118TH CONGRESS, 2d Session | HOUSE OF REPRESENTATIVES | REPORT 118–387

HSA MODERNIZATION ACT OF 2023

FEBRUARY 13, 2024.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. SMITH of Missouri, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 5687]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5687) to amend the Internal Revenue Code of 1986 to modernize health savings accounts, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "HSA Modernization Act of 2023".

SEC. 2. INDIVIDUALS WITHOUT SERVICE-CONNECTED DISABILITY AND ELIGIBLE FOR CERTAIN VETERANS BENEFITS PERMITTED TO CONTRIBUTE TO HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(1)(C) of the Internal Revenue Code of 1986 is amended by striking "for a service-connected disability (within the meaning of section 101(16) of title 38, United States Code)".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 3. INDIVIDUALS ENTITLED TO PART A OF MEDICARE BY REASON OF AGE ALLOWED TO CONTRIBUTE TO HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "and" at the end of clause (ii), by striking the period at the end of clause (iii) and inserting ", and", by adding at the end the following new clause:

"(iv) entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act by reason of section 226(a) of such Act.".

(b) TREATMENT OF HEALTH INSURANCE PURCHASED FROM ACCOUNT.—Section 223(d)(2)(C)(iv) of such Code is amended by inserting "and who is not an eligible individual" after "who has attained the age specified in section 1811 of the Social Security Act".

(c) COORDINATION WITH PENALTY ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Section 223(f)(4)(C) of such Code is amended by striking "Subparagraph (A)" and inserting "Except in the case of an eligible individual, subparagraph (A)"

(d) CONFORMING AMENDMENT.—Section 223(b)(7) of such Code is amended by inserting "(other than an entitlement to benefits described in subsection (c)(1)(B)(iv))" after "Social Security Act".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2025, in taxable years ending after such date.

SEC. 4. INDIVIDUALS ELIGIBLE FOR INDIAN HEALTH SERVICE ASSISTANCE NOT DISQUALIFIED FROM HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(1) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(E) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR ASSISTANCE UNDER INDIAN HEALTH SERVICE PROGRAMS.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives hospital care or medical services under a medical care program of the Indian Health Service or of a tribal organization.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 5. ALLOWANCE OF BRONZE AND CATASTROPHIC PLANS IN CONNECTION WITH HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(H) BRONZE AND CATASTROPHIC PLANS TREATED AS HIGH DEDUCTIBLE HEALTH PLANS.—The term 'high deductible health plan' shall include any plan described in subsection (d)(1)(A) or (e) of section 1302 of the Patient Protection and Affordable Care Act.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to months beginning after December 31, 2025, in taxable years ending after such date.

SEC. 6. SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR MENTAL HEALTH SERVICES.

(a) IN GENERAL.—Section 223(c)(2) of the Internal Revenue Code of 1986, as amended by this Act, is amended by adding at the end the following new subparagraph:

"(I) SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR MENTAL HEALTH SERVICES.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for not more than the first $500 of any mental health benefits (as defined in section 9812(e)(4)) specified by the plan for purposes of this subparagraph.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2025.

SEC. 7. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(E) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to coverage beginning after December 31, 2025.

SEC. 8. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) of the Internal Revenue Code of 1986 is amended to read as follows:

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

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

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

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

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

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

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 9. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

(a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A) of the Internal Revenue Code of 1986 is amended by striking "$2,250" and inserting "the amount in effect under subsection (c)(2)(A)(ii)(I)".

(b) FAMILY COVERAGE.—Section 223(b)(2)(B) of such Code is amended by striking "$4,500" and inserting "the amount in effect under subsection (c)(2)(A)(ii)(II)".

(c) CONFORMING AMENDMENTS.—Section 223(g)(1) of such Code is amended—

(1) by striking "subsections (b)(2) and" both places it appears and inserting "subsection", and

(2) in subparagraph (B), by striking "determined by" and all that follows through "'calendar year 2003'." and inserting "determined by substituting 'calendar year 2003' for 'calendar year 2016' in subparagraph (A)(ii) thereof.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2025.

SEC. 10. CLARIFICATION OF TREATMENT OF DISTRIBUTIONS FROM HEALTH SAVINGS ACCOUNT FOR LONG-TERM CARE SERVICES.

(a) IN GENERAL.—Section 223(d)(2)(A) of the Internal Revenue Code of 1986 is amended by inserting before the last sentence the following: "Such term includes amounts paid for qualified long-term care services (as defined in section 7702B(c)).".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to amounts paid after the date of the enactment of this Act.

(c) NO INFERENCE.—Nothing contained in this section or the amendment made thereby shall be construed to create any inference with respect to any amounts paid on or before such date.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 5687, the "HSA Modernization Act of 2023," as ordered reported by the Committee on Ways and Means on September 28, 2023, would expand high deductible health plan health savings account eligibility to more populations, increase contribution limits, and make technical changes to improve these accounts.

B. BACKGROUND AND NEED FOR LEGISLATION

In order for an individual to be eligible to make contributions or to receive contributions from an employer to a health savings account (HSA), the individual must have a high deductible health plan ("HDHP") and have no disqualifying health coverage. An HDHP is a health insurance plan that satisfies certain requirements with respect to minimum deductibles and maximum out-of-pocket expenses.

Individuals without a service-connected disability who are eligible for health care services through the Department of Veterans Affairs ("VA"), individuals who are entitled to Medicare Part A but

enrolled in an HDHP, and individuals who receive care under a medical care program of the Indian Health Service ("IHS") or tribal organization are all ineligible to contribute to an HSA under certain circumstances.

Under current law, some bronze plans on the Health Benefit Exchanges[1] may have maximum out-of-pocket costs that exceed limits for HDHPs defined by the Internal Revenue Service ("IRS"). In addition, catastrophic plans cannot be HDHPs.

Subject to several specific exceptions, under section 223(c)(2)(A) of the Internal Revenue Code, a HDHP may not provide benefits for any year until the minimum deductible for that year is satisfied.

HSA funds can only be used to pay for qualified medical expenses (QMEs) incurred after the HSA is established.

Under current law, if both spouses are HSA-eligible and age 55 or older, they must open separate HSA accounts for their respective "catch-up" contributions (an extra $1,000 annually).

The annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (*i.e.*, 1⁄12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month. For 2023, the general limit on annual contributions that can be made to an HSA is $3,850 in the case of self-only coverage and $7,750 in the case of family coverage.

Clarification is needed to affirm that HSA funds can be used for diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, for an individual that is unable to perform at least two of the following activities: eating, toileting, transferring, bathing, dressing, or continence as certified by a licensed health care practitioner.

C. Legislative History

Background

H.R. 5687 was introduced on September 26, 2023, and was referred to the Committee on Ways and Means.

Committee Hearings

On May 16, 2023, the Committee held a Full Committee Hearing on "Health Care Price Transparency: A Patient's Right to Know".

Committee Action

The Committee on Ways and Means marked up H.R. 5687, the "HSA Modernization Act of 2023," on September 28, 2023, and ordered the bill, as amended, favorably reported (with a quorum being present).

D. Designated Hearing

Pursuant to clause 3(c)(6) of rule XIII, the Committee on Ways and Means held a hearing on May 16, 2023, Ways and Means Hearing "Health Care Price Transparency: A Patient's Right to Know" which was used to develop and consider H.R. 5687.

[1] See secs. 1311 and 1321 of Patient Protection and Affordable Care Act (the "PPACA").

II. EXPLANATION OF THE BILL

A. INDIVIDUALS WITHOUT SERVICE-CONNECTED DISABILITY AND ELIGIBLE FOR CERTAIN VETERANS BENEFITS PERMITTED TO CONTRIBUTE TO HEALTH SAVINGS ACCOUNTS (SEC. 2 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

Health savings accounts

An individual may contribute to an HSA only if the individual is covered under a plan that meets the requirements for a high deductible health plan, as described below. In general, HSAs 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, an HSA is a tax-exempt trust or custodial account created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents.

Within limits,[2] contributions to an HSA made by or on behalf of an eligible individual (with the exception of contributions by the individual's employer) are deductible by the individual. HSA contributions made on behalf of an eligible individual by an employer are excludible from income and wages for employment tax purposes. Earnings on amounts in HSAs are not taxable. Distributions from an HSA for qualified medical expenses are not includible in gross income. Distributions from an HSA that are not used for qualified medical expenses are includible in gross income and are subject to an additional tax of 20 percent. The 20-percent additional tax does not apply if the distribution is made after death, disability, or the individual attains the age of Medicare eligibility (age 65).

