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HOUSE OF REPRESENTATIVES
REPORT
118–401

BIPARTISAN HSA IMPROVEMENT ACT OF 2023

FEBRUARY 26, 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. 5688]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5688) to amend the Internal Revenue Code of 1986 to improve health savings accounts, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

CONTENTS

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 "Bipartisan HSA Improvement Act of 2023".

SEC. 2. TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.

(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) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—

"(i) IN GENERAL.—A direct primary care service arrangement shall not be treated as a health plan for purposes of subparagraph (A)(ii).

"(ii) DIRECT PRIMARY CARE SERVICE ARRANGEMENT.—For purposes of this paragraph—

"(I) IN GENERAL.—The term 'direct primary care service arrangement' means, with respect to any individual, an arrangement under which such individual is provided medical care (as defined in section 213(d)) consisting solely of primary care services provided by primary care practitioners (as defined in section 1833(x)(2)(A) of the Social Security Act, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee.

"(II) LIMITATION.—With respect to any individual for any month, such term shall not include any arrangement if the aggregate fees for all direct primary care service arrangements (determined without regard to this subclause) with respect to such individual for such month exceed $150 (twice such dollar amount in the case of an individual with any direct primary care service arrangement (as so determined) that covers more than one individual).

"(iii) CERTAIN SERVICES SPECIFICALLY EXCLUDED FROM TREATMENT AS PRIMARY CARE SERVICES.—For purposes of this paragraph, the term 'primary care services' shall not include—

"(I) procedures that require the use of general anesthesia,

"(II) prescription drugs (other than vaccines), and

"(III) laboratory services not typically administered in an ambulatory primary care setting.

The Secretary, after consultation with the Secretary of Health and Human Services, shall issue regulations or other guidance regarding the application of this clause.".

(b) DIRECT PRIMARY CARE SERVICE ARRANGEMENT FEES TREATED AS MEDICAL EXPENSES.—Section 223(d)(2)(C) of such Code is amended by striking "or" at the end of clause (iii), by striking the period at the end of clause (iv) and inserting ", or", and by adding at the end the following new clause:

"(v) any direct primary care service arrangement.".

(c) INFLATION ADJUSTMENT.—Section 223(g)(1) of such Code is amended—

(1) by inserting ", (c)(1)(E)(ii)(II)," after "(b)(2)" each place it appears, and

(2) in subparagraph (B), by inserting "and (iii)" after "clause (ii)" in clause (i), by striking "and" at the end of clause (i), by striking the period at the end of

clause (ii) and inserting ", and", and by inserting after clause (ii) the following new clause:

"(iii) in the case of the dollar amount in subsection (c)(1)(E)(ii)(II) for taxable years beginning in calendar years after 2026, 'calendar year 2025'.".

(d) REPORTING OF DIRECT PRIMARY CARE SERVICE ARRANGEMENT FEES ON W-2.—Section 6051(a) of such Code is amended by striking "and" at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting ", and", and by inserting after paragraph (17) the following new paragraph:

"(18) in the case of a direct primary care service arrangement (as defined in section 223(c)(1)(E)(ii)) which is provided in connection with employment, the aggregate fees for such arrangement for such employee.".

(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. 3. ON-SITE EMPLOYEE CLINICS.

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

"(F) SPECIAL RULE FOR QUALIFIED ITEMS AND SERVICES.—

"(i) IN GENERAL.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in subclauses (I) and (II) of such subparagraph merely because the individual is eligible to receive, or receives, qualified items and services—

"(I) at a healthcare facility located at a facility owned or leased by the employer of the individual (or of the individual's spouse), or

"(II) at a healthcare facility operated primarily for the benefit of employees of the employer of the individual (or of the individual's spouse).

"(ii) QUALIFIED ITEMS AND SERVICES DEFINED.—For purposes of this subparagraph, the term 'qualified items and services' means the following:

"(I) Physical examination.

"(II) Immunizations, including injections of antigens provided by employees.

"(III) Drugs or biologicals other than a prescribed drug (as such term is defined in section 213(d)(3)).

"(IV) Treatment for injuries occurring in the course of employment.

"(V) Preventive care for chronic conditions (as defined in clause (iv)).

"(VI) Drug testing.

"(VII) Hearing or vision screenings and related services.

"(iii) AGGREGATION.—For purposes of clause (i), all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

"(iv) PREVENTIVE CARE FOR CHRONIC CONDITIONS.—For purposes of this subparagraph, the term 'preventive care for chronic conditions' means any item or service specified in the Appendix of Internal Revenue Service Notice 2019–45 which is prescribed to treat an individual diagnosed with the associated chronic condition specified in such Appendix for the purpose of preventing the exacerbation of such chronic condition or the development of a secondary condition, including any amendment, addition, removal, or other modification made by the Secretary (pursuant to the authority granted to the Secretary under paragraph (2)(C)) to the items or services specified in such Appendix subsequent to the date of enactment of this subparagraph.".

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

SEC. 4. CONTRIBUTIONS PERMITTED IF SPOUSE HAS HEALTH FLEXIBLE SPENDING ARRANGEMENT.

(a) CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ARRANGEMENT.—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", and by adding at the end the following new clause:

"(iv) coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reim-

bursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual.".

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

SEC. 5. FSA AND HRA TERMINATIONS OR CONVERSIONS TO FUND HSAs.

(a) IN GENERAL.—Section 106(e)(2) of the Internal Revenue Code of 1986 is amended to read as follows:

"(2) QUALIFIED HSA DISTRIBUTION.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'qualified HSA distribution' means, with respect to any employee, a distribution from a health flexible spending arrangement or health reimbursement arrangement of such employee contributed directly to a health savings account of such employee if—

"(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) if during the 4-year period preceding the date the employee so establishes coverage the employee was not covered under such a high deductible health plan, and

"(ii) such arrangement is described in section 223(c)(1)(B)(vi) with respect to any portion of the plan year remaining after such distribution is made, if such employee remains enrolled in such arrangement.

"(B) DOLLAR LIMITATION.—The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).".

(b) PARTIAL REDUCTION OF LIMITATION ON DEDUCTIBLE HSA CONTRIBUTIONS.—Section 223(b)(4) of such Code is amended by striking "and" at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ", and", and by inserting after subparagraph (C) the following new subparagraph:

"(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).".

(c) CONVERSION TO HSA-COMPATIBLE ARRANGEMENT FOR REMAINDER OF PLAN YEAR.—Section 223(c)(1)(B) of such Code, as amended by this preceding provisions of this Act, is amended by striking "and" at the end of clause (iii), by striking the period at the end of clause (iv) and inserting ", and", and by adding at the end the following new clause:

"(v) coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2) determined without regard to subparagraph (A)(ii) thereof) is made, if the terms of such arrangement which apply for such portion of the plan year are such that, if such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year.".

(d) INCLUSION OF QUALIFIED HSA DISTRIBUTIONS ON W–2.—

(1) IN GENERAL.—Section 6051(a) of such Code, as amended by this preceding provisions of this Act, is amended by striking "and" at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ", and", and by inserting after paragraph (18) the following new paragraph:

"(19) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.".

(2) CONFORMING AMENDMENT.—Section 6051(a)(12) of such Code is amended by inserting "(other than any qualified HSA distribution, as defined in section 106(e)(2))" before the comma at the end.

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

I. SUMMARY AND BACKGROUND

A. Purpose and Summary

The bill, H.R. 5688, the "Bipartisan HSA Improvement 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 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.

