a self-insured medical reimbursement arrangement, the exclusion applies to highly compensated employees only if certain nondiscrimination rules are satisfied. Sec. 105(h). Medical care is defined as under section 213(d) and generally includes amounts paid for qualified long-term care insurance and services.

[5] Secs. 125, 3121(a)(5)(G), and 3306(b)(5)(G). Long-term care insurance and services may not be provided through a cafeteria plan.

[6] Notice 2002-45, 2002-28 I.R.B. 93 (July 15, 2002); Rev. Rul. 2002-41, 2002-28 I.R.B. 75 (July 15, 2002).

Amounts paid or accrued by an employer within a taxable year for a sickness, accident, hospitalization, medical expense, or similar health plan for its employees are generally deductible as ordinary and necessary business expenses.[7]

Self-employed individuals

The exclusion for employer-provided health coverage does not apply to self-employed individuals. However, under present law, self-employed individuals (i.e., sole proprietors or partners in a partnership)[8] are entitled to deduct 100 percent of the amount paid for health insurance for themselves and their spouse and dependents.[9]

Itemized deduction for medical expenses

Under present law, individuals who itemize deductions may deduct amounts paid during the taxable year (to the extent not reimbursed by insurance or otherwise) for medical care of the taxpayer, the taxpayer's spouse, and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income.[10]

Archer medical savings accounts

In general

In general, an Archer medical savings account ("MSA") is a tax-exempt trust or custodial account created exclusively for the benefit of the account holder that is subject to rules similar to those applicable to individual retirement arrangements.[11]

Within limits, contributions to an Archer MSA are deductible in determining adjusted gross income if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. Earnings on amounts in an Archer MSA are not includible in gross income in the year earned (i.e., inside buildup is not taxable). Distributions from an Archer MSA for qualified medical expenses are not includible in gross income. Distributions not used for qualified medical expenses are includible in gross income and subject to an additional 15-percent tax unless the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

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[7] Sec. 162.

[8] Self-employed individuals include more than two-percent shareholders of S corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.

[9] Sec. 162(l).

[10] Sec. 213. The adjusted gross income percentage is 10 percent for purposes of the alternative minimum tax. Sec. 56(b)(1)(B).

[11] Sec. 220.

Qualified medical expenses are generally defined as under section 213(d), except that qualified medical expenses do not include expenses for health insurance other than long-term care insurance, premiums for health coverage during any period of continuation coverage required by Federal law, and premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law. For purposes of determining the itemized deduction for medical expenses, distributions from an Archer MSA for qualified medical expenses are not treated as expenses paid for medical care under section 213.

Eligible individuals

Archer MSAs are available only to employees of a small employer who are covered under an employer-sponsored high deductible health plan and to self-employed individuals covered under a high deductible health plan.[12] An employer is a small employer if it employed, on average, no more than 50 employees on business days during either of the two preceding calendar years. An individual is not eligible for an Archer MSA if he or she is covered under any other health plan that is not a high deductible health plan (other than a plan providing certain limited types of coverage). Individuals entitled to benefits under Medicare are not eligible individuals. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

Treatment of contributions

Individual contributions to an Archer MSA are deductible (within limits) in determining adjusted gross income (i.e., "above-the-line"). In addition, employer contributions are excludable from gross income and wages for employment tax purposes (within the same limits), except that this exclusion does not apply to contributions made through a cafeteria plan. In the case of an employee, contributions can be made to an Archer MSA either by the individual or by the individual's employer, but not by both.

The maximum annual contribution that can be made to an Archer MSA for a year is 65 percent of the annual deductible under the high deductible health plan in the case of self-only coverage and 75 percent of the annual deductible in the case of family coverage.

If an employer provides a high deductible health plan coupled with Archer MSAs for employees and makes employer contributions to the Archer MSAs, the employer must make available a comparable contribution on behalf of all employees with comparable coverage during the same period. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the high deductible health plan. If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to Archer MSAs of the employer for that period.

[12] Self-employed individuals include more than two-percent shareholders of S corporations who are treated as partners for purposes of fringe benefit rules pursuant to section 1372.