High deductible health plans

An HDHP is a health plan that has an annual deductible which is not less than $1,500 (for 2023) for self-only coverage (twice this amount for family coverage), and for which the sum of the annual deductible and other annual out-of-pocket expenses (other than premiums) for covered benefits does not exceed $7,500 (for 2023) for self-only coverage (twice this amount for family coverage).[3] These dollar thresholds are adjusted for inflation.[4]

An individual who is covered under an HDHP is eligible to contribute to an HSA, provided that while such individual is covered under the HDHP, the individual is not covered under any health plan that (1) is not an HDHP and (2) provides coverage for any benefit (subject to certain exceptions) covered under the HDHP.[5]

Various types of coverage are disregarded for this purpose, including coverage of any benefit provided by permitted insurance, coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, as well as cer-

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[2] For 2023, the basic limit on annual contributions that can be made to an HSA is $3,850 in the case of self-only coverage and $7,750 in the case of family coverage. Rev. Proc. 2022–24, 2022–20 I.R.B. 1075, May 16, 2022. The basic annual contribution limits are increased by $1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up" contributions). Sec. 223(b)(3).

[3] *Ibid*. Sec. 223(c)(2).

[4] Sec. 223(g).

[5] Sec. 223(c)(1).

tain limited coverage through health flexible spending arrangements.[6] Permitted insurance means insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, or such other similar liabilities as specified by the Secretary of the Treasury (the "Secretary") under regulations. Permitted insurance also means insurance for a specified disease or illness and insurance paying a fixed amount per day (or other period) of hospitalization.[7]

Under a safe harbor, an HDHP is permitted to provide coverage for preventive care (within the meaning of section 1861 of the Social Security Act, except as otherwise provided by the Secretary) before satisfaction of the minimum deductible.[8] IRS guidance provides a safe harbor for the types of coverage that constitute preventive care for this purpose.[9]

After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to the individual's HSA.[10]

Health savings accounts and veterans benefits

Prior to the passage of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 ("the Surface Transportation Act"),[11] under IRS guidance, an individual who was eligible to receive medical services or medical benefits through the VA, but who had not actually received such services during the previous three months, was an eligible individual for purposes of making contributions to an HSA.[12]

The Surface Transportation Act amended the Code to provide that an individual shall not fail to be treated as an eligible individual for any period merely because the individual receives hospital care or medical services under any law administered by the Secretary of Veterans Affairs for a service-connected disability.[13] In response, the IRS issued guidance providing that as a rule of administrative simplification, any hospital care or medical services received from the VA by a veteran who has a disability rating from the VA may be considered to be hospital care or medical services under a law administered by the Secretary of Veterans Affairs for service-connected disability.[14]

REASONS FOR CHANGE

The Committee believes that all veterans should be able to contribute to HSAs if they are otherwise eligible, not just those that have a service-connected disability, or who have not used VA medical benefits in the previous three months.

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[6] Sec. 223(c)(1)(B).

[7] Sec. 223(c)(3).

[8] Sec. 223(c)(2)(C).

[9] Notice 2004–23, 2004–1 C.B. 725. See also Notice 2004–50, 2004–33 I.R.B. 196, August 16, 2004, Q&A's–26 and 27; Notice 2008–59, 2008–29 I.R.B. 123, July 21, 2008; Notice 2013–57, 2013–40 I.R.B. 293, September 30, 2013; and Notice 2019–45, 2019–32 I.R.B. 593, August 5, 2019.

[10] See sec. 223(b)(7), as interpreted by Notice 2004–2, 2004–2 I.R.B. 269, January 12, 2004, corrected by Announcement 2004–67, 2004–36 I.R.B. 459, September 7, 2004.

[11] Pub. L. No. 114–41, July 31, 2015.

[12] Notice 2004–50, 2004–33 I.R.B. 196, August 16, 2004, Q&A–5.

[13] Pub. L. No. 114–41, sec. 4007(b), July 31, 2015 (adding sec. 223(c)(1)(C)). A service-connected disability is defined by reference to section 101(16) of title 38, United States Code.

[14] Notice 2015–87, 2015–52 I.R.B. 889, December 28, 2015, Q&A–20.

EXPLANATION OF PROVISION

Under the provision, an individual is not treated as covered under a health plan other than an HDHP merely because the individual receives hospital care or medical services under any law administered by the VA. Thus, an individual who is otherwise an eligible individual for purposes of making HSA contributions does not become ineligible merely because of receiving hospital care or medical services under a VA medical care program.

EFFECTIVE DATE

The provision applies to taxable years beginning after December 31, 2025.

B. Individuals Entitled to Part A of Medicare by Reason of Age Allowed to Contribute to Health Savings Accounts (Sec. 3 of the Bill and Sec. 223 of the Code)

PRESENT LAW

Health savings accounts and entitlement to Medicare

For a general description of HSA eligibility, see Part A of this document.

After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions can no longer be made to the individual's HSA.[15] An individual who is receiving retirement benefits from Social Security or the Railroad Retirement Board is automatically enrolled in both Medicare Part A (hospital insurance benefits) and Part B (supplementary medical insurance benefits) starting the first day of the month in which he or she turns age 65.[16] When an individual is automatically enrolled in Medicare at age 65, the amount that can be deducted by that individual for contributions to the HSA drops to zero for the first month (and each subsequent month) that the individual is entitled to Medicare benefits.[17] In addition, the 20-percent additional tax that otherwise applies to distributions not used for qualified medical expenses does not apply if the distribution is made after the individual attains age 65.

Qualified medical expenses

Generally, for purposes of distributions from HSAs, qualified medical expenses[18] mean amounts paid for medical care[19] or menstrual care products. Medical care generally means amounts paid for the diagnosis, cure, mitigation, treatment and prevention of dis-

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[15] See sec. 223(b)(7), as interpreted by Notice 2004–2, 2004–2 I.R.B. 269, January 12, 2004, corrected by Announcement 2004–67, 2004–36 I.R.B. 459, September 7, 2004 ("After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions, including catch-up contributions, cannot be made to an individual's HSA."). See also Notice 2004–50, 2004–33 I.R.B. 196, August 16, 2004, Q&A–2 ("Thus, an otherwise eligible individual under section 223(c)(1) who is not actually enrolled in Medicare Part A or Part B may contribute to an HSA until the month that individual is enrolled in Medicare."); Notice 2008–59, 2008–29 I.R.B. 123, July 21, 2008, Q&A–5 and Q&A–6 ("[A]n individual is not an eligible individual under section 223(c)(1) in any month during which such individual is both eligible for benefits under Medicare and enrolled to receive benefits under Medicare[, including Part D (or any other Medicare benefit)]").

[16] 42 U.S.C. 426(a). Medicare Part B, however, is a voluntary program, and enrollees must pay premiums. See sec. 1839 of the Social Security Act, 42 U.S.C. 1395r.

[17] Sec. 223(b)(7).

[18] Sec. 223(d)(2).

[19] Based on the definition under sec. 213(d).

ease, or for the purpose of affecting any structure or function of the body, as well as transportation primarily for and essential to medical care. Health insurance premiums are generally not qualified medical expenses,[20] but an individual who attains the age of Medicare eligibility (age 65) may use an HSA to pay for health insurance other than a Medicare supplemental policy.[21]

REASONS FOR CHANGE

As Americans increasingly work later into their lives, the Committee believes that a working individual should not be precluded from contributing to an HSA merely because the individual has reached the age of Medicare eligibility.

EXPLANATION OF PROVISION

Under the provision, with respect to an individual who is Medicare eligible but enrolled only in Medicare Part A, the allowable deduction for contributions to an HSA does not become zero during any month for such individual. Such an individual is also considered as not having a health plan or other coverage that would cause that individual to fail to be an eligible individual for purposes of making contributions to an HSA. Thus, an individual eligible for Medicare but enrolled only in Medicare Part A would not fail to be treated as eligible to make HSA contributions merely by reason of enrollment in Medicare Part A.

In addition, the provision provides that individuals who have attained age 65 and who are eligible to contribute to an HSA generally may not use HSA funds to pay for health insurance, unlike other individuals who have attained age 65, and that the 20-percent additional tax on HSA distributions that otherwise does not apply to individuals who have attained age 65 continues to apply if the individual is an eligible individual.