Currently, the Internal Revenue Service ("IRS") may view direct primary care arrangements as a separate form of disqualifying health coverage that is incompatible with contributing to an HSA. The IRS also may view some services performed at a worksite health clinic as significant benefits in the nature of medical care, disqualifying individuals who receive these services from contributing to their HSA.

Generally, individuals are not eligible for HSAs if their spouse is enrolled in a health Flexible Spending Arrangement (FSA).

Currently, individuals cannot convert their health reimbursement arrangements (HRAs) or FSAs into HSAs.

C. Legislative History

Background

H.R. 5688 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. 5688, the "Bipartisan HSA Improvement 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.

II. EXPLANATION OF THE BILL

A. Treatment of Direct Primary Care Service Arrangements (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,[1] 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).[2] These dollar thresholds are adjusted for inflation.[3]

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.[4]

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 certain limited coverage through health flexible spending arrange-

[1] 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).

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

[3] Sec. 223(g).

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

ments.[5] 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.[6]

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.[7] IRS guidance provides a safe harbor for the types of coverage that constitute preventive care for this purpose.[8]

After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to the individual's HSA.[9]

Direct primary care service arrangements

Under present law, a direct primary care service arrangement may constitute other health coverage, depending on the specific attributes of the arrangement, and therefore an individual covered by a direct primary care service arrangement may not be eligible to contribute to an HSA.[10]

REASONS FOR CHANGE

The Committee believes that direct primary care service arrangements are an important tool for families seeking access to low-cost, high-quality primary care, and that current law may impede the use of direct primary care service arrangements for patients and families who choose to enroll in and contribute to HSA eligible health plans. The Committee therefore believes it is vital to make clear that individuals enrolled in direct primary care service arrangements may continue to contribute to HSAs and may use HSA funds to pay for these types of arrangements.

EXPLANATION OF PROVISION

Under the provision, a direct primary care service arrangement is not treated as a health plan that makes an individual ineligible to contribute to an HSA. For this purpose, a direct primary care service arrangement means, with respect to any individual, an arrangement under which such individual is provided medical care consisting solely of such primary care services provided by primary

[5] Sec. 223(c)(1)(B).
[6] Sec. 223(c)(3).
[7] Sec. 223(c)(2)(C).
[8] 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.
[9] 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.
[10] See IRS, Certain Medical Care Arrangements, proposed rule, 85 Fed. Reg. 35398, June 10, 2020. In the proposed rule, the IRS proposed defining a direct primary care arrangement as a contract between an individual and one or more primary care physicians under which the physician or physicians agree to provide medical care for a fixed annual or periodic fee without billing a third party.

care practitioners [11] if the sole compensation for such care is a fixed periodic fee. With respect to any individual for any month, the aggregate fees for all direct primary care service arrangements for such individual for such month cannot exceed $150 per month (in the case of an individual with any such arrangement that covers more than one individual, twice such dollar amount, or $300). The aggregate limits are adjusted annually for inflation.

For this purpose, the term "primary care services'" does not include (1) procedures that require the use of general anesthesia, (2) prescription drugs other than vaccines (therefore, vaccines are permitted primary care services), and (3) laboratory services not typically administered in an ambulatory primary care setting. The Secretary, after consultation with the Secretary of Health and Human Services, is required to issue regulations or other guidance related to application of this rule.

In addition, fees paid for any direct primary care service arrangement are treated as qualified medical expenses (and not the payment of insurance). The aggregate fees paid by the employer for direct primary care service arrangements provided to an employee in connection with employment are required to be reported on Form W–2.

EFFECTIVE DATE

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

B. On-site Employee Clinics (sec. 3 of the bill and sec. 223 of the Code)

PRESENT LAW

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

On-site employee clinics

On-site employer-sponsored health clinics generally provide a range of health services to employees for free or at a reduced cost. Under IRS guidance, an otherwise eligible individual who has access to free health care services or health care services at charges below fair market value from a clinic on an employer's premises does not fail to be an eligible individual merely because of this free or reduced cost care as long as the clinic does not provide significant benefits in the nature of medical care in addition to disregarded coverage or preventive care.

For example, an employer that provides the following free health care services (in addition to disregarded coverage or preventive care) for employees does not provide significant benefits in the nature of medical care: (1) physicals and immunizations, (2) injecting antigens provided by employees, such as performing allergy injections, (3) a variety of aspirin and other nonprescription pain relievers, and (4) treatment for injuries caused by accidents at a plant. However, a hospital that permits its employees to receive care at its facilities for all their medical needs for free (when the employee

[11] As defined in sec. 1833(x)(2)(A) of the Social Security Act, 42 U.S.C. 13951, without regard to clause (ii) thereof.

does not have insurance) or that waives copays and deductibles (when the employee has health insurance) provides significant benefits in the nature of medical care, and the hospital's employees fail to be eligible individuals for purposes of HSA contributions.[12]

Preventive care

The IRS has issued guidance providing a safe harbor for preventive care benefits allowed under an HDHP.[13] In that guidance, the IRS defines preventive care as including, but not limited to (1) periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals; (2) routine prenatal and well- child care; (3) immunizations; (4) tobacco cessation programs; (5) obesity weight-loss programs; and (6) screening services (such as screening for cancer, heart and vascular diseases, infectious diseases, mental health conditions and substance abuse, metabolic, nutritional, and endocrine conditions, musculoskeletal disorders, obstetric and gynecologic conditions, pediatric conditions, and vision and hearing disorders).

Although the guidance provides that preventive care does not generally include any service or benefit intended to treat an existing illness, injury or condition (with the exception of chronic conditions, as described below), any treatment that is incidental or ancillary to a safe harbor preventive care service or screening (in situations where it would be unreasonable or impracticable to perform another procedure to treat the condition), such as the removal of polyps during a diagnostic colonoscopy, also falls within the safe harbor. In addition, drugs or medications are considered to be preventive care when taken by a person who has developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent, or to prevent the reoccurrence of a disease from which a person has recovered.

A 2019 executive order included a requirement that Treasury issue guidance to expand the ability of patients to select an HDHP that could be used with an HSA to cover, before the deductible, low-cost preventive care for individuals with chronic conditions.[14] The IRS then issued guidance expanding the list of preventive care benefits permitted to be provided by an HDHP, without a deductible, to include limited preventive care for specified chronic conditions (including congestive heart failure, diabetes, coronary artery disease, osteoporosis and/or osteopenia, hypertension, asthma, diabetes, liver disease and/or bleeding disorders, heart disease, and depression).[15]

Preventive care also encompasses such services that are required to be included by a group health plan or health insurance issuer offering group or individual health insurance coverage under section 2713 of the Public Health Service Act.[16]

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[12] Notice 2008–59, 2008–29 I.R.B. 123, July 21, 2008, Q&A–10.

[13] Notice 2004–23, 2004–1 C.B. 725. See also Notice 2004–50, 2004–33 I.R.B. 196, August 16, 2004; Notice 2008–59, 2008–29 I.R.B. 123, July 21, 2008; Notice 2013–57, 2013–40 I.R.B. 293, September 30, 2013; Notice 2018–12, 2018–12 I.R.B. 441, March 19, 2018; and Notice 2019–45, 2019–32 I.R.B. 593, August 5, 2019.

[14] Executive Order 13877, "Improving Price and Quality Transparency in American Healthcare to Put Patients First," 84 Fed. Reg. 30849, June 27, 2019.

[15] Notice 2019–45, 2019–32 I.R.B. 593, August 5, 2019.

[16] Notice 2013–57, 2013–40 I.R.B. 293, September 30, 2013.