Definition of high deductible health plan

A high deductible health plan is a health plan with an annual deductible of at least $1,700 and no more than $2,500 in the case of self-only coverage and at least $3,350 and no more than $5,050 in the case of family coverage. In addition, the maximum out-of-pocket expenses with respect to allowed costs (including the deductible) must be no more than $3,350 in the case of self-only coverage and no more than $6,150 in the case of family coverage.[13] A plan does not fail to qualify as a high deductible health plan merely because it does not have a deductible for preventive care as required under State law. A plan does not qualify as a high deductible health plan if substantially all of the coverage under the plan is certain permitted insurance or is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

Treatment of death of account holder

Upon death, any balance remaining in the decedent's Archer MSA is includible in his or her gross estate. If the account holder's surviving spouse is the named beneficiary of the Archer MSA, then, after the death of the account holder, the Archer MSA becomes the Archer MSA of the surviving spouse and the amount of the Archer MSA balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction.[14] If, upon the account holder's death, the Archer MSA passes to a named beneficiary other than the decedent's surviving spouse, the Archer MSA ceases to be an Archer MSA as of the date of the decedent's death, and the beneficiary is required to include the fair market value of the Archer MSA assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includible in gross income is reduced by the amount in the Archer MSA used, within one year after death, to pay qualified medical expenses incurred prior to the death. If there is no named beneficiary for the decedent's Archer MSA, the Archer MSA ceases to be an Archer MSA as of the date of death, and the fair market value of the assets in the Archer MSA as of such date is includible in the decedent's gross income for the year of the death.

Limit on number of MSAs; termination of MSA availability

The number of taxpayers benefiting annually from an Archer MSA contribution is limited to a threshold level (generally 750,000 taxpayers). The number of Archer MSAs established has not exceeded the threshold level.

After 2003, no new contributions can be made to Archer MSAs except by or on behalf of individuals who previously had Archer MSA contributions and employees who are employed by a participating employer.

[13] The deductible and out-of-pocket expenses dollar amounts are for 2003. These amounts are indexed for inflation in $50 increments.

[14] Sec. 2056.

Explanation of Provision

In general

The provision creates health savings accounts ("HSAs") and health savings security accounts ("HSSAs") which provide tax-favored treatment for current medical expenses as well as the ability to save on a tax-favored basis for future medical expenses. In general, HSAs and HSSAs are tax-exempt trusts or custodial accounts created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents that are subject to rules similar to those applicable to individual retirement arrangements.[15] Unless otherwise provided, the following description applies to both HSAs and HSSAs (jointly referred to as "health accounts").

Within limits, contributions to health accounts are deductible if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual. In the case of HSSAs only, family members may make nondeductible contributions on behalf of an eligible individual. Distributions from health accounts for qualified medical expenses are not includible in gross income. Distributions that are not for qualified medical expenses are includible in gross income and subject to an additional 15 percent tax. The additional 15 percent tax does not apply after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

Eligible individuals

HSAs

Eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that is not a high deductible health plan. Individuals entitled to benefits under Medicare are not eligible individuals. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

An individual with other coverage in addition to a high deductible health plan is still eligible for an HSA if such other coverage is certain permitted insurance or permitted coverage. Permitted insurance is: (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

A high deductible health plan is a health plan that in the case of self-only coverage has an annual deductible between $1,000 and $2,500 and in the case of family coverage has an annual

[15] The provision provides that the present-law requirement applicable to insurance companies that certain policy acquisition expenses must be capitalized and amortized (sec. 848) does not apply in the case of any contract that is a health account.

deductible between $2,000 and $5,050.[16] The maximum out-of-pocket expenses must be no more than $3,350 in the case of self-only coverage and no more than $6,150 in the case of family coverage. The annual deductible maximum and minimum and out-of-pocket expense amounts are indexed for inflation. A plan is not a high deductible health plan if substantially all of the coverage is for permitted coverage or coverage that may be provided by permitted insurance, as described above.

HSSAs

Individuals eligible for HSSAs are individuals who (1) are covered under a health plan meeting minimum deductible requirements and no other health plan that does not meet the minimum deductible requirements, or (2) are uninsured. Individuals entitled to benefits under Medicare are not eligible individuals. Eligible individuals do not include individuals who may be claimed as a dependent on another person's tax return.

An individual with other coverage in addition to a plan meeting the minimum deductible requirements is still eligible for an HSSA if such other coverage is for permitted coverage or coverage that may be provided by permitted insurance, as described above. In addition, an individual is treated as uninsured if his or her only coverage is permitted coverage or coverage that may be provided by permitted insurance.

A plan meets the minimum deductible requirements if the plan is a health plan with an annual deductible of at least $500 in the case of self-only coverage and at least $1,000 in the case of family coverage. These dollar amounts are indexed for inflation. There are no maximum deductible requirements and no limits on out-of-pocket expenses. A plan is not a minimum deductible plan if substantially all of the coverage is for permitted coverage or coverage that may be provided by permitted insurance, as described above.