EFFECTIVE DATE

The provision applies to months beginning after December 31, 2025, in taxable years ending after such date.

C. INDIVIDUALS ELIGIBLE FOR INDIAN HEALTH SERVICE ASSISTANCE NOT DISQUALIFIED FROM HEALTH SAVINGS ACCOUNTS (SEC. 4 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

For a general description of what constitutes permitted insurance or permitted coverage related to eligibility to make HSA contributions, see Part A of this document.

Under IRS guidance, an individual who is eligible to receive medical services at an IHS facility, but who has not actually received such services during the previous three months, is an eligible individual for purposes of making contributions to an HSA.[22] However, an individual generally is not an eligible individual if the individual has received medical services at an IHS facility at any time during the previous three months.

[20] Sec. 223(d)(2)(B).
[21] As defined in section 1882 of the Social Security Act, 42 U.S.C. 1395ss. Sec. 223(d)(2)(C)(iv).
[22] Notice 2012–14, 2012–8 I.R.B. 411, February 21, 2012.

REASONS FOR CHANGE

The Committee believes Native Americans should be able to contribute to HSAs if otherwise eligible, not just individuals that have not received IHS or similar tribal medical benefits within the past three months.

EXPLANATION OF PROVISION

Under the provision, an individual is not treated as covered under a health plan other than an HDHP merely because the individual receives hospital care or medical services under a medical care program of the IHS or of a tribal organization. Thus, an individual who is otherwise an eligible individual for purposes of making HSA contributions does not become ineligible merely because of receiving hospital care or medical services under a medical care program of the IHS or of a tribal organization.

EFFECTIVE DATE

The provision applies to taxable years beginning after December 31, 2025.

D. ALLOWANCE OF BRONZE AND CATASTROPHIC PLANS IN CONNECTION WITH HEALTH SAVINGS ACCOUNTS (SEC. 5 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

For a general description of HDHPs, see Part A of this document.

Plans in the Health Benefit Exchanges[23] are defined by reference to various metal categories which correspond to the percentage of costs an enrollee is expected to incur, including bronze, silver, gold, and platinum plans.[24] A bronze plan provides coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.[25] This percentage increases to 70 percent in a silver plan, 80 percent in a gold plan, and 90 percent in a platinum plan.

Catastrophic plans[26] do not fall into any of these categories and have low monthly premiums and higher deductibles. Catastrophic plans are available only to individuals under 30 or individuals of any age with a hardship exemption. Under present law, catastrophic plans cannot be qualified as HDHPs.

REASONS FOR CHANGE

The Committee believes that, consistent with the intent of HDHPs, individuals enrolled in qualified health coverage with deductibles above the HDHP threshold should be eligible to contribute to HSAs and have identified bronze and catastrophic plans as meeting this requirement.

[23] See secs. 1311 and 1321 of Patient Protection and Affordable Care Act (the "PPACA").
[24] See sec. 1302 of the PPACA.
[25] Sec. 1302(d) of the PPACA.
[26] See sec. 1302(e) of the PPACA.

EXPLANATION OF PROVISION

Under the provision, any bronze or catastrophic plan [27] is treated as an HDHP.

EFFECTIVE DATE

The provision is applicable to months beginning after December 31, 2025, in taxable years ending after such date.

E. SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR MENTAL HEALTH SERVICES (SEC. 6 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

For a general description of HDHPs, see Part A of this document.

REASONS FOR CHANGE

The Committee believes that subject to a dollar limit, permitting individuals with HSAs to access mental health services at reduced rates before reaching their annual deductible would increase access to these important services.

EXPLANATION OF PROVISION

The provision provides that an HDHP is permitted to provide coverage for up to $500 of any mental health benefits [28] specified by the plan before satisfaction of the plan's annual deductible.

EFFECTIVE DATE

The provision applies to plan years beginning after December 31, 2025.

F. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT (SEC. 7 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

Health savings accounts and high deductible health plans

For a general description of HSAs and HDHPs, see Part A of this document.

In order for a distribution from an HSA to be excludable as a payment for a qualified medical expense, the medical expense must be incurred on or after the date that the HSA is established.[29] Thus, a distribution from an HSA is not excludable as a payment for a qualified medical expense if the medical expense is incurred after a taxpayer enrolls in an HDHP but before the taxpayer establishes an HSA.

REASONS FOR CHANGE

The Committee believes connecting consumers to their health care dollars through consumer-directed health plans, including HDHPs, reduces health care costs. The Committee further believes that HSAs are an important tool used in conjunction with HDHPs

[27] See sec. 1302(d)(1)(A) and (e) of the PPACA.
[28] As defined in sec. 9812(c)(4).
[29] Notice 2004–2, 2004–1 C.B. 269, Q&A–26.

to permit consumers to set aside funds and provide such consumers the choice on how to spend those funds to pay for medical care.

The Committee believes that allowing an HSA to be treated as established on the date coverage under an HDHP begins will avoid confusion and delays in care for individuals setting up their HSAs while expanding access to and enhancing the utility of HSAs.

EXPLANATION OF PROVISION

Under the provision, if an HSA is established during the 60-day period beginning on the date that an individual's coverage under an HDHP begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, the HSA is treated as having been established on the date that coverage under the HDHP begins. Thus, if a taxpayer establishes an HSA within 60 days of the date that the taxpayer's coverage under an HDHP begins, any distribution from an HSA used as a payment for a qualified medical expense incurred during that 60-day period after the HDHP coverage began is excludable from gross income as a payment for a qualified medical expense even though the expense was incurred before the date that the HSA was established.

EFFECTIVE DATE

The provision is effective with respect to coverage beginning after December 31, 2025.

G. Allow Both Spouses To Make Catch-Up Contributions to the Same Health Savings Account (Sec. 8 of the Bill and Sec. 223 of the Code)

PRESENT LAW

Health savings accounts

For a general description of HSAs, see Part A of this document.

Within limits, contributions to an HSA made by or on behalf of an eligible individual (with the exception of contributions by the individual's employer) are deductible by the individual. For 2023, the basic limit on annual contributions that can be made to an HSA is $3,850 in the case of self-only coverage and $7,750 in the case of family coverage.[30] The basic annual contributions limits are increased by $1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up" contributions).[31] If eligible individuals are married to each other and either spouse has family coverage, both spouses are treated as having only family coverage, so that the coverage limit for family coverage applies. The contribution limit, after being reduced by the aggregate amount paid to the Archer Medical Savings Accounts ("Archer MSAs") of the spouses, but without regard to any catch-up contribution amounts, is divided equally between the spouses unless they agree to a different division.[32]

If both spouses of a married couple are eligible individuals, each may contribute to an HSA, but they cannot have a joint HSA.[33]

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[30] Rev. Proc. 2022–24, 2022–20 I.R.B. 1075, May 16, 2022.
[31] Sec. 223(b)(3).
[32] Sec. 223(b)(5).
[33] Notice 2004–50, 2004–2 C.B. 196, Q&A–63.

Under the rule described above, however, the spouses may divide their basic contribution limit for the year by allocating the entire amount to one spouse to be contributed to that spouse's HSA.[34] However, this allocation rule does not apply to catch-up contribution amounts. Thus, if both spouses are at least age 55 and eligible to make catch-up contributions, each must make the catch-up contribution to his or her own HSA.[35]

REASONS FOR CHANGE

The Committee believes that HSAs are a useful tool to allow and encourage individuals and families to cover current and future health care expenses. The Committee further believes that there should be fewer barriers for those wishing to contribute to their HSAs.

Therefore, the Committee believes that spouses should be allowed to make catch-up contributions to the same HSA, without requiring each spouse to make the catch-up contribution to his or her own HSA.

EXPLANATION OF PROVISION

Under the provision, if both spouses of a married couple are eligible for catch-up contributions (*i.e.*, both spouses are at least age 55) and either has family coverage under a high deductible health plan as of the first day of any month, the annual contribution limit that can be allocated between them (after being reduced by the aggregate amount paid to the Archer MSAs of the spouses) includes the catch-up contribution amounts of both spouses. Thus, for example, the spouses may agree to have their combined basic and catch-up contribution amounts allocated to one spouse to be contributed to that spouse's HSA.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2025.

H. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION (SEC. 9 OF THE BILL AND SEC. 223 OF THE CODE)

PRESENT LAW

Health savings accounts and high deductible health plans

For a general description of HSAs and HDHPs, see Part A of this document.

