DESCRIPTION OF H.R. 5687, THE "HSA MODERNIZATION ACT OF 2023"

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
on September 28, 2023

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION

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INTRODUCTION

The House Committee on Ways and Means has scheduled for September 28, 2023, a markup of H.R. 5687, the "HSA Modernization Act of 2023." 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. 5687, the "HSA Modernization Act of 2023"* (JCX-41-23), September 26, 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. Individuals Without Service-Connected Disability and Eligible for Certain Veterans Benefits Permitted to Contribute to Health Savings Accounts

Present Law

Health savings accounts

An individual may contribute to a health savings account (an "HSA") only if the individual is covered under a plan that meets the requirements for a high deductible health plan, as described below. In general, HSAs provide tax-favored treatment for current medical expenses, as well as the ability to save on a tax-favored basis for future medical expenses. In general, an HSA is a tax-exempt trust or custodial account created exclusively to pay for the qualified medical expenses of the account holder and his or her spouse and dependents.

Within limits,[2] contributions to an HSA made by or on behalf of an eligible individual (with the exception of contributions by the individual's employer) are deductible by the individual. HSA contributions made on behalf of an eligible individual by an employer are excludible from income and wages for employment tax purposes. Earnings on amounts in HSAs are not taxable. Eligibility for HSA contributions is generally determined monthly, based on the individual's status and health plan coverage as of the first day of the month.

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

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

An individual who is covered under an HDHP is eligible to contribute to an HSA, provided that while such individual is covered under the HDHP, the individual is not covered

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

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

[4] Sec. 223(g).

under any health plan that (1) is not an HDHP and (2) provides coverage for any benefit (subject to certain exceptions) covered under the HDHP.[5]

Various types of coverage are disregarded for this purpose, including coverage of any benefit provided by permitted insurance, coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care, as well as certain limited coverage through health flexible spending arrangements.[6] Permitted insurance means insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, or such other similar liabilities as specified by the Secretary of the Treasury (the "Secretary") under regulations. Permitted insurance also means insurance for a specified disease or illness and insurance paying a fixed amount per day (or other period) of hospitalization.[7]

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

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

Health savings accounts and veterans benefits

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

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

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

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

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

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

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

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

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

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

Description of Proposal

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

Effective Date

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

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

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

B. Individuals Entitled to Part A of Medicare by Reason of Age Allowed to Contribute to Health Savings Accounts

Present Law

Health savings accounts and entitlement to Medicare

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

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

Qualified medical expenses

Generally, for purposes of distributions from HSAs, qualified medical expenses[18] mean amounts paid for medical care[19] or menstrual care products. Medical care generally means amounts paid for the diagnosis, cure, mitigation, treatment and prevention of disease, or for the purpose of affecting any structure or function of the body, as well as transportation primarily for and essential to medical care. Health insurance premiums are generally not qualified medical

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

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

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

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

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

expenses,[20] but an individual who attains the age of Medicare eligibility (age 65) may use an HSA to pay for health insurance other than a Medicare supplemental policy.[21]

Description of Proposal

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

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

Effective Date

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

[20] Sec. 223(d)(2)(B).

[21] As defined in section 1882 of the Social Security Act, 42 U.S.C. 1395ss. Sec. 223(d)(2)(C)(iv).

C. Individuals Eligible for Indian Health Service Assistance Not Disqualified from Health Savings Accounts

Present Law

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

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

Description of Proposal

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

Effective Date

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

[22] Notice 2012-14, 2012-8 I.R.B. 411, February 21, 2012.

D. Allowance of Bronze and Catastrophic Plans in Connection with Health Savings Accounts

Present Law

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

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

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

Description of Proposal

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

Effective Date

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

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

[24] See sec. 1302 of the PPACA.

[25] Sec. 1302(d) of the PPACA.

[26] See sec. 1302(e) of the PPACA.

[27] See sec. 1302(d)(1)(A) and (e) of the PPACA.

E. Safe Harbor for Absence of Deductible for Mental Health Services

Present Law

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

Description of Proposal

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

Effective Date

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

[28] As defined in sec. 9812(c)(4).

F. Special Rule for Certain Medical Expenses Incurred Before Establishment of Health Savings Account

Present Law

Health savings accounts and high deductible health plans

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

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

Description of Proposal

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

Effective Date

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

[29] Notice 2004-2, 2004-1 C.B. 269, Q&A-26.

G. Allow Both Spouses to Make Catch-up Contributions to the Same Health Savings Account

Present Law

Health savings accounts

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

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

If both spouses of a married couple are eligible individuals, each may contribute to an HSA, but they cannot have a joint HSA.[33] Under the rule described above, however, the spouses may divide their basic contribution limit for the year by allocating the entire amount to one spouse to be contributed to that spouse's HSA.[34] However, this allocation rule does not apply to catch-up contribution amounts. Thus, if both spouses are at least age 55 and eligible to make catch-up contributions, each must make the catch-up contribution to his or her own HSA.[35]

Description of Proposal

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

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[30] Rev. Proc. 2022-24, 2022-20 I.R.B. 1075, May 16, 2022.

[31] Sec. 223(b)(3).

[32] Sec. 223(b)(5).

[33] Notice 2004-50, 2004-2 C.B. 196, Q&A-63.

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

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

the spouses may agree to have their combined basic and catch-up contribution amounts allocated to one spouse to be contributed to that spouse's HSA.

Effective Date

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

H. Maximum Contribution Limit to Health Savings Account Increased to Amount of Deductible and Out-of-pocket Limitation

Present Law

Health savings accounts and high deductible health plans

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

Within limits, contributions to an HSA made by or on behalf of an eligible individual (with the exception of contributions by the individual's employer) are deductible by the individual. The annual HSA contribution limit for an individual is generally the sum of the limits determined separately for each month (*i.e.*, 1/12 of the limit for the year, including the catch-up limit, if applicable), based on the individual's status and health plan coverage as of the first day of the month.[36] For 2023, the basic limit on annual contributions that can be made to an HSA is $3,850 in the case of self-only coverage and $7,750 in the case of family coverage.[37] The basic annual contribution limits are increased by $1,000 for individuals who have attained age 55 by the end of the taxable year (referred to as "catch-up" contributions).[38]

Description of Proposal

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

Effective Date

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

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[36] Sec. 223(b).

[37] Rev. Proc. 2022-24, 2022-20 I.R.B. 1075, May 16, 2022.

[38] Sec. 223(b)(3).

I. Clarification of Treatment of Distributions from Health Savings Account for Long-term Care Services

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

Qualified medical expenses

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

Qualified long-term care services

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

Description of Proposal

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

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[39] Sec. 223(d)(2); see also Notice 2004-50, 2004-2 C.B. 196, Q&A-42.

[40] Based on the definition under sec. 213(d). For HSA purposes, amounts paid for menstrual care products are treated as paid for medical care. Sec. 223(d)(2)(A).

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

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

Effective Date

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

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