118TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
118–109

TELEHEALTH EXPANSION ACT OF 2023

JUNE 13, 2023.—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. 1843]

The Committee on Ways and Means, to whom was referred the bill (H.R. 1843) to amend the Internal Revenue Code of 1986 to permanently extend the exemption for telehealth services from certain high deductible health plan rules, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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39–006

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 "Telehealth Expansion Act of 2023".

SEC. 2. MAKING PERMANENT THE SAFE HARBOR FOR ABSENCE OF DEDUCTIBLE FOR TELEHEALTH.

(a) IN GENERAL.—Section 223(c)(2)(E) of the Internal Revenue Code of 1986 is amended by striking "In the case of" and all that follows through "a plan" and inserting "A plan".

(b) CERTAIN COVERAGE DISREGARDED.—Section 223(c)(1)(B)(ii) of the Internal Revenue Code of 1986 is amended by striking "(in the case of months or plan years to which paragraph (2)(E) applies)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2024.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 1843, the "Telehealth Expansion Act of 2023," as ordered reported by the Committee on Ways and Means on June 7, 2023, to permanently extend the safe harbor that allows employers who offer High Deductible Health Plans (HDHP) paired with a Health Savings Account (HSA) to allow for the absence of a deductible for telehealth.

B. BACKGROUND AND NEED FOR LEGISLATION

In order for an individual with a HDHP to make or receive contributions to a HSA, an individual cannot have disqualifying health coverage. An HDHP is a health insurance plan that satisfies certain requirements with respect to minimum deductibles and maximum out-of-pocket expenses. Generally, under section 223(c)(2)(A) of the Internal Revenue Code, a HDHP may not provide benefits for any year until the minimum deductible for that year is satisfied. In the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, PL 116–136) Congress established a safe harbor for the absence of a deductible for telehealth for plan years beginning on or before December 31, 2021. This flexibility was subsequentially extended in the Consolidated Appropriations Act of 2022 (PL 117–103) and the Consolidated Appropriations Act of 2023 (PL 117–328). This safe harbor is set to expire for plan years beginning after January 1, 2025. The Committee believes that this legislation is needed to permanently extend the ability for employees who are enrolled in HDHPs paired with an HSA to utilize first dollar coverage for telehealth services.

C. LEGISLATIVE HISTORY

Background

H.R. 1843 was introduced on March 28, 2023, and was referred to the Committee on Ways and Means.

Committee hearings

On Tuesday, March 23, 2023, the Committee held a Full Committee Hearing on "Why Health Care is Unaffordable: The Fallout of Democrats" Inflation on Patients and Small Businesses".

Committee action

The Committee on Ways and Means marked up H.R. 1843, the "Telehealth Expansion Act of 2023," on June 7, 2023, and ordered the bill, as amended, favorably reported (with a quorum being present).

D. Legislative History

Pursuant to clause 3(c)(6) of rule XIII, the following hearings were used to develop and consider H.R. 1843:

(1) Committee on Ways and Means Full Committee Hearing "Why Health Care is Unaffordable: The Fallout of Democrats" Inflation on Patients and Small Businesses".

II. EXPLANATION OF THE BILL

A. Making Permanent the Safe Harbor for Absence of Deductible for Telehealth (sec. 2 of the bill and sec. 223 of the Code)

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.[1] 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,[2] an eligible individual is allowed a deduction for contributions to an HSA made by or on behalf of the individual.[3] Contributions to an HSA are excludible from an individual's income and from employment taxes if made by theindividual's employer. Earnings in HSAs are not taxable.[4] Distributions from an HSA for qualified medical expenses are not includible in the HSA beneficiary's gross income.[5] 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 per-

[1] Sec. 223(d).

[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. 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).

[3] 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).

[4] Sec. 223(e).

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

cent.[6] 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).[7]

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) for self-only coverage and twice this amount for family coverage ($15,000 for 2023).[8] These dollar thresholds are adjusted for inflation.[9]

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.[10]

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.[11] 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 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.[12]

A plan does not fail to qualify as an HDHP by reason of failing to have a deductible for preventive care.[13]

For plan years beginning on or before December 31, 2021, an HDHP is permitted to cover telehealth and other remote care services without satisfaction of the plan's minimum deductible.[14] Thus, a health plan does not fail to be treated as an HDHP merely by reason of failing to require a deductible for telehealth and other remote care services for plan years beginning on or before December 31, 2021, and an individual who is covered under such a plan may contribute to an HSA.[15] Section 307 of Division P of the Consolidated Appropriations Act, 2022 extended the exemption for telehealth services to include months beginning after March 31, 2022, and before January 1, 2023.[16] Finally, Section 4151 of Division FF of the Consolidated Appropriations Act, 2023, extended the exemp-

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[6] Sec. 223(f)(2), (4).
[7] Sec. 223(f)(4).
[8] Sec. 223(c)(2).
[9] Sec. 223(g).
[10] Sec. 223(c)(1).
[11] Sec. 223(c)(1)(B).
[12] Sec. 223(c)(3).
[13] Sec. 223(c)(2)(C).
[14] CARES Act, Pub. L. No. 116–136, sec. 3701, March 27, 2020.
[15] Notice 2020–29, 2020–22 I.R.B. 864, provides that this standard applies with respect to services provided on or after January 1, 2020.
[16] Pub. L. No. 117–103, March 15, 2022.

tion for telehealth services to include plan years beginning after December 31, 2022, and before January 1, 2025.[17]

REASONS FOR CHANGE

The Committee observes that many individuals who have coverage under an HDHP, especially working parents and individuals living in rural areas, rely on telehealth and other remote care services for their medical care. The Committee also notes that telehealth has made it easier for individuals who have HDHP coverage to receive timely medical care and avoid future medical complications. The provision is intended to preserve access to telehealth and other remote care services for individuals with HDHP coverage.