Within limits, contributions to an HSA made by or on behalf of an eligible individual (with the exception of contributions by the individual's employer) are deductible by the individual. The annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (*i.e.*, 1⁄12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day

[34] Notice 2004–50, 2004–2 C.B. 196, Q&A–32. Funds from the spouse's HSA may be used to pay qualified medical expenses for either spouse on a tax-free basis. Notice 2004–50, Q&A–36.

[35] Notice 2004–50, 2004–2 C.B. 196, Q&A–22.

of the month.[36] For 2023, the basic limit on annual contributions that can be made to an HSA is $3,850 in the case of self-only coverage and $7,750 in the case of family coverage.[37] The basic annual contribution limits are increased by $1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up" contributions).[38]

REASONS FOR CHANGE

The Committee believes that the basic HSA contribution limit should be aligned to better reflect the actual health care costs (*i.e.*, the out-of-pocket expenses and the deductible) that individuals and families may have to cover.

EXPLANATION OF PROVISION

The provision increases the basic limit on aggregate HSA contributions for a year to equal the sum of the annual deductible and out-of-pocket expenses permitted under an HDHP. Thus, for 2023, the basic limit is $7,500 for self-only coverage and $15,000 in the case of family coverage. As under present law, the basic contribution limit is increased by $1,000 for an eligible individual who has attained age 55 by the end of the taxable year. In addition, as under present law, the annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (*i.e.*, 1⁄12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2025.

I. Clarification of Treatment of Distributions from Health Savings Account for Long-Term Care Services (Sec. 10 of the Bill and Sec. 223 of the Code)

PRESENT LAW

For general information on HSAs and HDHPs, see Part A of this document.

Qualified medical expenses

Generally, for purposes of distributions from HSAs, qualified medical expenses[39] mean amounts paid for medical care.[40] Medical care generally means (with respect to an account beneficiary) amounts paid for the diagnosis, cure, mitigation, treatment and prevention of disease, or for the purpose of affecting any structure or function of the body, as well as transportation primarily for and essential to medical care.

[36] Sec. 223(b).
[37] Rev. Proc. 2022–24, 2022–20 I.R.B. 1075, May 16, 2022.
[38] Sec. 223(b)(3).
[39] Sec. 223(d)(2); see also Notice 2004–50, 2004–2 C.B. 196, Q&A–42.
[40] Based on the definition under sec. 213(d). For HSA purposes, amounts paid for menstrual care products are treated as paid for medical care. Sec. 223(d)(2)(A).

Qualified long-term care services

Medical care also includes qualified long-term care services[41] which are certain necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal services required by a chronically ill individual which are provided pursuant to a plan of care prescribed by a licensed health care practitioner. The term "chronically ill individual" includes any individual who has been certified by a licensed health care practitioner (within the preceding 12-month period) as being unable to perform (without substantial assistance from another individual) at least two activities of daily living—eating, toileting, transferring, bathing, dressing, or continence—for a period of at least 90 days due to a loss of functional capacity. The term "maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment). A "licensed health care practitioner" is any physician[42] and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

REASONS FOR CHANGE

The Committee believes connecting consumers to their health care dollars through consumer-directed health plans, including high deductible health plans, reduces health care costs. The Committee further believes that HSAs are an important tool used in conjunction with HDHPs to permit consumers to set aside funds and provide such consumers the choice on how to spend those funds to pay for medical care.

The Committee believes that individuals should be able to use their HSAs to pay for qualified long-term care services, including certain home health care services, for chronically ill individuals.

EXPLANATION OF PROVISION

The provision clarifies that qualified medical expenses include amounts paid for qualified long-term care services, allowing HSA distributions to be used to pay for needed assistance for chronically ill individuals.

EFFECTIVE DATE

The provision is effective for amounts paid after the date of enactment.

Nothing contained in the provision is to be construed to create any inference with respect to any amounts paid on or before the date of enactment.

[41] Sec. 213(d)(1)(C). Qualified long-term care services are defined in section 7702B(c).

[42] As defined in section 1861(r)(1) of the Social Security Act, 42 U.S.C. 1395x. Section 1861(r)(1) of the Social Security Act provides that a doctor of medicine or osteopathy must be legally authorized to practice medicine and surgery by the State in which he performs such function or action.

III. VOTE OF THE COMMITTEE

Pursuant to clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 5687, the “HSA Modernization Act of 2023,” on September 28, 2023.

H.R. 5687 was ordered favorably reported to the House of Representatives as amended by a roll call vote of 24 yeas to 18 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Smith (MO)	X			Mr. Neal		X	
Mr. Buchanan	X			Mr. Doggett		X	
Mr. Smith (NE)	X			Mr. Thompson		X	
Mr. Kelly	X			Mr. Larson		X	
Mr. Schweikert	X			Mr. Blumenauer		X	
Mr. LaHood	X			Mr. Pascrell		X	
Dr. Wenstrup	X			Mr. Davis		X	
Mr. Arrington	X			Ms. Sánchez		X	
Dr. Ferguson	X			Mr. Higgins		X	
Mr. Estes	X			Ms. Sewell		X	
Mr. Smucker	X			Ms. DelBene		X	
Mr. Hern	X			Ms. Chu		X	
Ms. Miller	X			Ms. Moore		X	
Dr. Murphy	X			Mr. Kildee		X	
Mr. Kustoff	X			Mr. Beyer		X	
Mr. Fitzpatrick	X			Mr. Evans		X	
Mr. Steube				Mr. Schneider		X	
Ms. Tenney	X			Mr. Panetta		X	
Mrs. Fischbach	X						
Mr. Moore	X						
Mrs. Steel	X						
Ms. Van Duyne	X						
Mr. Feenstra	X						
Ms. Malliotakis	X						
Mr. Carey	X						

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 5687, as reported.

The estimate prepared by the Congressional Budget Office (CBO) is included below.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

At a Glance

H.R. 5687, HSA Modernization Act of 2023
As ordered reported by the House Committee on Ways and Means on September 28, 2023

By Fiscal Year, Billions of Dollars	2024	2024-2028	2024-2033
Direct Spending (Outlays)	0	-0.5	-2.7
Revenues	0	-15.9	-61.1
Increase or Decrease (-) in the Deficit	0	15.3	58.3
Spending Subject to Appropriation (Outlays)	0	*	not estimated

Increases *net direct spending* in any of the four consecutive 10-year periods beginning in 2034?	No	Statutory pay-as-you-go procedures apply?	Yes
		Mandate Effects	
Increases *on-budget deficits* in any of the four consecutive 10-year periods beginning in 2034?	> $5 billion	Contains intergovernmental mandate?	No
		Contains private-sector mandate?	No

* = between zero and $500,000.

The bill would:
- Expand eligibility for health savings accounts (HSAs)
- Increase annual HSA contribution limits to $7,500 for self-only coverage and $15,000 for family coverage
- Increase the HSA catch-up contribution limit by $1,000 for people age 55 or older

Estimated budgetary effects would mainly stem from:
- Decreased Medicare outlays caused by increased use of HSAs
- Reduced revenues from expanding HSA contribution limits and eligibility

Areas of significant uncertainty include:
- Anticipating the number of taxpayers who would contribute to HSAs and the amount of their contributions

The Congressional Budget Act of 1974, as amended, stipulates that revenue estimates provided by the staff of the Joint Committee on Taxation (JCT) are the official estimates for all tax legislation considered by the Congress. CBO therefore incorporates such estimates into its cost estimates of the effects of legislation. Most of the estimates for the provisions of this bill were provided by JCT.

Bill summary: H.R. 5687 would increase contribution limits and expand eligibility for health savings accounts (HSAs)—tax-favored accounts used to cover medical expenses for people with high-deductible health plans (HDHPs). The bill also would modify certain coverage requirements for HDHPs. H.R. 5687 would take effect for tax years beginning after December 31, 2025.

Estimated Federal cost: The estimated budgetary effect of H.R. 5687 is shown in Table 1. The costs of the legislation fall within budget functions 570 (Medicare), 550 (health), 700 (veterans benefits and services), and 800 (general government).

Basis of estimate: The Congressional Budget Act of 1974, as amended, stipulates that revenue estimates provided by the staff of the Joint Committee on Taxation (JCT) are the official estimates

for all tax legislation considered by the Congress. CBO therefore incorporates such estimates into its cost estimates of the effects of legislation. JCT provided all revenue estimates presented here for H.R. 5687.[1]

For this estimate, CBO and JCT assume that the bill will be enacted in fiscal year 2024 and that, except as otherwise specified, its provisions would affect tax years beginning in 2026.