Tax treatment of and limits on contributions

Contributions to a health account made by an eligible individual are deductible (within limits) in determining adjusted gross income (i.e., "above-the-line"). In addition, employer contributions to a health account (including salary reduction contributions made through a cafeteria plan) are excludable from gross income and wages for employment tax purposes to the extent the contribution would be deductible if made by the employee (e.g., in the case of an HSSA, subject to the adjusted gross income limits).[17] Nondeductible contributions may be made to an HSSA by a family member of an eligible individual. In the case of an employee, contributions to a health account may be made by both the individual (and family members in the

[16] Special rules apply for determining whether a health plan that is a preferred provider organization plan meets the requirements of a high deductible plan.

[17] Employer contributions to a health account are excludable from wages for employment tax purposes if at the time of payment, it is reasonable to believe that the employee will be able to exclude such payment from income (e.g., a reasonable basis to believe that the employee's income is within the applicable adjusted gross income limits for an HSSA).

case of an HSSA) and the individual's employer. All contributions are aggregated for purposes of the maximum annual contribution limit.

The maximum aggregate annual contribution that can be made to an HSA is 100 percent of the annual deductible under the high deductible plan.[18]

The maximum aggregate annual contribution that can be made to an HSSA is (1) $2,000 for (a) persons with self-only coverage and (b) uninsured individuals with no dependents[19] who do not file a joint return, and (2) $4,000 for (a) individuals with family coverage and (b) uninsured individuals with dependents or who file a joint return. In the case of individuals age 55 and older, the $2,000 and $4,000 HSSA annual contribution limits are increased by $500 in 2004, $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and thereafter.

The maximum allowable contribution to an HSSA is phased out for taxpayers with adjusted gross income[20] above certain levels. In the case of individuals with self-only coverage (other than individuals filing a joint return), the phase-out range is $75,000 to $85,000. For individuals with family coverage and individuals filing a joint return, the phase-out range is $150,000 to $170,000. The adjusted gross income limits apply to HSSA contributions from all sources (e.g., both individual and employer contributions).

The maximum annual contribution limits for the health accounts are coordinated so that contributions to one type of health account reduce the annual contribution limit for the other type of health account.[21]

An excise tax applies to contributions in excess of the maximum contribution amount for the health account. The excise tax is generally equal to six percent of the cumulative amount of excess contributions that are not distributed from the health account to the contributor.[22]

Amounts can be rolled over into a health account from an Archer MSA or a health FSA on a tax-free basis. Amounts can be rolled over into an HSA from another HSA or HSSA and

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[18] The annual contribution limit for a health account is the sum of the limits determined separately for each month, based on the individual's status and health plan coverage as of the first day of the month.

[19] Written declarations releasing a claim to a dependency exemption under section 152(e)(2) are disregarded in determining whether an individual has dependents.

[20] Adjusted gross income is defined generally as under the rules relating to individual retirement arrangements ("IRAs"), and is computed after the deduction for contributions to IRAs and before the deductions provided by the provision.

[21] The contribution limits are also coordinated with contributions to Archer MSAs.

[22] Ordering rules apply to determine the nature of any distributed excess contributions (e.g., nondeductible family contributions in the case of an HSSA or employer contributions).

into an HSSA from another HSSA on a tax-free basis. Rollovers from an HSA into an HSSA are not permitted. Rollovers from a health FSA are limited to up to $500 annually (under section 3 of the bill) and are taken into account under the annual contribution limits. Amounts transferred from another health account or Archer MSA are not taken into account under the annual contribution limits.

If an employer makes contributions to employees' health accounts, the employer must make available comparable contributions on behalf of all employees with comparable coverage during the same period. Contributions are considered comparable if they are either of the same amount or the same percentage of the deductible under the plan. The comparability rule is applied separately to part-time employees (i.e., employees who are customarily employed for fewer than 30 hours per week). The comparability rule does not apply to amounts transferred from an employee's health account, health FSA, or Archer MSA or to contributions made through a cafeteria plan.

If employer contributions do not satisfy the comparability rule during a period, then the employer is subject to an excise tax equal to 35 percent of the aggregate amount contributed by the employer to health accounts of the employer for that period. The excise tax is designed as a proxy for the denial of the deduction for employer contributions. In the case of a failure to comply with the comparability rule which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed to the extent that the payment of the tax would be excessive relative to the failure involved. For purposes of the comparability rule, employers under common control are aggregated.