EXPLANATION OF PROVISION

The provision provides a permanent safe harbor under which a plan does not fail to be treated as an HDHP merely by reason of providing, without satisfaction of the plan's deductible, telehealth and other remote care services.

EFFECTIVE DATE

The provision applies to plan years beginning after December 31, 2024.

III. VOTE OF THE COMMITTEE

Pursuant to clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 1843, the "Telehealth Expansion Act of 2023," on June 7, 2023.

The bill, H.R. 1843, the "Telehealth Expansion Act of 2023," as amended, was ordered favorably reported to the House of Representatives as amended by a roll call vote of 30 yeas to 12 nays (with a quorum being present).

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. Sanchez			
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	X			Mr. Panetta	X		
Mrs. Fischbach	X						
Mr. Moore	X						
Mrs. Steel	X						
Ms. Van Duyne	X						

[17] Pub. L. No. 117–328, December 29, 2022.

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
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. 1843, as reported. The estimate prepared by the Congressional Budget Office (CBO) is included below.

The bill is estimated to decrease Federal fiscal year budget receipts by $5.1 billion for the period 2023 through 2033.

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

The Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether this bill contains any new budget authority, spending authority, credit authority, or an increase or decrease in revenues or tax expenditures.

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

A. Committee Oversight Findings and Recommendations

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

B. Statement of General Performance Goals and Objectives

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

C. Information Relating to Unfunded Mandates

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

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

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

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

E. Tax Complexity Analysis

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Internal Revenue Code of 1986 and that have "widespread applicability" to individuals or small businesses, 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. Changes in Existing Law Proposed 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 VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

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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 applicable limitation under subparagraphs (A) and (B) of paragraph (2) shall be increased by the additional contribution amount.

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

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

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

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

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

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

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

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

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

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

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

(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.

(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.

(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] *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).

(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) 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), "calendar year 1997", and

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

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

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

(h) REPORTS.—The Secretary may require—

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

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

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

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VII. DISSENTING VIEWS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, June 7, 2023.

DISSENTING VIEWS ON TELEHEALTH EXPANSION ACT OF 2023, H.R. 1843

H.R. 1843 (Steel, R–CA; Schneider, D–IL) makes permanent the safe harbor for telehealth services covered under the deductible for high deductible health plans (HDHPs), without impacting the health services account (HSA) eligibility of such a plan. This temporary safe harbor was put in place during the COVID–19 pandemic and would be made permanent with this legislation. The safe harbor was extended most recently in December of 2022 for two years.

The safe harbor is in effect to study access and usage of telehealth. Only five months ago, a bipartisan, bicameral agreement was signed into law providing a two-year extension of the safe harbor for coverage of telehealth services under the HDHP deductible. The two-year extension was intended to provide time for Congress to evaluate how this safe harbor is working, including potential challenges, and allow for an informed path forward. H.R. 1843, which makes permanent the safe harbor, is an attempt by Republicans to bypass this bipartisan agreement, making a provision permanent that has little empirical data about its operation.

Telehealth has the potential to exacerbate disparities. Marginalized communities often face heightened obstacles when it comes to utilizing telehealth services due to a myriad of issues, including lack of access to appropriate devices or broadband. One study showed that numerous groups of patients were less likely to utilize telehealth services, including Hispanic, Asian, Spanish-speaking, low-income, and Medicaid populations.[1] Permanently allowing HDHPs to cover telehealth services under the deductible could benefit wealthier individuals who have access to additional resources, while lower-income individuals may not benefit from such provisions. This approach, inappropriately implemented, could exacerbate inequities and allow for more plan benefit designs that are discriminatory.

This provision is not solely about telehealth access, but also about advantaging triple tax-preferred health savings accounts (HSAs) that benefit the wealthy. Health plans can already provide any allowable pre-deductible services via telehealth without any change in law. This legislation would vastly expand the scope of services subject to the pre-deductible safe harbor, only if provided by telehealth. Under this policy, if a person with an HDHP wanted an in-person physician visit, s/he would be subject to the full cost of care

[1] https://onlinelibrary.wiley.com/doi/10.1002/cam4.4518.

until the deductible is met; however, if s/he used a telehealth visit, the plan could pay for the visit before the person hit his/her deductible (while maintaining an HSA), favoring telehealth as a modality of care over any in-person services.