Direct spending and revenues: CBO and JCT estimate that enacting H.R. 5687 would reduce Medicare outlays because some people would remain in an HDHP who would not do so under current law. JCT estimates that enacting the bill would reduce income tax receipts because new or larger HSA contributions would reduce income tax liabilities for some filers.

CBO and JCT estimate that, in total, H.R. 5687 would reduce revenues by $61.1 billion and reduce outlays by $2.7 billion over the 2024–2033 period. The bill's revenue reductions include Social Security taxes, which are classified as off-budget.

[1] For JCT's preliminary estimates of the provisions that include detail beyond the summary presented here, see Joint Committee on Taxation, *Estimated Revenue Effects of H.R. 5687, the "HSA Modernization Act of 2023," Scheduled for Markup by the Committee on Ways and Means on September 28, 2023*, JCX–42–43 (September 26, 2023), www.jct.gov/publications/2023/jcx-42-23; other details are in Joint Committee on Taxation, *Description of the Chairman's Amendment in the Nature of a Substitute to H.R. 5687, The "HSA Modernization Act of 2023,"* JCX–44–23 (September 27, 2023), www.jct.gov/publications/2023/jcx-44-23.

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF H.R. 5687

	By fiscal year, billions of dollars—											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024–2028	2024–2033
Decreases in Direct Spending												
Estimated Budget Authority	0	0	−0.1	−0.2	−0.3	−0.4	−0.4	−0.4	−0.5	−0.5	−0.6	−2.7
Estimated Outlays	0	0	−0.1	−0.2	−0.3	−0.4	−0.4	−0.4	−0.5	−0.5	−0.6	−2.7
Decreases in Revenues												
Section 3, Extend Tax Exclusion of HSA Contributions to Certain Medicare Part A Enrollees												
Estimated Revenues	0	0	−0.2	−0.5	−0.9	−1.2	−1.3	−1.4	−1.4	−1.5	−1.7	−8.5
On-Budget Revenues	0	0	−0.1	−0.4	−0.6	−0.8	−0.9	−0.9	−1.0	−1.1	−1.2	−5.9
Off-Budget Revenues	0	0	−0.1	−0.2	−0.3	−0.4	−0.4	−0.4	−0.4	−0.5	−0.5	−2.6
Section 9, Increase HSA Contribution Limits												
Estimated Revenues	0	0	−2.5	−4.5	−5.2	−5.6	−6.0	−6.4	−6.8	−7.2	−12.2	−44.2
On-Budget Revenues	0	0	−1.9	−3.5	−4.0	−4.2	−4.5	−4.8	−5.2	−5.5	−9.3	−33.5
Off-Budget Revenues	0	0	−0.6	−1.1	−1.3	−1.3	−1.4	−1.5	−1.7	−1.8	−2.9	−10.7
All Other Sections [a]												
Estimated Revenues	0	0	−0.3	−0.7	−0.9	−1.1	−1.2	−1.3	−1.4	−1.5	−2.0	−8.4
On-Budget Revenues	0	0	−0.2	−0.6	−0.7	−0.9	−1.0	−1.0	−1.1	−1.2	−1.5	−6.7
Off-Budget Revenues	0	0	−0.1	−0.1	−0.2	−0.2	−0.2	−0.3	−0.3	−0.3	−0.4	−1.7
Total Decreases												
Estimated Revenues	0	0	−3.0	−5.8	−7.1	−7.9	−8.5	−9.0	−9.6	−10.2	−15.9	−61.1
On-Budget Revenues	0	0	−2.3	−4.4	−5.4	−5.9	−6.4	−6.8	−7.3	−7.7	−12.0	−46.1
Off-Budget Revenues	0	0	−0.7	−1.4	−1.7	−1.9	−2.1	−2.2	−2.4	−2.5	−3.8	−15.0
Net Increase in the Deficit From Changes in Direct Spending and Revenues												
Effect on the Deficit	0	0	2.9	5.6	6.8	7.5	8.1	8.6	9.2	9.7	15.3	58.3
On-Budget Increases	0	0	2.2	4.2	5.1	5.6	6.0	6.4	6.8	7.2	11.5	43.4
Off-Budget Increases	0	0	0.7	1.4	1.7	1.9	2.1	2.2	2.4	2.5	3.8	15.0

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.
Components may not sum to totals because of rounding; HSA = health savings account.
CBO estimates that implementing H.R. 5687 would increase spending subject to appropriation by less than $500,000 in any year over the 2024–2028 period.
[a] Includes effects of interactions among all of the bill's provisions.

Section 3. This section would expand HSA eligibility to include some people who are eligible for Medicare Part A: People enrolled in an HDHP would no longer lose the tax preference for HSA contributions when they enroll in Medicare at age 65. As a result, CBO and JCT expect that some beneficiaries who, under current law, would drop their HDHP coverage would instead retain that coverage and thus make Medicare their secondary payer.

CBO and JCT estimate that as a result, Medicare outlays would decline by $2.7 billion over the 2024–2033 period. JCT also estimates that, as a result of the additional HSA contributions, enacting section 3 would reduce revenues by $8.5 billion over the same period.

Section 9. This section would raise the annual HSA contribution limit from $3,850 for self-only coverage to $7,500 and from $7,750 for family coverage to $15,000 (if the policy was in place for 2023). As under current law, those amounts would be indexed for inflation and people age 55 or older could make an additional $1,000 in catch-up contributions. All of the increases would take effect for tax years after 2025. JCT estimates that the changes to contribution limits would reduce revenues by $44.2 billion over the 2024–2033 period.

All Other Sections. Provisions in other sections of the bill would expand HSA eligibility to include veterans receiving care through the Department of Veterans Affairs, enrollees in certain health care exchange plans with low premiums, and people receiving medical care through the Indian Health Service. In addition, the bill would allow HDHPs to cover as much as $500 annually for mental health services before the plan's deductible is met and would allow HSA funds to be used for health care services provided up to 60 days before the HSA is established. Finally, H.R. 5687 would allow a spouse to make catch-up contributions into the same HSA rather than having to establish a separate account to do so. JCT estimates that enacting those provisions would reduce revenues by an additional $8.4 billion over the 2024–2033 period; that estimate accounts for interactions among all of the bill's provisions. CBO estimates that some veterans who currently forego receiving health care through the Department of Veterans Affairs in order to maintain an HSA would no longer do so under H.R. 5687. Some costs for health care provided through the Department of Veterans Affairs are paid from the Toxic Exposures Fund, which is a mandatory appropriation; CBO estimates that any changes to such direct spending stemming from those provisions would be insignificant.

Spending subject to appropriation: CBO estimates that implementing H.R. 5687 would increase the Internal Revenue Service's administrative costs by less than $500,000 over the 2024–2028 period. There also would be an insignificant cost for spending on health care for veterans and for people receiving medical care through the Indian Health Service over the same period. That spending would be subject to the availability of appropriated funds.

Uncertainty: JCT's and CBO's estimates of the budgetary effects of H.R. 5687 are subject to uncertainty because they are made on the basis of underlying projections and other factors that could change significantly. In particular, the estimates here rely on CBO's economic projections for the next decade under current law and on expectations about the way taxpayers and beneficiaries of

other health care programs might respond to changes in tax law. In this case, the uncertainty involves how many people would decide to contribute to an HSA after the 2025 tax year and how much they would contribute.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures. The net changes in outlays and revenues that are subject to those pay-as-you-go procedures are shown in Table 2.

TABLE 2.—CBO'S ESTIMATE OF THE STATUTORY PAY-AS-YOU-GO EFFECTS OF H.R. 5687, THE HSA MODERNIZATION ACT OF 2023, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON SEPTEMBER 28, 2023

	By fiscal year, billions of dollars—											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024–2028	2024–2033
Net Increase in the On-Budget Deficit												
Pay-As-You-Go Effect	0	0	2.2	4.2	5.1	5.6	6.0	6.4	6.8	7.2	11.5	43.4
Memorandum:												
Changes in Outlays	0	0	−0.1	−0.2	−0.3	−0.4	−0.4	−0.4	−0.5	−0.5	−0.6	−2.7
Changes in Revenues	0	0	−2.3	−4.4	−5.4	−5.9	−6.4	−6.8	−7.3	−7.7	−12.0	−46.1

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Increase in long-term net direct spending and deficits: CBO and JCT estimate that enacting H.R. 5687 would not increase net direct spending in any of the four consecutive 10-year periods beginning in 2034.