REASONS FOR CHANGE

The Committee believes that on-site employee clinics can be an important way for employees and their spouses to access low-cost health care. Employers may be hesitant to offer on-site clinics, however, because of uncertainty as to whether access to on-site clinics may prevent employees and their families from contributing to HSAs. Therefore, the Committee believes it is important to specify that on-site clinics may offer a variety of standard items and services without disqualifying employees and their spouses from contributing to HSAs.

EXPLANATION OF PROVISION

Under the provision, qualified items and services received by an eligible individual at (1) a health care facility located at a facility owned or leased by the eligible individual's employer (or the employer of the individual's spouse) or (2) at a health care facility operated primarily for the benefit of employees of the individual's employer (or the employees of the individual's spouse's employer) are not treated as coverage under a health plan for purposes of determining the individual's eligibility to contribute to an HSA. Qualified items and services include: (1) physical examinations, (2) immunizations, including injections of antigens provided by employees, (3) drugs or biologicals other than a prescribed drug, (4) treatment for injuries occurring in the course of the individual's employment, (5) preventive care for chronic conditions,[17] (6) drug testing, and (7) hearing or vision screenings and related services.

All entities treated as a single employer[18] under the Code are treated as a single employer under this provision.

EFFECTIVE DATE

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

C. Contributions Permitted if Spouse Has Health Flexible Spending Arrangement (sec. 4 of the bill and sec. 223 of the Code)

PRESENT LAW

Flexible spending arrangements

An FSA generally is defined as a benefit program which provides employees with coverage under which specific incurred expenses may be reimbursed (subject to reimbursement maximums and other conditions) and the maximum amount of reimbursement reasonably available is less than 500 percent of the value of such coverage.[19] An FSA under a cafeteria plan[20] allows an employee to

[17] Defined as any item or service specified in the Appendix of Notice 2019–45 (including any amendment, addition, removal or other modification made by the Secretary to that Appendix subsequent to the date of enactment of the provision) which is prescribed to treat an individual diagnosed with an associated chronic condition for the purpose of preventing (1) the exacerbation of such condition or (2) the development of a secondary condition.

[18] Under sec. 414(b), (c), (m) or (o).

[19] See sec. 106(c)(2) and Prop. Treas. Reg. sec. 1.125–5(a).

[20] A cafeteria plan is a separate written plan of an employer under which all participants are employees, and participants are permitted to choose among at least one permitted taxable benefit (for example, current cash compensation) and at least one qualified benefit. Sec. 125(d). Qualified benefits are generally employer-provided benefits that are not includible in gross in-

make salary reduction contributions for use in receiving reimbursements for certain incurred expenses.[21] The arrangement can also include non-elective employer contributions (known as employer flex-credits) that the employer makes available for every employee eligible to participate in the employer's cafeteria plan, to be used only for certain tax-excludable benefits (but not as cash or a taxable benefit).[22] Types of expenses that may be reimbursed under a flexible spending arrangement in a cafeteria plan include medical expenses (a "health FSA") and dependent care expenses.

FSAs that are funded on a salary reduction basis are subject to the requirements for cafeteria plans, including a requirement that amounts remaining in a health FSA at the end of a plan year generally must be forfeited by the employee (referred to as the "use-it-or-lose-it rule").[23] However, a cafeteria plan may allow a grace period not to exceed two and one-half months immediately following the end of the plan year during which unused amounts may be paid or reimbursed to participants for qualified expenses incurred during the grace period.[24] Alternatively, a cafeteria plan may permit up to $610 (for 2023) of unused amounts remaining in a health FSA at the end of a plan year to be paid or reimbursed to plan participants for qualifying medical expenses during the following plan year.[25] Such a carryover is not permitted in a dependent care FSA. A cafeteria plan may only permit a carryover of amounts in a health FSA if the plan does not also allow a grace period with respect to the health FSA.

Health FSAs

In order for coverage and reimbursements under a health FSA to qualify for tax-favored treatment, the health FSA must qualify as an accident and health plan.[26] Under the Code, the value of employer-provided health coverage under an accident or health plan is generally excludable from gross income,[27] as are reimbursements under the plan for medical care expenses for employees, their spouses, and their dependents.[28] A health FSA may only reimburse medical expenses as defined in section 213(d).

A benefit provided under a cafeteria plan through employer contributions to a health FSA is not treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect salary reduction contributions in excess of $2,500, adjusted for infla-

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come by reason of an express provision of the Code. Sec. 125(f). Examples of qualified benefits include employer-provided health coverage (including a health FSA), group term life insurance coverage not in excess of $50,000, and benefits under a dependent care assistance program.

[21] Sec. 125 and Prop. Treas. Reg. sec. 1.125–5.

[22] Prop. Treas. Reg. sec. 1.125–5(b).

[23] Sec. 125(d)(2).

[24] Notice 2005–42, 2005–1 C.B. 1204, and Prop. Treas. Reg. sec. 1.125–1(e).

[25] Rev. Proc. 2022–38, 2022–45 I.R.B. 445, November 7, 2022; Notice 2020–33, 2020–22 I.R.B. 868, May 26, 2020; Notice 2013–71, 2013–47 I.R.B. 532, November 18, 2013.

[26] Secs. 105 and 106; Prop. Treas. Reg. sec. 1.125–5(k)(1).

[27] Sec. 106. Health coverage provided to active members of the uniformed services, military retirees, and their dependents are excludable from gross income under section 134. That section provides an exclusion for "qualified military benefits," defined as benefits received by reason of status or service as a member of the uniformed services and which were excludable from gross income on September 9, 1986, under any provision of law, regulation, or administrative practice then in effect.

[28] Sec. 105(b).

tion, for any taxable year.[29] For taxable year 2023, the limit is $3,050.

Health savings accounts and high deductible health plans

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

REASONS FOR CHANGE

The Committee wishes to help working families by improving access to tax-advantaged health care accounts such as HSAs. The Committee believes that an individual should not be ineligible for an HSA merely because the individual's spouse is covered under a health FSA. Thus, the Committee believes that a spouse's coverage under a health FSA should not prevent an individual from being eligible for an HSA, provided that the spouse's FSA is not used to cover the individual's medical expenses.

EXPLANATION OF PROVISION

The provision provides that for purposes of determining whether an individual is eligible to contribute to an HSA, coverage under the employee's spouse's health FSA for any plan year of such FSA is disregarded, provided that certain requirements are met. To qualify for this exception, the aggregate reimbursements under the health FSA for the plan year must not exceed the aggregate expenses that would be eligible for reimbursement under the FSA if the expenses were determined without regard to any expenses paid or incurred with respect to the otherwise HSA-eligible individual.

EFFECTIVE DATE

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

D. FSA AND HRA TERMINATIONS OR CONVERSIONS TO FUND HSAS (SEC. 5 OF THE BILL AND SECS. 106 AND 223 OF THE CODE)

PRESENT LAW

Flexible spending arrangements

For a general description of FSAs, see Part C of this document.

Health reimbursement arrangements

HRAs operate in a manner similar to health FSAs, in that they are employer-maintained arrangements that reimburse employees and their dependents[30] for medical expenses. Some of the rules applicable to HRAs and health FSAs are similar (e.g., the amounts in the arrangements can only be used to reimburse medical expenses and not for other purposes), but the rules are not identical. In particular, HRAs cannot be funded on a salary reduction basis and the use-it-or- lose-it rule does not apply. Thus, amounts remaining in an HRA at the end of the year may be carried forward to be used to reimburse medical expenses in following years.[31] Un-

[29] Sec. 125(i).
[30] As defined in sec. 152.
[31] Guidance with respect to HRAs, including the interaction of FSAs and HRAs in the case of an individual covered under both, is provided in Notice 2002–45, 2002–2 C.B. 93.

like a health FSA, an HRA is permitted to reimburse an employee for health insurance premiums.