This policy provides the greatest benefit, as is evidenced by the Joint Committee on Taxation analysis, to those in the highest income brackets. HSAs are primarily utilized by high-income earners, those who have the financial wherewithal to set aside funds and invest in future medical costs. In fact, 86 percent of the HSA tax benefits from this policy will go to families earning over $100,000 annually.

DISTRIBUTION OF THE CHANGES IN LIABILITY FROM THE TELEHEALTH EXPANSION ACT OF 2023

Income Category (1)	Tax Year 2025			Tax Year 2033		
	Number of returns (thousands)	Change in tax liability ($millions)	Total tax change (percent)	Number of returns (thousands)	Change in tax liability ($millions)	Total tax change (percent)
Less than $10,000	(2)	(3)	(4)	(2)	(3)	(4)
$10,000 to $20,000	2	(3)	(4)	(2)	(3)	(4)
$20,000 to $30,000	1	−1	0.3	3	(3)	(4)
$30,000 to $40,000	7	−1	0.3	8	−5	0.7
$40,000 to $50,000	26	−7	2.4	24	−9	1.2
$50,000 to $75,000	45	−14	4.8	84	−69	9.4
$75,000 to $100,000	35	−18	6.3	74	−84	11.4
$100,000 to $200,000	90	−87	29.9	164	−279	38.0
$200,000 to $500,000	90	−128	43.9	91	−240	32.6
$500,000 to $1,000,000	11	−26	9.0	12	−34	4.7
$1,000,000 and over	4	−10	3.3	3	−12	1.7
Total, All Taxpayers	311	−293	100.00	464	−735	100.0

Source: Joint Committee on Taxation.
Detail may not add to total due to rounding.
(1) The income concept used to place tax returns into income categories is adjusted gross income (''AGI'') plus: [1] tax-exempt interest, [2] employer contributions for health plans and life insurance, [3] employer share of FICA tax, [4] workers compensation, [5] nontaxable Social Security Benefits, [6] insurance value of Medicare benefits, [7] alternative minimum tax preference items, [8] individual share of business taxes, and [9] exclude income of U.S. citizens living abroad. Categories are measured at 2023 levels.
(2) Less than 500 returns.
(3) Less than $50,000.
(4) Less than .05 percent.

Republican legislation aiming to increase the amounts of services covered under the deductible of a HDHP is merely an attempt to free up additional money for the wealthy to contribute to a triple-advantaged savings account, not to benefit the most vulnerable.

The promotion of HDHPs and HSAs will hinder access to care, further exacerbating health care inequities. Studies have repeatedly demonstrated that high out-of-pocket costs imposed by HDHPs result in consumers delaying or neglecting necessary care. In fact, according to a Commonwealth Fund study, nearly 45 percent of adults with high out-of-pocket expenses push off or forgo health care services altogether. By attempting to add additional services covered under the deductible for HDHPs, individuals might be further incentivized to enroll in a plan that ultimately provides insufficient coverage and requires higher out-of-pocket costs. Furthermore, the promotion of HDHPs and HSAs might pose harmful consequences as it relates to health care equity. As it stands today, Black and Hispanic Americans report facing more obstacles when paying for necessary health care services when enrolled in a HDHP than White Americans. When stratified by race, there are promi-

nent differences in account balances and distributions of HSA accounts.

The legislation contributes to the deficit, while predominantly aiding the wealthy. Nearly a week after passing the debt ceiling bill, which placed heightened burden on vulnerable populations, Republicans seek to add five billion dollars to the federal deficit with this bill, 86 percent of which will benefit American families that make $100,000 or more every year.

RICHARD E. NEAL,
Ranking Member.

RANKING MEMBER RICHARD E. NEAL, OPENING STATEMENT, COMMITTEE ON WAYS AND MEANS MARKUP OF H.R. 1843,

Wednesday, June 7, 2023.

I thank my colleague Mr. Schneider for his efforts on the issue of telehealth, which we can all agree has become an important vehicle for accessing care. With that, I'll yield to him.

REPRESENTATIVE SCHNEIDER REMARKS FOR H.R. 1843

Thank you, Ranking Member Neal, I appreciate it. I believe, and I think evidence demonstrates that we saw it during the pandemic, telehealth saves time, as representative Steel mentioned; it saves money, but most importantly, I believe it saves lives.

Telehealth has been demonstrated to improve outcomes, allow people who otherwise wouldn't have access to care to access—whether it's a primary care physician to talk, perhaps, about a child who has an ear infection that might need more attention, or someone in the midst of a mental health issue reaching out and finding someone they can talk to during a period of pandemic where we couldn't meet face to face. I agree with the ranking member: we need to understand how to best use it and we're learning that. I've often spoken before the pandemic—folks I knew were from interested to skeptical, ran the spectrum. I consider myself now fully evangelical about the potential of telehealth both from my personal experience, the experience of my family, the experience of my neighbors, constituents, and seeing it across the country.

What's important to me as we move forward is that the access to telehealth remain available to everyone needing care. At all income levels, in all locations, whether they live in a city with congested traffic, or a rural community where the nearest physician might be 100 miles away or more. This bill would ensure that access to telehealth is not precluded; it is protected in keeping these plans in safe harbor. I look forward to talking more about this, but I yield back for now. Thank you.

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