CBO and JCT estimate that enacting H.R. 5687 would increase on-budget deficits by more than $5 billion in at least one of the four consecutive 10-year periods beginning in 2034.

Mandates: JCT has determined that H.R. 5687 would not impose intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

Estimate prepared by: Federal Revenues: Nathaniel Frentz, Staff of the Joint Committee on Taxation; Federal Costs: Sarah Sajewski for Medicare, Matthew Pickford for Internal Revenue Service, Staff of the Joint Committee on Taxation; Mandates: Andrew Laughlin, Staff of the Joint Committee on Taxation.

Estimate reviewed by: Joshua Shakin, Chief, Revenue Estimating Unit; Robert Reese, Chief, Natural and Physical Resources Cost Estimates Unit; Asha Saavoss, Chief, Medicare and Health Systems Cost Estimates Unit; Kathleen FitzGerald, Chief, Public and Private Mandates Unit; H. Samuel Papenfuss, Deputy Director of Budget Analysis; John McClelland, Director of Tax Analysis.

Estimate approved by: Phillip L. Swagel, Director, Congressional Budget Office.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee made findings and recommendations that are reflected in this report.

B. Statement of General Performance Goals and Objectives

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill does not authorize funding, so no statement of general performance goals and objectives is required.

C. Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104–4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill, and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

E. Duplication of Federal Programs

In compliance with clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program; (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139; or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to the Federal Program Information Act (Pub. L. No. 95–220, as amended by Pub. L. No. 98–169).

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

A. Text of Existing Law Amended or Repealed by the Bill, as Reported

With respect to the requirement of clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are reflected in the following.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, and existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

* * * * * * *

Subtitle A—Income Taxes

* * * * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * * * *

Subchapter B—COMPUTATION OF TAXABLE INCOME

* * * * * * *

PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

* * * * * * *

SEC. 223. HEALTH SAVINGS ACCOUNTS.

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

(b) LIMITATIONS.—

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

(2) MONTHLY LIMITATION.—The monthly limitation for any month is $^{1}/_{12}$ of—

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

(B) in the case of an eligible individual who has family coverage under a high deductible health plan as of the first day of such month, 【$4,500】 *the amount in effect under subsection (c)(2)(A)(ii)(II)*.

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

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

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

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

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

(B) the aggregate amount contributed to health savings accounts of such individual which is excludable from the taxpayer's gross income for such taxable year under section 106(d) (and such amount shall not be allowed as a deduction under subsection (a)), and

(C) the aggregate amount contributed to health savings accounts of such individual for such taxable year under section 408(d)(9) (and such amount shall not be allowed as a deduction under subsection (a)).

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

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

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

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

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

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

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

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

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

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

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

(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is sub-

ject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.

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

(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act *(other than an entitlement to benefits described in subsection (c)(1)(B)(iv))* and for each month thereafter.

(8) INCREASE IN LIMIT FOR INDIVIDUALS BECOMING ELIGIBLE INDIVIDUALS AFTER THE BEGINNING OF THE YEAR.—

(A) IN GENERAL.—For purposes of computing the limitation under paragraph (1) for any taxable year, an individual who is an eligible individual during the last month of such taxable year shall be treated—

(i) as having been an eligible individual during each of the months in such taxable year, and

(ii) as having been enrolled, during each of the months such individual is treated as an eligible individual solely by reason of clause (i), in the same high deductible health plan in which the individual was enrolled for the last month of such taxable year.

(B) FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(i) IN GENERAL.—If, at any time during the testing period, the individual is not an eligible individual, then—

(I) gross income of the individual for the taxable year in which occurs the first month in the testing period for which such individual is not an eligible individual is increased by the aggregate amount of all contributions to the health savings account of the individual which could not have been made but for subparagraph (A), and

(II) the tax imposed by this chapter for any taxable year on the individual shall be increased by 10 percent of the amount of such increase.

(ii) EXCEPTION FOR DISABILITY OR DEATH.—Subclauses (I) and (II) of clause (i) shall not apply if the individual ceased to be an eligible individual by reason of the death of the individual or the individual becoming disabled (within the meaning of section 72(m)(7)).

(iii) TESTING PERIOD.—The term "testing period" means the period beginning with the last month of the taxable year referred to in subparagraph (A) and ending on the last day of the 12th month following such month.

(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—The term "eligible individual" means, with respect to any month, any individual if—

(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

(I) which is not a high deductible health plan, and

(II) which provides coverage for any benefit which is covered under the high deductible health plan.

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

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

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, long-term care, or (in the case of months or plan years to which paragraph (2)(E) applies) telehealth and other remote care, [and]

(iii) for taxable years beginning after December 31, 2006, coverage under a health flexible spending arrangement during any period immediately following the end of a plan year of such arrangement during which unused benefits or contributions remaining at the end of such plan year may be paid or reimbursed to plan participants for qualified benefit expenses incurred during such period if—

(I) the balance in such arrangement at the end of such plan year is zero, or

(II) the individual is making a qualified HSA distribution (as defined in section 106(e)) in an amount equal to the remaining balance in such arrangement as of the end of such plan year, in accordance with rules prescribed by the Secretary[.]*, and*

(iv) entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act by reason of section 226(a) of such Act.

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

(D) SPECIAL RULE FOR INDIVIDUALS RECEIVING BENEFITS SUBJECT TO SURPRISE BILLING STATUTES.—An individual shall not fail to be treated as an eligible individual for any period merely because the individual receives benefits for

medical care subject to and in accordance with section 9816 or 9817, section 2799A–1 or 2799A–2 of the Public Health Service Act, or section 716 or 717 of the Employee Retirement Income Security Act of 1974, or any State law providing similar protections to such individual.

(E) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR ASSISTANCE UNDER INDIAN HEALTH SERVICE PROGRAMS.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in such subparagraph merely because the individual receives hospital care or medical services under a medical care program of the Indian Health Service or of a tribal organization.

(2) HIGH DEDUCTIBLE HEALTH PLAN.—

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

(i) which has an annual deductible which is not less than—

(I) $1,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage, and

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

(I) $5,000 for self-only coverage, and

(II) twice the dollar amount in subclause (I) for family coverage.

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

(C) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care (within the meaning of section 1861 of the Social Security Act, except as otherwise provided by the Secretary).

(D) SPECIAL RULES FOR NETWORK PLANS.—In the case of a plan using a network of providers—

(i) ANNUAL OUT-OF-POCKET LIMITATION.—Such plan shall not fail to be treated as a high deductible health plan by reason of having an out-of-pocket limitation for services provided outside of such network which exceeds the applicable limitation under subparagraph (A)(ii).

(ii) ANNUAL DEDUCTIBLE.—Such plan's annual deductible for services provided outside of such network shall not be taken into account for purposes of subsection (b)(2).

(E) SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR TELEHEALTH.—In the case of—

(i) months beginning after March 31, 2022, and before January 1, 2023, and

(ii) plan years beginning on or before December 31, 2021, or after December 31, 2022, and before January 1, 2025,

a plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for telehealth and other remote care services.

(F) SPECIAL RULE FOR SURPRISE BILLING.—A plan shall not fail to be treated as a high deductible health plan by reason of providing benefits for medical care in accordance with section 9816 or 9817, section 2799A–1 or 2799A–2 of the Public Health Service Act, or section 716 or 717 of the Employee Retirement Income Security Act of 1974, or any State law providing similar protections to individuals, prior to the satisfaction of the deductible under paragraph (2)(A)(i).

(G) SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR CERTAIN INSULIN PRODUCTS.—

(i) IN GENERAL.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for selected insulin products.

(ii) SELECTED INSULIN PRODUCTS.—For purposes of this subparagraph—

(I) IN GENERAL.—The term "selected insulin products" means any dosage form (such as vial, pump, or inhaler dosage forms) of any different type (such as rapid-acting, short-acting, intermediate-acting, long-acting, ultra long-acting, and premixed) of insulin.

(II) INSULIN.—The term "insulin" means insulin that is licensed under subsection (a) or (k) of section 351 of the Public Health Service Act (42 U.S.C. 262) and continues to be marketed under such section, including any insulin product that has been deemed to be licensed under section 351(a) of such Act pursuant to section 7002(e)(4) of the Biologics Price Competition and Innovation Act of 2009 (Public Law 111–148) and continues to be marketed pursuant to such licensure.