Taxation of distributions

Distributions from a health account for qualified medical expenses of the individual and his or her spouse or dependents generally are excludable from gross income. In general, amounts in a health account can be used for qualified medical expenses even if the individual is not currently eligible for contributions to the health account.[23]

Qualified medical expenses generally are defined as under section 213(d) and include expenses for diagnosis, cure, mitigation, treatment, or prevention of disease, including prescription drugs, transportation primarily for and essential to such care, and qualified long-term care expenses. Qualified medical expenses do not include expenses for insurance other than for (1) long-term care insurance, (2) premiums for health coverage during any period of continuation coverage required by Federal law, and (3) premiums for health care coverage while an individual is receiving unemployment compensation under Federal or State law. In the case of HSSAs, qualified medical expenses also include (1) health insurance meeting the minimum

[23] However, in any year for which a contribution is made to an HSA, withdrawals from the HSA maintained by that individual generally are excludable from income only if the individual for whom the expenses were incurred was covered under a high deductible plan for the month in which the expenses were incurred. The rule does not apply for continuation coverage or coverage while the individual is receiving unemployment compensation even if for an individual who is not an eligible individual.

deductible requirements if no portion of the cost of the insurance is paid by the employer or former employer of the individual or the individual's spouse,[24] and (2) health insurance for individuals who are older than age 65 (including Medicare expenses). For purposes of determining the itemized deduction for medical expenses, distributions from a health account for qualified medical expenses are not treated as expenses paid for medical care under section 213.

Distributions from a health account that are not for qualified medical expenses are includible in gross income (except to the extent that the distribution is attributable to a return of nondeductible family contributions in the case of an HSSA).[25] Distributions includible in gross income are also subject to an additional 15-percent tax unless made after death, disability, or the individual attains the age of Medicare eligibility (i.e., age 65).

Tax treatment of HSAs and HSSAs after death

Upon death, any balance remaining in the decedent's health account is includible in his or her gross estate.

If the health account holder's surviving spouse is the named beneficiary of the health account, then, after the death of the health account holder, the health account becomes the health account of the surviving spouse and the amount of the health account balance may be deducted in computing the decedent's taxable estate, pursuant to the estate tax marital deduction.[26] The surviving spouse is not required to include any amount in gross income as a result of the death; the general rules applicable to the health account apply to the surviving spouse's health account (e.g., the surviving spouse is subject to income tax only on distributions from the health account for nonmedical purposes). The surviving spouse can exclude from gross income amounts withdrawn from the health account for expenses incurred by the decedent prior to death, to the extent they otherwise are qualified medical expenses.

If, upon death, the health account passes to a named beneficiary other than the decedent's surviving spouse, the health account ceases to be a health account as of the date of the decedent's death, and the beneficiary is required to include the fair market value of health account assets as of the date of death in gross income for the taxable year that includes the date of death. The amount includible in income is reduced by the amount in the health account used, within one year after death, to pay qualified medical expenses incurred by the decedent prior to the death. As is the case with other health account distributions, whether the expenses are qualified medical expenses is determined as of the time the expenses were incurred. In computing taxable income,

[24] Amounts paid by the employer include salary reduction contributions.

[25] Ordering rules apply to determine the extent to which distributions are attributable to nondeductible contributions.

[26] Sec. 2056.

the beneficiary may claim a deduction for that portion of the Federal estate tax on the decedent's estate that was attributable to the amount of the health account balance.[27]

If there is no named beneficiary of the decedent's health account, the health account ceases to be a health account as of the date of death, and the fair market value of the assets in the health account as of such date is includible in the decedent's gross income for the year of the death. This rule applies in all cases in which there is no named beneficiary, even if the surviving spouse ultimately obtains the right to the health account assets (e.g., if the surviving spouse is the sole beneficiary of the decedent's estate).

Reporting requirements

Trustees of health accounts may be required to report to the Secretary amounts with respect to contributions, distributions, and other matters as determined appropriate by the Secretary. In addition, providers of health insurance are required to report information as prescribed by the Secretary.

Effective Date

The provision is effective for taxable years beginning after December 31, 2003.

[27] The deduction is calculated in accordance with the present-law rules relating to income in respect of a decedent set forth in section 691(c).