Health savings accounts and high deductible health plans

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

Interactions of health savings accounts with FSAs and HRAs

Individuals who are covered by a health plan that is not an HDHP generally are not eligible to contribute to an HSA. Under IRS guidance, a health FSA and an HRA are generally considered health plans under this definition.[32] However, FSA and HRA terminations could be used to fund HSAs within a certain period (as described further below). In addition, an individual does not fail to be an eligible individual for the purpose of making contributions to an HSA if the individual is covered under the following HSA-compatible arrangements (or some combination of the following arrangements): (1) a limited-purpose health FSA that pays or reimburses only permitted coverage or preventive care services, (2) a limited-purpose HRA that pays or reimburses benefits for permitted insurance, permitted coverage, or preventive care services, (3) a suspended HRA that does not pay or reimburse any medical expense incurred during the suspension period except permitted insurance, permitted coverage, or preventive care services, or (4) a post-deductible health FSA or HRA, which does not pay or reimburse medical expenses incurred below the minimum annual deductible for a plan to be an HDHP.[33]

If a general purpose health FSA allows reimbursement for expenses incurred during a grace period following the end of the plan year, a participant in the health FSA is generally not eligible to make contributions to an HSA until the first day of the first month following the end of the grace period.[34] However, this rule does not apply if the participant has a zero balance in the general purpose health FSA on the last day of the health FSA plan year (as determined on a cash basis[35]).[36] Thus, in that case the individual's FSA coverage during the grace period does not cause the individual to fail to be eligible to contribute to an HSA, and the individual (if otherwise eligible) would be eligible to contribute to the HSA as of the first day after the end of the health FSA plan year. Similarly, an individual with a zero balance in a general purpose HRA, determined on a cash basis, on the last day of the HRA plan year, does not fail to be an eligible individual on the first day of the immediately following HRA plan year, as long as certain requirements are satisfied.[37] Coverage by an HSA-compatible health FSA or

[32] Rev. Rul. 2004–45, 2004–1 C.B. 971.
[33] As defined in sec. 223(c)(2)(A)(i). Rev. Rul. 2004–45, 2004–1 C.B. 971.
[34] Notice 2005–42, 2005–1 C.B. 1204.
[35] "Cash basis" means the balance as of any date, without taking into account expenses incurred that have not been reimbursed as of that date. Thus, pending claims, claims submitted, claims received or claims under review that have not been paid as of a date are not taken into account for purposes of determining the account balance as of that date.
[36] Sec. 223(c)(1)(B)(iii)(I).
[37] One of the following requirements must be satisfied: (1) effective on the first of the immediately following HRA plan year, the employee elects to waive participation in the HRA, or (2) effective on or before the first day of the following HRA plan year, the employer terminates the general purpose HRA with respect to all employees, or (3) effective on or before the first day

Continued

HRA does not affect an employee's eligibility to contribute to an HSA, including during a health FSA grace period.[38]

FSA and HRA terminations to fund HSAs

The Health Opportunity Empowerment Act of 2006[39] amended the Code to allow for certain amounts in a health FSA or HRA to be rolled over into an HSA with favorable tax treatment ("qualified HSA distributions"). However, such distributions were permitted only for contributions made to an HSA before January 1, 2012.[40]

As implemented by the IRS, a plan implementing the provision must be amended in writing, the employee must elect the rollover, and the year-end balance must be frozen.[41] The amount of the qualified HSA distribution may not exceed the lesser of the balance in the health FSA or HRA on September 21, 2006 or the date of distribution.[42] Funds must be transferred by the employer within two and a half months after the end of the plan year and result in a zero balance in the health FSA or HRA.[43]

In addition, a qualified HSA distribution must be contributed directly to the HSA trustee by the employer.[44] Only one qualified HSA distribution is allowed with respect to each health FSA or HRA of an individual. Qualified HSA distributions are not taken into account in applying the annual limit for HSA contributions. Qualified HSA distributions are treated as rollovers, and thus are not deductible.

If an employee fails to remain HSA-eligible for 12 months (the "testing period")[45] following the distribution, the employee is not eligible directly following the distribution, and the amount of the rollover is included in gross income and is subject to an additional 20-percent tax unless the individual dies or becomes disabled.[46] Failure to remain an eligible individual does not require the withdrawal of the qualified HSA distribution, and the amount is not an excess contribution.

An individual making a qualified HSA distribution from a health FSA does not fail to be eligible to participate in an HSA at the beginning of the next plan year merely because the health FSA includes a grace period, provided that the qualified HSA distribution equals the remaining balance in the FSA at the end of the FSA plan year and is made at the end of such plan year.[47]

REASONS FOR CHANGE

To improve access to health care savings through HSAs, the Committee believes it is important to increase flexibility for individuals with health FSAs of HRAs seeking to enroll in HSAs.

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of the following HRA plan year, with respect to all employees, the employer converts the general purpose HRA to an HSA-compatible HRA. See Rev. Rul. 2004–45, 2004–1 C.B. 971.

[38] Rev. Rul. 2004–45, 2004–1 C.B. 971.

[39] The Health Opportunity Patient Empowerment Act of 2006, included in the Tax Relief and Health Care Act of 2006, Pub. L. No. 109–432, sec. 302, December 20, 2006.

[40] Sec. 106(e)(2)(B).

[41] Notice 2007–22, 2007–1 C.B. 670.

[42] Sec. 106(e)(2)(A).

[43] The IRS provided guidance on special transition relief for amounts remaining at the end of 2006. See Notice 2007–22, 2007–1 C.B. 670.

[44] Sec. 106(e).

[45] The testing period is defined to be the period beginning with the month in which the qualified HSA distribution is contributed to the HSA and ending on the last day of the 12th month following that month.

[46] Sec. 106(e)(3).

[47] Sec. 223(c)(1)(B)(iii)(II); Notice 2007–22, 2007–1 C.B. 670.

Therefore, the Committee believes that individuals who wish to convert their health FSA or HRA to an HSA should be permitted to do so.

EXPLANATION OF PROVISION

The provision amends the rules permitting certain amounts in a health FSA or HRA to be rolled over into an HSA by no longer requiring such rollovers to be completed by January 1, 2012. Rather, under the provision, a "qualified HSA distribution" is a distribution from an employee's health FSA or HRA contributed directly to an employee's HSA if (1) such distribution is made in connection with the employee establishing coverage under an HDHP, and (2) during the four-year period preceding the establishment of such coverage, the employee was not covered under an HDHP. In addition, if the qualified HSA distribution is made before the end of the plan year, the health FSA or HRA from which the distribution is made must be converted to an HSA-compatible FSA or HRA, as applicable, for the portion of the plan year after the distribution is made, if the individual remains enrolled in the health FSA or HRA.

Under the provision, the aggregate amount of qualified HSA distributions may not exceed the total annual limit on FSA contributions ($3,050 in 2023)[48] or twice this amount in the case of an eligible individual who has family coverage under an HDHP. The provision does not limit individuals to one qualified HSA distribution, as under the prior rule. Qualified HSA distributions also reduce the amount of deductible contributions that an individual is permitted to make to an HSA during the taxable year.[49]

The provision also specifies that if a general purpose health FSA or HRA is converted to an HSA-compatible FSA or HRA, coverage under this health FSA or HRA for the portion of the plan year after a qualified HSA distribution is made is disregarded in determining whether the individual is eligible to make deductible contributions to an HSA.