(H) BRONZE AND CATASTROPHIC PLANS TREATED AS HIGH DEDUCTIBLE HEALTH PLANS.—The term "high deductible health plan" shall include any plan described in subsection (d)(1)(A) or (e) of section 1302 of the Patient Protection and Affordable Care Act.

(I) SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR MENTAL HEALTH SERVICES.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for not more than the first $500 of any mental health benefits (as defined in section 9812(e)(4)) specified by the plan for purposes of this subparagraph.

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

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

(i) liabilities incurred under workers' compensation laws,

(ii) tort liabilities,

(iii) liabilities relating to ownership or use of property, or

(iv) such other similar liabilities as the Secretary may specify by regulations,

(B) insurance for a specified disease or illness, and

(C) insurance paying a fixed amount per day (or other period) of hospitalization.

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

(5) ARCHER MSA.—The term "Archer MSA" has the meaning given such term in section 220(d).

(d) HEALTH SAVINGS ACCOUNT.—For purposes of this section—

(1) IN GENERAL.—The term "health savings account" means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a rollover contribution described in subsection (f)(5) or section 220(f)(5), no contribution will be accepted—

(i) unless it is in cash, or

(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the sum of—

(I) the dollar amount in effect under subsection (b)(2)(B), and

(II) the dollar amount in effect under subsection (b)(3)(B).

(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term "qualified medical expenses" means, with respect to an account beneficiary, amounts paid by such beneficiary for medical care (as defined in section 213(d)) for such individual, the spouse of such individual, and any dependent (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) of such individual, but only to the extent such amounts are not compensated for by insurance or otherwise. *Such term includes amounts paid for qualified long-term care services (as defined in section 7702B(c)).* For purposes of this subparagraph, amounts paid for men-

strual care products shall be treated as paid for medical care.

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A) shall not apply to any payment for insurance.

(C) EXCEPTIONS.—Subparagraph (B) shall not apply to any expense for coverage under—

(i) a health plan during any period of continuation coverage required under any Federal law,

(ii) a qualified long-term care insurance contract (as defined in section 7702B(b)),

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

(iv) in the case of an account beneficiary who has attained the age specified in section 1811 of the Social Security Act *and who is not an eligible individual*, any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act).

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

(E) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.

(3) ACCOUNT BENEFICIARY.—The term "account beneficiary" means the individual on whose behalf the health savings account was established.

(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

(A) Section 219(d)(2) (relating to no deduction for rollovers).

(B) Section 219(f)(3) (relating to time when contributions deemed made).

(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

(D) Section 408(g) (relating to community property laws).

(E) Section 408(h) (relating to custodial accounts).

(e) TAX TREATMENT OF ACCOUNTS.—

(1) IN GENERAL.—A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(f) TAX TREATMENT OF DISTRIBUTIONS.—

(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

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

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

(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

(i) such distribution is received by the individual on or before the last day prescribed by law (including extensions of time) for filing such individual's return for such taxable year, and

(ii) such distribution is accompanied by the amount of net income attributable to such excess contribution.

Any net income described in clause (ii) shall be included in the gross income of the individual for the taxable year in which it is received.

(B) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term "excess contribution" means any contribution (other than a rollover contribution described in paragraph (5) or section 220(f)(5)) which is neither excludable from gross income under section 106(d) nor deductible under this section.

(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 20 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—【Subparagraph (A)】 *Except in the case of an eligible individual, subparagraph (A)* shall not apply to any payment or distribution after the date on which the ac-

count beneficiary attains the age specified in section 1811 of the Social Security Act.

(5) ROLLOVER CONTRIBUTION.—An amount is described in this paragraph as a rollover contribution if it meets the requirements of subparagraphs (A) and (B).

(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of this paragraph.

(6) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of determining the amount of the deduction under section 213, any payment or distribution out of a health savings account for qualified medical expenses shall not be treated as an expense paid for medical care.

(7) TRANSFER OF ACCOUNT INCIDENT TO DIVORCE.—The transfer of an individual's interest in a health savings account to an individual's spouse or former spouse under a divorce or separation instrument described in clause (i) of section 121(d)(3)(C) shall not be considered a taxable transfer made by such individual notwithstanding any other provision of this subtitle, and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the account beneficiary.

(8) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—

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

(B) OTHER CASES.—

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

(I) such account shall cease to be a health savings account as of the date of death, and

(II) an amount equal to the fair market value of the assets in such account on such date shall be includible if such person is not the estate of such beneficiary, in such person's gross income for the taxable year which includes such date, or if such person is the estate of such beneficiary, in such

beneficiary's gross income for the last taxable year of such beneficiary.

(ii) SPECIAL RULES.—

(I) REDUCTION OF INCLUSION FOR PREDEATH EXPENSES.—The amount includible in gross income under clause (i) by any person (other than the estate) shall be reduced by the amount of qualified medical expenses which were incurred by the decedent before the date of the decedent's death and paid by such person within 1 year after such date.

(II) DEDUCTION FOR ESTATE TAXES.—An appropriate deduction shall be allowed under section 691(c) to any person (other than the decedent or the decedent's spouse) with respect to amounts included in gross income under clause (i) by such person.

(g) COST-OF-LIVING ADJUSTMENT.—

(1) IN GENERAL.—Each dollar amount in [subsections (b)(2) and] *subsection* (c)(2)(A) shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

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

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

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

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

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

(h) REPORTS.—The Secretary may require—

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

(2) any person who provides an individual with a high deductible health plan to make such reports to the Secretary and to the account beneficiary with respect to such plan as the Secretary determines appropriate.

The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

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VII. DISSENTING VIEWS

H.R. 5687 (Van Duyne, R–TX–24) includes a series of provisions intended to incentivize use of health savings accounts (HSAs), which are tax-preferred savings accounts that are paired with high-deductible health plans (HDHPs). HDHPs, as the name implies, are health plans that have high deductibles, requiring Americans to pay thousands of dollars out-of-pocket before insurance begins. More specifically, this bill expands HSA contribution eligibility and categorizes Affordable Care Act marketplace Bronze and Catastrophic plans as HDHPs for the purposes of HSA eligibility. It also changes contribution rules, allows individuals to disburse funds for expenses incurred before establishing an HSA, allows for catch-up contributions for individuals over 55, and increases the maximum contribution limit to the qualifying deductible and out-of-pocket maximum for an HDHP (for 2023, $7,500 for individuals and $15,000 for families). According to the Joint Committee on Taxation, this bill would cost American taxpayers $58.34 billion over 10 years—and the provisions do not take effect until 2026.

This legislation neither lowers out-of-pocket health care costs nor improves insurance coverage. These provisions do nothing to lower the cost of care or provide coverage to the millions of underinsured or uninsured Americans. HSAs are not health insurance but tax-preferred savings accounts: Contributions are pretax, assets grow tax-free, and distributions are not taxed for qualified medical expenses.[1] The fundamental premise behind HSAs is that individuals should be responsible for saving for their own health care needs, which is a flawed approach because even paying for non-catastrophic events is beyond the reach of most American families. The American Hospital Association points to the prevalence of HDHPs as one of the paramount drivers of medical debt. Twenty percent of employers that offer HDHPs do not contribute to an HSA for their employees, and most firms offer a modest $400 to $799 for individual coverage.[2] This trend leaves employees at risk for all or most of the cost of the deductible. Thus, individuals with incomes below $75,000 who have HDHPs are likely to forgo needed medical care, specifically low-cost primary care services.[3] Unlike the Republican approach to health care, the Democrats' *Inflation Reduction Act* made key investments to lower prescription drug prices, reduce

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[1] Joseph Slife & Matt Bell, *A Health Savings Account: The Other "Retirement Account,"* SOUND MIND INVESTING (Jan. 27, 2023), https://soundmindinvesting.com/articles/a-health-savings-account-the-other-retirement-account.

[2] *2022 employer health benefits survey—section 8: High-deductible health plans with savings option.* KFF. (2022, October 27). https://www.kff.org/report-section/ehbs-2022-section-8-high-deductible-health-plans-with-savings-option/#:~:text=ENROLLMENT%20IN%20HDHP%2FHRAS%20AND%20HSA%2DQUALIFIED%20HDHPS&text=Enrollment%20in%20HDHP%2FSOs%20has,HSA%2Dqualified%20HDHPs%20in%202022.