B. Disposition of Unused Health Benefits in Flexible Spending Arrangements (sec. 3 of the bill and sec. 125 of the Code)

Present Law

A flexible spending arrangement ("FSA") is defined under the Code as a benefit program which provides employees with coverage under which specified incurred expenses may be reimbursed and 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.[28] A health FSA is an FSA that provides for reimbursement of medical expenses.[29] Health FSAs are typically part of a cafeteria plan and may be funded through salary reduction.[30] Health FSAs are commonly used, for example, to reimburse employees for medical expenses not covered by insurance. There is no special exclusion for benefits provided under an FSA. Thus, health benefits provided under an FSA are excludable from income only if they qualify for exclusion under sections 105 or 106.

FSAs that are part of a cafeteria plan must comply with the rules applicable to cafeteria plans generally. One of these rules is that a cafeteria plan may not offer deferred compensation except through a qualified cash or deferred arrangement.[31] Under proposed Treasury regulations, a cafeteria plan is considered to permit the deferral of compensation if it includes a health FSA which reimburses participants for medical expenses incurred beyond the end of the plan year.[32] Thus, amounts in an employee's health account that are not used for medical expenses incurred before the end of a plan year must be forfeited. This rule is often referred to as the "use it or lose it" rule.

Explanation of Provision

The provision allows up to $500 of unused health benefits in an employee's health FSA to be carried forward to the employee's health account for the next plan year of the health FSA or transferred to an HSA or HSSA maintained for the benefit of the employee.[33] Amounts transferred to an HSA or HSSA are treated as employer contributions for purposes of the HSA and HSSA rules. Under the provision, if an individual is not eligible to contribute to an HSA or HSSA for the taxable year, the individual may transfer up to $500 of unused health benefits in

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[28] Sec. 106(c).

[29] FSAs may also be used to provide certain other nontaxable benefits, such as dependent care.

[30] Long-term care insurance cannot be offered through a cafeteria plan. Sec. 125(f).

[31] Sec. 401(k).

[32] Prop. Treas. Reg. 1.125-2 Q&A-5(a).

[33] Section 2 of the bill provides the eligibility rules for contributions to an HSA or HSSA.

the employee's health FSA to a tax-qualified retirement plan, a tax-sheltered annuity (section 403(b)), an individual retirement arrangement ("IRA"), or an eligible deferred compensation plan of a State or local government (section 457). An employee's unused health benefit is the excess of the maximum amount of reimbursement allowable to the employee over the actual amount of reimbursement made during the year. Amounts transferred are subject to the rules and limits on contributions that would otherwise apply to contributions to the transferee plan.

Effective Date

The provision applies to taxable years beginning after December 31, 2003.

C. Exception to Information Reporting Requirements for Certain Health Arrangements (sec. 4 of the bill and sec. 6041 of the Code)

Present Law

Any person in a trade or business who, in the course of that trade or business, makes specified payments to another person totaling $600 or more in a year, must provide an information report to the IRS (as well as a copy to the recipient) on the payments.[34] Reporting is required to be done on Form 1099. In general, these information reports remind taxpayers of amounts of income that should be reflected on their tax returns and assist the IRS in verifying that taxpayers have correctly reported these amounts.

Treasury regulations specify that fees for professional services, including the services of physicians, must be reported.[35] Treasury regulations also provide a general exception from these information reporting requirements for payments made to corporations, except that this exception is inapplicable if the corporation is "engaged in providing medical and health care services."[36]

Earlier this year, the IRS issued a revenue ruling describing whether employer-provided expense reimbursements made through debit or credit cards or other electronic media are excludible from gross income.[37] The ruling states that "payments made to medical service providers through the use of debit, credit, and stored value cards are reportable by the employer on Form 1099-MISC under section 6041."[38]

Explanation of Provision

The provision provides an exception from the generally applicable information reporting provisions for payments for medical care made under either: (1) a flexible spending arrangement,[39] or (2) a health reimbursement arrangement that is treated as employer-provided coverage.

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[34] Section 6041.

[35] Treas. Reg. sec. 1.6041-1(d)(2).

[36] Treas. Reg. sec. 1.6041-3(p)(1). These regulations also provide an exception from these information reporting requirements if the payment is made to a hospital that is tax-exempt or that is owned and operated by a governmental entity.

[37] Rev. Rul. 2003-43, 2003-21 I.R.B. 935 (May 27, 2003).

[38] *Id.*

[39] This term is defined in section 106(c)(2).

Effective Date

The provision applies to payments made after December 31, 2002.