Finally, the provision provides that the amount of any qualified HSA distribution is to be included on the information to be reported on Form W–2.[50]

EFFECTIVE DATE

The provision is effective for distributions made after December 31, 2025, in taxable years ending after such date.

III. VOTES OF THE COMMITTEE

Pursuant to clause 3(b) of rule XIII of the Rules of the House of the Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023," on September 28, 2023.

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[48] Sec. 125(i).

[49] The deductible contribution limit with respect to an HSA is reduced by so much of any qualified HSA distribution made by an individual during the taxable year that does not exceed the aggregate increases in the balance of the arrangement from which the distribution is made that occur during the portion of the plan year preceding the distribution (other than any balance carried over to such plan year and determined without regard to any decrease in the balance during such portion of the plan year).

[50] Sec. 6051(a).

The vote on the amendment offered by Mr. Doggett to the amendment in the nature of a substitute to H.R. 5688, which would eliminate the exception from the additional tax on Health Savings Account distributions used for non-qualifying medical expenses after Medicare eligibility was not agreed to by a roll call vote of 18 yeas to 23 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				Ms. Sánchez	X		
Dr. Ferguson		X		Mr. Higgins	X		
Mr. Estes		X		Ms. Sewell	X		
Mr. Smucker		X		Ms. DelBene	X		
Mr. Hern				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		X		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					

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023," on September 28, 2023.

The vote on the amendment offered by Mr. Larson to the amendment in the nature of a substitute to H.R. 5688, which would ensure the protection of the Social Security Trust Fund was not agreed to by a roll call vote of 17 yeas to 24 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			
Dr. Murphy		X		Mr. Kildee	X		
Mr. Kustoff		X		Mr. Beyer	X		
Mr. Fitzpatrick				Mr. Evans	X		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Steube		X		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					

In compliance with the Rules of the House of Representatives, this following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023," on September 28, 2023.

The vote on the amendment offered by Ms. Chu to the amendment in the nature of a substitute to H.R. 5688, which would require that nothing in H.R. 5688 shall be construed to prevent Health Savings Accounts from Covering all needed reproductive and sexual health care was not agreed to by a roll call vote of 16 yeas to 24 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			
Dr. Wenstrup		X		Mr. Davis			
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		X		Mr. Schneider	X		
Ms. Tenney				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					

In compliance with the Rules of the House of Representatives, this following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023," on September 28, 2023.

The vote on the amendment offered by Mr. Kildee to the amendment in the nature of a substitute to H.R. 5688, which would place an income cap onbeing able to use the tax advantage of HSAs was not agreed to by a roll call vote of 17 yeas to 24 nays with 1 voting present (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		X		Mr. Schneider	X		
Ms. Tenney				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					

In compliance with the Rules of the House of Representatives, this following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023," on September 28, 2023.

The vote on the amendment offered by Mr. Pascrell to the amendment in the nature of a substitute to H.R. 5688, which would add to H.R. 5688 a new section that prevents the bill from taking effect until the Secretary of the Treasury certifies that the cap on the State and Local Tax (SALT) deduction will not result in an increase in the tax liability of any taxpayer with an adjusted gross income less than $50,000 in calendar year 2023, 2024, or 2025 was not agreed to by a roll call vote of 16 yeas to 24 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		X		Mr. Schneider	X		
Ms. Tenney				Mr. Panetta	X		
Mrs. Fischbach		X					
Mr. Moore		X					
Mrs. Steel		X					

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Ms. Van Duyne		X					
Mr. Feenstra		X					
Ms. Malliotakis		X					
Mr. Carey		X					

In compliance with the Rules of the House of Representatives, this following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023," on September 28, 2023.

H.R. 5688 was ordered favorably reported to the House of Representatives as amended by a roll call vote of 28 yeas to 14 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	X			Mr. Schneider	X		
Ms. Tenney				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. 5688, 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. 5688, Bipartisan HSA Improvement 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	0
Revenues	0	-3.3	-12.9
Increase in the Deficit	0	3.3	12.9
Spending Subject to Appropriation (Outlays)	0	*	0

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)
- Allow distributions in certain circumstances from health flexible spending arrangements or health reimbursement arrangements into HSAs

Estimated budgetary effects would mainly stem from:

- Reduced collections of individual income taxes because of contributions made by newly eligible HSA participants
- Reduced collections of income and employment taxes because of exclusions for employer contributions to employees' HSAs

Areas of significant uncertainty include:

- Anticipating the number of people who would contribute to HSAs and projecting the amounts distributed from various arrangements into HSAs

The Congressional Budget Act of 1974, as amended, stipulates that revenue estimates provided by the staff of the Joint Committee on Taxation (JCT) will be the official estimates for all tax legislation considered by the Congress. As such, CBO incorporates those estimates into its cost estimates of the effects of legislation. All of the estimates for the revenue provisions of H.R. 5688 were provided by JCT.

Bill summary: H.R. 5688 would amend the Internal Revenue Code to expand eligibility for health savings accounts (HSAs) and, in certain circumstances, allow distributions from health flexible spending arrangements (FSAs) and health reimbursement arrangements (HRAs) into HSAs. The bill's provisions would affect tax years beginning after December 31, 2025.

Estimated federal cost: The estimated budgetary effect of H.R. 5688 is shown in Table 1. The costs of the legislation fall within budget function 800 (general government).

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF H.R. 5688

	By fiscal year, billions of dollars—											
	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2024–2028	2024–2033
	Decreases in Revenues											
Estimated Revenues: ..	0	0	−0.6	−1.2	−1.5	−1.7	−1.8	−1.9	−2.0	−2.2	−3.3	−12.9
On-Budget	*0*	*0*	*−0.5*	*−0.9*	*−1.1*	*−1.2*	*−1.3*	*−1.4*	*−1.5*	*−1.6*	*−2.4*	*−9.5*
Off-Budget	*0*	*0*	*−0.2*	*−0.3*	*−0.4*	*−0.4*	*−0.5*	*−0.5*	*−0.5*	*−0.6*	*−0.9*	*−3.4*

Source: Staff of the Joint Committee on Taxation.
Enacting the bill would increase spending subject to appropriation by less than $500,000 in every year and over the 2024–2028 period. Any spending would be subject to the availability of appropriated funds.
Components may not sum to totals because of rounding.

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 the revenue estimates presented here for H.R. 5688.[1]

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

Revenues: H.R. 5688 would modify HSAs, tax-favored savings accounts used to cover medical expenses for people enrolled in a high-deductible health plan (HDHP), a type of health insurance plan with large deductibles and low monthly premiums. Contributions to HSAs are deductible from individual income taxes, and contributions on behalf of employees are excludable both from individual income taxes and from employment taxes. H.R. 5688 would reduce revenues from income tax and payroll tax receipts by increasing tax-exempt contributions to HSAs.

Sections 2, 3, and 4 would expand eligibility for HSAs. Under current law, people who are in an HDHP and also have additional coverage are not generally eligible to contribute to an HSA. H.R. 5688 would expand eligibility to people with certain types of additional coverage, such as an arrangement with a practitioner to provide primary care services for a fixed periodic fee (called a direct primary care service arrangement), access through an employer to primary care services at an on-site or retail clinic, or access to a spouse's FSA. The bill also would treat fees for direct primary care service arrangements as medical expenses, allowing participants to pay for the service from an HSA.

