DESCRIPTION OF H.R. 3800, THE "CHRONIC DISEASE FLEXIBLE COVERAGE ACT"

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
on June 7, 2023

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

June 5, 2023
JCX-13-23

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INTRODUCTION

The House Committee on Ways and Means has scheduled a committee markup of H.R. 3800, the "Chronic Disease Flexible Coverage Act." This document,[1] prepared by the staff of the Joint Committee on Taxation, provides a description of the bill.

[1] This document may be cited as follows: Joint Committee on Taxation, *Description of H.R. 3800, the ''Chronic Disease Flexible Coverage Act''* (JCX-13-23), June 5, 2023. This document can also be found on the Joint Committee on Taxation website at www.jct.gov. All section references in the document are to the Internal Revenue Code of 1986, as amended (the "Code"), unless otherwise stated.

A. Services and Items for Chronic Conditions Treated as Preventive Care

Present Law

Health savings accounts

An individual may contribute to a health savings account ("HSA") only if the individual is covered under a plan that meets the requirements for a high deductible health plan, as described below. 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.[2] The HSA rules allow deductible contributions to, and tax-exempt distributions from, HSAs for current medical expenses as well as an income tax exemption for earnings on HSA investments to be used for future medical expenses.

Within limits,[3] an eligible individual is allowed a deduction for contributions to an HSA made by or on behalf of the individual.[4] Contributions to an HSA are excludible from an individual's income and from employment taxes if made by the individual's employer. Earnings in HSAs are not taxable.[5] Distributions from an HSA for qualified medical expenses are not includible in the HSA beneficiary's gross income.[6] Distributions from an HSA that are not used for qualified medical expenses are includible in the HSA beneficiary's gross income and are subject to an additional tax of 20 percent.[7] The 20-percent additional tax does not apply if the distribution is made after the beneficiary dies, becomes disabled, or attains the age of Medicare eligibility (age 65).[8]

High deductible health plans

A high deductible health plan ("HDHP") is a health plan that has an annual deductible of at least $1,500 (for 2023) for self-only coverage and twice this amount for family coverage ($3,000 for 2023), 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)

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[2] Sec. 223(d).

[3] 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. The basic annual contributions limits are increased by $1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up" contributions). Sec. 223(b)(3).

[4] A family member (or any other person) may make contributions to an HSA on behalf of an eligible individual. See Notice 2004-50, Q & A 38, 2003-33, I.R.B. 196 (August 9, 2004).

[5] Sec. 223(e).

[6] Sec. 223(f)(1).

[7] Sec. 223(f)(2), (4).

[8] Sec. 223(f)(4).

for self-only coverage and twice this amount for family coverage ($15,000 for 2023).[9] These dollar thresholds are adjusted for inflation.[10]

An individual who is covered under an HDHP is eligible to contribute to an HSA if the individual is not also covered under a non-HDHP that provides coverage for any benefit (subject to certain exceptions) that is covered under the HDHP.[11]

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 arrangements.[12] 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 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.[13]

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.[14] Internal Revenue Service ("IRS") guidance provides a safe harbor for the types of coverage that constitute preventive care for this purpose.[15]

Preventive care

As noted, IRS guidance provides a safe harbor for preventive care benefits allowed under an HDHP. 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,

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[9] Sec. 223(c)(2).

[10] Sec. 223(g).

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

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

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

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

[15] Notice 2004-23, 2004-15 I.R.B. 725 (April 12, 2004). See also Notice 2004-50, 2004-33 IRB 1 (August 9, 2004); Notice 2008-59, 2008-29 I.R.B. 123 (July 21, 2008); Notice 2013-37, 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).

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.

Under a 2019 Executive Order, the Treasury Department was required to 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.[16]

Notice 2019-45[17] expands the list of preventive care benefits permitted to be provided by an HDHP, before the deductible, to include specified preventive care for specified chronic conditions.

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.[18]

Description of Proposal

The proposal provides that the IRS Notice 2019-45 guidance describing the additional preventive care services and items for chronic conditions that, under Notice 2019-45, may be treated as preventive care for purposes of Code section 223(c)(2)(C), has the same force and effect as if included in the enactment of this Act.

To the extent not inconsistent with the proposal, no inference may be made with respect to such other rules or guidance as the Secretary has provided, or may provide, with respect to preventive services for purposes of Code section 223(c)(2)(C).

Effective Date

The proposal is effective on the date of enactment.

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[16] Executive Order 13877, "Improving Price and Quality Transparency in American Healthcare to Put Patients First," 84 FR 30849 (June 27, 2019).

[17] 2019-32 I.R.B. 593 (August 5, 2019).

[18] Notice 2019-45 provides that "[a]lthough this notice clarifies that benefits for the specified services and items for individuals with the specified chronic conditions listed in the Appendix are preventive care for purposes of section 223(c)(2)(C), it does not treat these services and items as preventive care required to be provided without cost sharing for purposes of section 2713 of the PHS Act."

B. Estimated Revenue Effects of the Proposal

The proposal is estimated to have no effect on Federal fiscal year budget receipts for the period 2023-2033.