[3] Schnettler, T. (2022, July 19). *Impact of high deductible health plans on Health Care Utilization.* Vital Record. https://vitalrecord.tamhsc.edu/impact-of-high-deductible-health-plans-on-health-care-utilization/.

patients' out-of-pocket health costs, reduce insurance premiums, and enhance the tax credits that make insurance coverage affordable for more than 13 million Americans.[4]

HSAs provide little benefit for the average American family. While 75 percent of HSA *account holders* live in ZIP codes with a median household income of less than $100,000 only four percent of all HSA *contributions* come from households with incomes $50,000 or below, demonstrating that most lower and middle income Americans with an account do not actually contribute to it.[5] [6] In contrast, 77 percent of contributions to HSAs come from households with incomes over $100,000 and 44 percent from households with incomes over $200,000.[7] People with incomes over $100,000 represent 78 percent of participants maxing out HSA contributions.[8]

HSAs exacerbate health disparities. This legislation does nothing to reduce health disparities or address the generational wealth gaps and poorer health outcomes for people of color. A typical White family in 2019 had *eight times* the wealth of a typical Black family and five times the wealth of a typical Latino family. The median wealth of White households was $171,000, compared with $17,100 for Black households and $20,600 for Latino households.[9] Thus, people of color benefit from the tax benefits of HSAs far less than White people, as the preferential tax treatment accrues inequitably along income lines and is disproportionately out of reach for many people of color. Account balances, contributions, and distributions from HSA accounts differ significantly by race, and HSA expansion will only exacerbate the health equity and wealth gap.[10]

HSAs impact solvency of Medicare and Social Security Trust Funds. HSAs have multiple tax advantages for accumulating wealth. Contributions to HSAs are made with pretax dollars (in most states), assets grow tax-free, and distributions are tax-free if used to pay for qualified medical expenses or as reimbursement for such expenses. These tax giveaways will cost the federal government more than $180 billion over the next 10 years, disproportionately benefitting the wealthy—and H.R. 5688 would add another

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[4] *The Inflation Reduction Act Turns One: Millions of Americans Are Saving On Health Care, With More To Come.* PROTECT OUR CARE, (2023). https://www.protectourcare.org/wp-content/uploads/2023/08/IRA-First-Anniversary-Fact-Sheet.pdf.

[5] *2022 Devenir & HSA Council Demographic Survey.* DEVENIR RESEARCH (July, 13, 2023), https://www.devenir.com/wp-content/uploads/2022-Devenir-and-HSA-Council-Demographic-Report.pdf.

[5] Gideon Lukens, *House Bills Expanding HSAs Would Boost High-Income Tax Breaks—Not Affordability of Care,* CENTER ON BUDGET AND POLICY PRIORITIES (Sep. 27, 2023), https://www.cbpp.org/blog/house-bills-expanding-hsas-would-boost-high-income-tax-breaks-not-affordability-of-care#:~:text=Two%20bills%20due%20for%20House,costing%20over%20%2470%20billion%20combined%2C.

[7] Gideon Lukens, *House Bills Expanding HSAs Would Boost High-Income Tax Breaks—Not Affordability of Care,* CENTER ON BUDGET AND POLICY PRIORITIES (Sep. 27, 2023), https://www.cbpp.org/blog/house-bills-expanding-hsas-would-boost-high-income-tax-breaks-not-affordability-of-care#:~:text=Two%20bills%20due%20for%20House,costing%20over%20%2470%20billion%20combined%2C.

[8] Gideon Lukens, *Expanding Health Savings Accounts Would Boost Tax Shelters, Not Access to Care,* CENTER ON BUDGET AND POLICY PRIORITIES (June 22, 2023). https://www.cbpp.org/research/health/expanding-health-savings-accounts-would-boost-tax-shelters-not-access-to-care.

[9] DOROTHY BROWN, THE WHITENESS OF WEALTH: HOW THE TAX SYSTEM IMPOVERISHES BLACK AMERICANS—AND HOW WE CAN FIX IT 18 (2021).

[10] Spiegel, J. *Examining HSAs through a DEI lens.* EMPLOYEE BENEFIT RESEARCH INSTITUTE, (2022, April 7).

$12.95 billion to that total over the next decade.[11] Because employer contributions to HSAs are not subject to the payroll tax imposed on either the employer or the employee, expanding their use will inevitably reduce contributions into the Medicare and Social Security Trust Funds, harming America's seniors and people with disabilities. Closing the Medicaid coverage gap or extending marketplace premium tax credits for the next 10 years would cost about the same as continuing to fund HSAs.[12]

HSAs are a tax shelter for the wealthy. HSAs disproportionately benefit wealthy Americans—and this legislation seeks to make HSAs more attractive. People with higher incomes receive the biggest tax benefit for each dollar contributed to an HSA because the value of a tax deduction rises with an individual's tax bracket.[13] People with income in the lowest tax brackets save up to 12 cents on the dollar in federal income taxes for their HSA contributions.[14] By comparison, those earning over half a million dollars save 37 cents for each dollar in federal income taxes put into an HSA.[15] At age 65, withdrawals can be used for *any* purpose with no penalty. This loophole means HSA funds can be used for any non-medical expenses after age 65 without paying a penalty for non-medical use. HSA funds can be used to cover day-to-day expenses, pay for home renovations, or even finance a new boat.[16] [17] Investment advisors see a lucrative opportunity and are now marketing HSAs as retirement and wealth accumulation products, not health care accounts.[18] Democrats offered an amendment to H.R. 5688 to close this tax loophole, but the majority rejected the changes. Republicans would rather exacerbate disparities by giving away billions to the wealthy.

Low- and middle-income Americans often cannot take advantage of the tax benefits of HSAs in the same way wealthy Americans do. Those with higher incomes can afford to take on the risk of a high deductible and are more likely to establish HSAs compared to low-income consumers. For those who have little to contribute, given fees and extremely low interest rates, these accounts may offer little value. Some account holders could actually be *losing* money. Six of seven major institutions require a minimum balance to invest their HSA contributions, some up to $2,000. Some accounts offer

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[11] Gideon Lukens, *Expanding Health Savings Accounts Would Boost Tax Shelters, Not Access to Care,* CENTER ON BUDGET AND POLICY PRIORITIES (June 22, 2023). https://www.cbpp.org/research/health/expanding-health-savings-accounts-would-boost-tax-shelters-not-access-to-care.

[12] *House GOP Health Care Bills Benefit the Wealthy and Diminish Affordable Care Act Protections,* PROTECT OUR CARE (June 7, 22023). https://www.protectourcare.org/house-gop-health-care-bills-benefit-the-wealthy-and-diminish-affordable-care-act-protections/.

[13] Ryan Ermey, *This savings account offers a 'triple tax benefit'—but 88% of users are missing out,* CNBC (Feb. 9, 2023), https://www.cnbc.com/2023/02/09/health-savings-accounts-how-to-save-for-retirement.html.

[14] Gideon Lukens, *Expanding Health Savings Accounts Would Boost Tax Shelters, Not Access to Care,* CENTER ON BUDGET AND POLICY PRIORITIES (June 22, 2023). https://www.cbpp.org/research/health/expanding-health-savings-accounts-would-boost-tax-shelters-not-access-to-care.

[15] *Id.*

[16] *How to avoid penalties on an HSA withdrawal,* BENEFIT RESOURCE (Aug 4, 2022), https://www.benefitresource.com/blog/how-to-avoid-penalties-on-an-hsa-withdrawal/.

[17] *5 ways HSAs can help with your retirement,* FIDELITY (Dec. 7, 2022), https://www.fidelity.com/viewpoints/wealth-management/hsas-and-your-retirement.

[18] *Id.*

paltry returns of only 0.01 percent on money invested.[19] Nearly half of American families do not have enough money in the bank to pay a $1,000 medical bill in the next 30 days, let alone fund an account that might earn less interest than a checking account.[20]

Sincerely,

RICHARD E. NEAL,
Ranking Member.

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[19] *What is the standard interest rate for a Lively HSA?* LIVELY (Aug 21, 2023), https://support.livelyme.com/hc/en-us/articles/4405466272667-What-is-the-standard-interest-rate-for-a-Lively-HSA.

[20] Sara Collins, Lauren Haynes, & Relebohile Masitha, *The State of U.S. Health Insurance in 2022,* THE COMMONWEALTH FUND (Sep. 29, 2022) https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.