Section 5 would allow rollovers from a health FSA or HRA directly into an HSA if coverage is established under an HDHP when an enrollee has been without such coverage for a four-year period. The section sets the allowable amount of such qualified HSA distributions up to the total annual limit on FSA contributions ($3,050 in 2023, or twice that amount in the case of an eligible person who

[1] See Joint Committee on Taxation, *Estimated Revenue Effects of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023,"* JCX–40–23 (September 26, 2023), www.jct.gov/publications/2023/jcx-40-23. For more about the provisions, see Joint Committee on Taxation, *Description of H.R. 5688, the "Bipartisan HSA Improvement Act of 2023,"* JCX 39 23 (September 26, 2023), www.jct.gov/publications/2023/jcx-39-23.

has family coverage under an HDHP). Such rollovers would reduce the amount allowable for tax-deductible contributions to an HSA during a given year.

JCT estimates that enacting the bill would decrease revenues by $12.9 billion over the 2024–2033 period. That change includes a reduction of $3.4 billion in off-budget revenues (from Social Security payroll taxes).

Spending subject to appropriation: CBO estimates that implementing H.R. 5688 would increase the Internal Revenue Service's administrative costs by less than $500,000 over the 2024–2028 period. That spending would be subject to the availability of appropriated funds.

Uncertainty: JCT's estimates of the budgetary effects of H.R. 5688 are uncertain because they are made on the basis of underlying projections and other factors that could change significantly. In particular, the estimates rely in part on CBO's economic projections for the next decade under current law and on expectations of the way taxpayers might respond to changes in tax law. In this case, the uncertainty involves how many people would contribute to an HSA and the amount of distributions from various arrangements into HSAs.

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 revenues that are subject to those procedures are shown in Table 2.

TABLE 2.—CBO's ESTIMATE OF THE STATUTORY PAY-AS-YOU-GO EFFECTS OF H.R. 5688, THE BIPARTISAN HSA IMPROVEMENT 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	0.5	0.9	1.1	1.2	1.3	1.4	1.5	1.6	2.4	9.5

Increase in long-term net direct spending and deficits: JCT estimates that enacting H.R. 5688 would not increase net direct spending in any of the four consecutive 10-year periods beginning in 2034.

JCT estimates that enacting H.R. 5688 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. 5688 would not impose intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

Estimate prepared by: Federal Revenues: Kathleen Burke, Staff of the Joint Committee on Taxation; Federal Costs: Matthew Pickford; Mandates: Andrew Laughlin, Staff of the Joint Committee on Taxation.

Estimate reviewed by: Robert Reese, Chief, Natural and Physical Resources Cost Estimates Unit; Joshua Shakin, Chief, Revenue Estimating 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. Tax Complexity Analysis

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, for each such provision identified by the staff of the Joint Committee on Taxation, a summary description of the provision is provided below along with an estimate of the number and type of affected taxpayers, and a discussion regarding the relevant complexity and administrative issues.

Following the analysis of the staff of the Joint Committee on Taxation are the comments of the IRS and Treasury regarding the provision included in the complexity analysis.

LIST OF PROVISIONS IN THE COMPLEXITY ANALYSIS

1. Contributions permitted if spouse has health flexible spending arrangement

Summary description of provision

Section 4 of the bill provides that for purposes of determining whether an individual is eligible to contribute to an HSA, coverage under the employee's health FSA for any plan year of such FSA is disregarded, provided that certain requirements are met. In order to qualify for this exception, the aggregate reimbursements under the health FSA for the plan year must not exceed the aggregate expenses that would be eligible for reimbursement under the FSA if the expenses were determined without regard to any expenses paid or incurred with respect to the otherwise HSA-eligible individual.

This provision is effective for plan years beginning after December 31, 2025.

Number of affected taxpayers

It is estimated that the provision will affect over 10 percent of taxpayers during the budget window.

Discussion

The IRS will need to modify its forms and publications to reflect the provision. It will need to update information on its website and provide communications to external stakeholders. It will also need to issue guidance under the provision, and may need to make IT programming changes to process form changes. Additionally, taxpayers enrolled in a spousal FSA may need to keep additional records regarding incurred medical expenses.

2. FSA and HRA terminations or conversions to fund HSAs

Summary description of provision

Section 5 of the bill permits amounts in a health FSA or HRA to be rolled over into an HSA if (1) the distribution is made in connection with the employee establishing coverage under an HDHP, and (2) during the four-year period preceding the establishment of such coverage, the employee was not covered under an HDHP ("four-year rule"). Limits apply to the amount that may be rolled over, and the distribution must be reported on Form W–2. In addition, if the qualified HSA distribution is made before the end of the plan year, and the individual remains enrolled in the health FSA or HRA after the distribution, the health FSA or HRA from which the distribution is made must be converted to an HSA-compatible FSA or HRA, as applicable, for the portion of the plan year after the distribution is made. The provision is effective for distributions made after December 31, 2025, in taxable years ending after such date.

Number of affected taxpayers

It is estimated that the provision will affect over 10 percent of taxpayers during the budget window.

Discussion

Enforcement of the four-year rule may be challenging. In order to determine whether an individual has been covered under an HDHP for the four-year period, the IRS will need to rely on the individual's reporting of this information on the Form 8889, and it will be difficult for the IRS to collect and verify the necessary information for an individual over a period of years.

The IRS will also need to modify its forms and publications to reflect the provision. It will need to issue guidance under the provision, and it may need to make IT programming changes to process form changes. It will need to coordinate with the Social Security Administration on changes to the Form W–2. In addition, the IRS will need to develop a comprehensive communication strategy to ensure that IRS employees and taxpayers understand the change. Taxpayers may need to keep additional records regarding rollovers

and conversions of FSAs and HRAs to HSA-compatible arrangements.

Comments from IRS and Treasury

D. 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.

E. 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.

F. 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, this section was not made available to the Committee in time for the filing of this report.

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

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter B—COMPUTATION OF TAXABLE INCOME

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PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

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SEC. 106. CONTRIBUTIONS BY EMPLOYER TO ACCIDENT AND HEALTH PLANS.

(a) GENERAL RULE.—Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan.

(b) CONTRIBUTIONS TO ARCHER MSAS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any Archer MSA of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 220(b)(1) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of any employee solely because the employee may choose between the contributions referred to in paragraph (1) and employer contributions to another health plan of the employer.

(3) SPECIAL RULE FOR DEDUCTION OF EMPLOYER CONTRIBUTIONS.—Any employer contribution to an Archer MSA, if otherwise allowable as a deduction under this chapter, shall be allowed only for the taxable year in which paid.

(4) EMPLOYER MSA CONTRIBUTIONS REQUIRED TO BE SHOWN ON RETURN.—Every individual required to file a return under section 6012 for the taxable year shall include on such return the aggregate amount contributed by employers to the Archer MSAs of such individual or such individual's spouse for such taxable year.

(5) MSA CONTRIBUTIONS NOT PART OF COBRA COVERAGE.—Paragraph (1) shall not apply for purposes of section 4980B.

(6) DEFINITIONS.—For purposes of this subsection, the terms "eligible individual" and "Archer MSA" have the respective meanings given to such terms by section 220.

(7) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the Archer MSAs of comparable employees, see section 4980E.

(c) INCLUSION OF LONG-TERM CARE BENEFITS PROVIDED THROUGH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—Gross income of an employee shall include employer-provided coverage for qualified long-term care services (as defined in section 7702B(c)) to the extent that such coverage is provided through a flexible spending or similar arrangement.

(2) FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, a flexible spending arrangement is a benefit program which provides employees with coverage under which—

(A) specified incurred expenses may be reimbursed (subject to reimbursement maximums and other reasonable conditions), and

(B) the maximum amount of reimbursement which is reasonably available to a participant for such coverage is less than 500 percent of the value of such coverage.

In the case of an insured plan, the maximum amount reasonably available shall be determined on the basis of the underlying coverage.

(d) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

(1) IN GENERAL.—In the case of an employee who is an eligible individual (as defined in section 223(c)(1)), amounts contributed by such employee's employer to any health savings account (as defined in section 223(d)) of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

(3) CROSS REFERENCE.—For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.

(e) FSA AND HRA TERMINATIONS TO FUND HSAS.—

(1) IN GENERAL.—A plan shall not fail to be treated as a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because such plan provides for a qualified HSA distribution.

[(2) QUALIFIED HSA DISTRIBUTION.—The term "qualified HSA distribution" means a distribution from a health flexible spending arrangement or health reimbursement arrangement to the extent that such distribution—

[(A) does not exceed the lesser of the balance in such arrangement on September 21, 2006, or as of the date of such distribution, and

[(B) is contributed by the employer directly to the health savings account of the employee before January 1, 2012.

Such term shall not include more than 1 distribution with respect to any arrangement.**]**

(2) QUALIFIED HSA DISTRIBUTION.—For purposes of this subsection—

(A) IN GENERAL.—The term "qualified HSA distribution" means, with respect to any employee, a distribution from a

health flexible spending arrangement or health reimbursement arrangement of such employee contributed directly to a health savings account of such employee if—

(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) if during the 4-year period preceding the date the employee so establishes coverage the employee was not covered under such a high deductible health plan, and

(ii) such arrangement is described in section 223(c)(1)(B)(vi) with respect to any portion of the plan year remaining after such distribution is made, if such employee remains enrolled in such arrangement.

(B) DOLLAR LIMITATION.—The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).

(3) ADDITIONAL TAX FOR FAILURE TO MAINTAIN HIGH DEDUCTIBLE HEALTH PLAN COVERAGE.—

(A) IN GENERAL.—If, at any time during the testing period, the employee is not an eligible individual, then the amount of the qualified HSA distribution—

(i) shall be includible in the gross income of the employee for the taxable year in which occurs the first month in the testing period for which such employee is not an eligible individual, and

(ii) the tax imposed by this chapter for such taxable year on the employee shall be increased by 10 percent of the amount which is so includible.

(B) EXCEPTION FOR DISABILITY OR DEATH.—Clauses (i) and (ii) of subparagraph (A) shall not apply if the employee ceases to be an eligible individual by reason of the death of the employee or the employee becoming disabled (within the meaning of section 72(m)(7)).

(4) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

(A) TESTING PERIOD.—The term "testing period" means the period beginning with the month in which the qualified HSA distribution is contributed to the health savings account and ending on the last day of the 12th month following such month.

(B) ELIGIBLE INDIVIDUAL.—The term "eligible individual" has the meaning given such term by section 223(c)(1).

(C) TREATMENT AS ROLLOVER CONTRIBUTION.—A qualified HSA distribution shall be treated as a rollover contribution described in section 223(f)(5).

(5) TAX TREATMENT RELATING TO DISTRIBUTIONS.—For purposes of this title—

(A) IN GENERAL.—A qualified HSA distribution shall be treated as a payment described in subsection (d).

(B) COMPARABILITY EXCISE TAX.—

(i) IN GENERAL.—Except as provided in clause (ii), section 4980G shall not apply to qualified HSA distributions.

(ii) FAILURE TO OFFER TO ALL EMPLOYEES.—In the case of a qualified HSA distribution to any employee, the failure to offer such distribution to any eligible individual covered under a high deductible health plan of the employer shall (notwithstanding section 4980G(d)) be treated for purposes of section 4980G as a failure to meet the requirements of section 4980G(b).

(f) REIMBURSEMENTS FOR MENSTRUAL CARE PRODUCTS.—For purposes of this section and section 105, expenses incurred for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as incurred for medical care.

(g) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this section and section 105, payments or reimbursements from a qualified small employer health reimbursement arrangement (as defined in section 9831(d)) of an individual for medical care (as defined in section 213(d)) shall not be treated as paid or reimbursed under employer-provided coverage for medical expenses under an accident or health plan if for the month in which such medical care is provided the individual does not have minimum essential coverage (within the meaning of section 5000A(f)).

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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.

(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.

(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 ap-

plicable 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))**[**.**]**, *and*

(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).

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

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

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

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

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

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

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

(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to

benefits under title XVIII of the Social Security Act and for each month thereafter.

(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[.],

(iv) coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reimbursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual, and

(v) coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2) determined without regard to subparagraph (A)(ii) thereof) is made, if the terms of such arrangement which apply for such portion of the plan year are such that, if such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year.

(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) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—

(i) IN GENERAL.—A direct primary care service arrangement shall not be treated as a health plan for purposes of subparagraph (A)(ii).

(ii) DIRECT PRIMARY CARE SERVICE ARRANGEMENT.—For purposes of this paragraph—

(I) IN GENERAL.—The term "direct primary care service arrangement" means, with respect to any individual, an arrangement under which such individual is provided medical care (as defined in section 213(d)) consisting solely of primary care services provided by primary care practitioners (as defined in section 1833(x)(2)(A) of the Social Security Act, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee.

(II) LIMITATION.—With respect to any individual for any month, such term shall not include any arrangement if the aggregate fees for all direct primary care service arrangements (determined without regard to this subclause) with respect to such individual for such month exceed $150 (twice such dollar amount in the case of an individual with any direct primary care service arrangement (as so determined) that covers more than one individual).

(iii) CERTAIN SERVICES SPECIFICALLY EXCLUDED FROM TREATMENT AS PRIMARY CARE SERVICES.—For purposes of this paragraph, the term "primary care services" shall not include—

(I) procedures that require the use of general anesthesia,

(II) prescription drugs (other than vaccines), and

(III) laboratory services not typically administered in an ambulatory primary care setting.

The Secretary, after consultation with the Secretary of Health and Human Services, shall issue regulations or other guidance regarding the application of this clause.

(F) SPECIAL RULE FOR QUALIFIED ITEMS AND SERVICES.—

(i) IN GENERAL.—For purposes of subparagraph (A)(ii), an individual shall not be treated as covered under a health plan described in subclauses (I) and (II) of such subparagraph merely because the individual is eligible to receive, or receives, qualified items and services—

(I) at a healthcare facility located at a facility owned or leased by the employer of the individual (or of the individual's spouse), or

(II) at a healthcare facility operated primarily for the benefit of employees of the employer of the individual (or of the individual's spouse).

(ii) QUALIFIED ITEMS AND SERVICES DEFINED.—For purposes of this subparagraph, the term "qualified items and services" means the following:

(I) Physical examination.

(II) Immunizations, including injections of antigens provided by employees.

(III) Drugs or biologicals other than a prescribed drug (as such term is defined in section 213(d)(3)).

(IV) Treatment for injuries occurring in the course of employment.

(V) Preventive care for chronic conditions (as defined in clause (iv)).

(VI) Drug testing.

(VII) Hearing or vision screenings and related services.

(iii) AGGREGATION.—For purposes of clause (i), all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

(iv) PREVENTIVE CARE FOR CHRONIC CONDITIONS.—For purposes of this subparagraph, the term "preventive care for chronic conditions" means any item or service specified in the Appendix of Internal Revenue Service Notice 2019–45 which is prescribed to treat an individual diagnosed with the associated chronic condition specified in such Appendix for the purpose of preventing the exacerbation of such chronic condition or the development of a secondary condition, including any amendment, addition, removal, or other modification made by the Secretary (pursuant to the authority granted to the Secretary under paragraph (2)(C)) to the items or services specified in such Appendix subsequent to the date of enactment of this subparagraph.

(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.

(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. For purposes of this subparagraph, amounts paid for menstrual 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, any health insurance other than a medicare supplemental policy (as defined in section 1882 of the Social Security Act)[.], *or*

(v) any direct primary care service arrangement.

(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.

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

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

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

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

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

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

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

(e) TAX TREATMENT OF ACCOUNTS.—

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

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

(f) TAX TREATMENT OF DISTRIBUTIONS.—

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

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

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

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

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

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

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

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

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

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

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

(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account

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

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

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

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

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

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

(8) TREATMENT AFTER DEATH OF ACCOUNT BENEFICIARY.—

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

(B) OTHER CASES.—

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

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

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

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

(ii) SPECIAL RULES.—

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

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

(g) COST-OF-LIVING ADJUSTMENT.—

(1) IN GENERAL.—Each dollar amount in subsections (b)(2)*, (c)(1)(E)(ii)(II),* and (c)(2)(A) shall be increased by an amount equal to—

(A) such dollar amount, multiplied by

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

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

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

(iii) in the case of the dollar amount in subsection (c)(1)(E)(ii)(II) for taxable years beginning in calendar years after 2026, "calendar year 2025".

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)*, (c)(1)(E)(ii)(II),* and (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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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—RETURNS AND RECORDS

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PART III—INFORMATION RETURNS

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Subpart C—INFORMATION REGARDING WAGES PAID EMPLOYEES

SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

(1) the name of such person,

(2) the name of the employee (and an identifying number for the employee if wages as defined in section 3121(a) have been paid),

(3) the total amount of wages as defined in section 3401(a),

(4) the total amount deducted and withheld as tax under section 3402,

(5) the total amount of wages as defined in section 3121(a),

(6) the total amount deducted and withheld as tax under section 3101,

(8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),

(9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),

(10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned income as determined for purposes of section 32 (relating to earned income credit),

(11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,

(12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse *(other than any qualified HSA distribution, as defined in section 106(e)(2))*,

(13) the total amount of deferrals for the year under a nonqualified deferred compensation plan (within the meaning of section 409A(d)),

(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in subsection (g)), except that this paragraph shall not apply to—

(A) coverage to which paragraphs (11) and (12) apply, or

(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125),

(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee,

(16) the amount includible in gross income under subparagraph (A) of section 83(i)(1) with respect to an event described in subparagraph (B) of such section which occurs in such calendar year, **[**and**]**

(17) the aggregate amount of income which is being deferred pursuant to elections under section 83(i), determined as of the close of the calendar year**[**.**]**,

(18) in the case of a direct primary care service arrangement (as defined in section 223(c)(1)(E)(ii)) which is provided in connection with employment, the aggregate fees for such arrangement for such employee, and

(19) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by

paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) ADDITIONAL REQUIREMENTS.—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) STATEMENTS TO CONSTITUTE INFORMATION RETURNS.—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) RAILROAD EMPLOYEES.—

(1) ADDITIONAL REQUIREMENT.—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) INFORMATION TO BE SUPPLIED TO EMPLOYEES.—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.—

(1) STATEMENTS REQUIRED FROM PAYOR.—

(A) IN GENERAL.—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

(i) the name and, if there is withholding under section 3402(*o*), the social security number of such employee,

(ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and

(iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term "third-party sick pay" means any sick pay (as defined in section 3402(*o*)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(*o*)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

(A) the information shown on the statement furnished under paragraph (1)(A), and

(B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable.

To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

(g) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—For purposes of subsection (a)(14)—

(1) IN GENERAL.—The term "applicable employer-sponsored coverage" means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

(2) EXCEPTIONS.—The term "applicable employer-sponsored coverage" shall not include—

(A) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care,

(B) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, or

(C) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(*l*) is not allowable.

(3) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

(4) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

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VII. DISSENTING VIEWS

H.R. 5688 (Smucker, R–PA–11 and Blumenauer, D–OR–3) 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 allows individuals participating in a direct primary care arrangement or receiving qualified items and services at a worksite health clinic to contribute to an HSA. It also allows an individual to maintain an HSA even if the individual's spouse has a Flexible Spending Account (FSA) provided each spouse is under a separate health insurance plan. Finally, H.R. 5688 allows distributions from an FSA or Health Reimbursement Arrangement (HRA) directly to an HSA in connection with establishing coverage under an HDHP. According to the Joint Committee on Taxation, this bill would cost American taxpayers $12.95 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*

[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/.

Act made key investments to lower prescription drug prices, reduce 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 $100,00, 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.

[6] 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 PRIORIITES (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 PRIORIITES (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 PRIORIITES (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]

Amendments

Mr. Doggett (D–TX) offered an amendment to close a loophole whereby those over 65 years of age can spend HSA balances on non-health luxury items without penalty. Under current law, HSA funds can be used for anything—luxury items, like a yacht, a vacation home, a swimming pool—once an HSA account holder turns 65. In fact, investment advisors are even advertising the fact when they sell these accounts. This amendment would have ended that practice, eliminating the current law loophole that exempts HSAs distributions used for non- qualifying medical expenses. The amendment was defeated by Republicans on a party line roll- call vote (18 yeas to 23 nays).

Mr. Larson (D–CT) offered an amendment to ensure the provisions would not take effect unless the Secretary of the Treasury, in consultation with the Social Security Administration, ensured the Social Security Trust Funds would not be affected by implementation of the policies. 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. The amendment was defeated by Republicans on a party line roll-call vote (18 yeas to 24 nays).

Ms. Chu (D–CA) offered an amendment to require that nothing in H.R. 5688 shall be construed to prevent individuals from using their HSAs to cover vital reproductive and sexual health care. Women's access to health care is under attack by extremist Republicans. With the fall of *Roe*, needed health care services are no longer available for millions of women. This amendment simply would have ensured that women can use their HSAs to pay for needed health items and services, such as contraception or out-of-state travel costs to receive miscarriage- or abortion-related services. The amendment was defeated by Republicans on a party line roll-call vote (16 yeas to 24 nays).

Mr. Kildee (D–MI) offered an amendment to prevent individuals with adjusted gross incomes above $400,000 from taking a tax deduction. Given that the benefits of HSAs disproportionately accrue to the wealthy who are able to use these accounts for tax shelters rather than to make health services more affordable, this amendment would limit the tax advantages of the accounts to those most in need. The amendment was defeated by Republicans on a party line roll-call vote (16 yeas to 24 nays).

Mr. Pascrell (D–NJ) offered an amendment to increase the cap on the State and Local Tax deduction to $60,000 for single filers

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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.

and $120,000 for married couples filing jointly, and adjust the cap each year for the cost-of-living. The amendment was ruled non-germane. The appeal of the ruling of the chair was defeated. Restoring the State and Local Tax deduction is a matter of fairness. It properly measures a taxpayer's income, prevents double taxation, and it ends the Republican policy of penalizing states that raise adequate funds to provide crucial services such as police, fire protection, quality public schools, and social services to their citizens.

Mr. Pascrell (D–NJ) offered an amendment to add to H.R. 5688 a new section that prevents the bill from taking effect until the Secretary of the Treasury certifies that the cap on the State and Local Tax (SALT) deduction will not result in an increase in the tax liability of any taxpayer with an adjusted gross income less than $50,000 in calendar years 2023, 2024, or 2025. The amendment was defeated by Republicans on a party line roll-call vote (16 yeas to 24 nays).

Sincerely,

RICHARD E. NEAL,
Ranking Member.

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