DESCRIPTION OF H.R. 5688, THE "BIPARTISAN HSA IMPROVEMENT ACT OF 2023"

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
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Prepared by the Staff
of the
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CONTENTS

INTRODUCTION

The House Committee on Ways and Means has scheduled for September 28, 2023, a markup of H.R. 5688, the "Bipartisan HSA Improvement 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. 5688, the "Bipartisan HSA Improvement Act of 2023"* (JCX-39-23), 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. Treatment of Direct Primary Care Service Arrangements

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. 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 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]

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

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

[4] Sec. 223(g).

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

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]

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.[11]

Description of Proposal

Under the proposal, 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

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

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

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

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

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

[11] 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.

which such individual is provided medical care consisting solely of such primary care services provided by primary care practitioners[12] 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 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 proposal applies to months beginning after December 31, 2025, in taxable years ending after such date.

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

B. On-site Employee Clinics

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 or health care 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 (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 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.[13]

Preventive care

The IRS has issued guidance providing a safe harbor for preventive care benefits allowed under an HDHP.[14] 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

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

[14] 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.

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.[15] 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).[16]

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.[17]

Description of Proposal

Under the proposal, 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,[18] (6) drug testing, and (7) hearing or vision screenings and related services.

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

[16] Notice 2019-45, 2019-32 I.R.B. 593, August 5, 2019.

[17] Notice 2013-57, 2013-40 I.R.B. 293, September 30, 2013.

[18] 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 proposal) 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.

All entities treated as a single employer[19] under the Code are treated as a single employer under this proposal.

Effective Date

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

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

C. Contributions Permitted If Spouse HAS Health Flexible Spending Arrangement

Present Law

Flexible spending arrangements

A flexible spending arrangement (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.[20] An FSA under a cafeteria plan[21] allows an employee to make salary reduction contributions for use in receiving reimbursements for certain incurred expenses.[22] 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).[23] 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").[24] 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.[25] 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.[26] Such a carryover is not permitted in a

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

[21] 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 income 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.

[22] Sec. 125 and Prop. Treas. Reg. sec. 1.125-5.

[23] Prop. Treas. Reg. sec. 1.125-5(b).

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

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

[26] 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.

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.[27] Under the Code, the value of employer-provided health coverage under an accident or health plan is generally excludable from gross income,[28] as are reimbursements under the plan for medical care expenses for employees, their spouses, and their dependents.[29] 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 inflation, for any taxable year.[30] 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.

Description of Proposal

The proposal 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. 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.

Effective Date

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

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

[28] 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.

[29] Sec. 105(b).

[30] Sec. 125(i).

D. FSA and HRA Terminations or Conversions to Fund HSAs

Present Law

Flexible spending arrangements

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

Health reimbursement arrangements

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[31] 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.[32] Unlike 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.[33] 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.[34]

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[31] As defined in sec. 152.

[32] 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.

[33] Rev. Rul. 2004-45, 2004-1 C.B. 971.

[34] As defined in sec. 223(c)(2)(A)(i). Rev. Rul. 2004-45, 2004-1 C.B. 971.

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.[35] 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[36]).[37] 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.[38] Coverage by an HSA-compatible health FSA or HRA does not affect an employee's eligibility to contribute to an HSA, including during a health FSA grace period.[39]

FSA and HRA terminations to fund HSAs

The Health Opportunity Empowerment Act of 2006[40] 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.[41]

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.[42] The amount of the qualified HSA distribution may not exceed the lesser of the balance in the health

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[35] Notice 2005-42, 2005-1 C.B. 1204.

[36] "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.

[37] Sec. 223(c)(1)(B)(iii)(I).

[38] 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 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.

[39] Rev. Rul. 2004-45, 2004-1 C.B. 971.

[40] 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.

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

[42] Notice 2007-22, 2007-1 C.B. 670.

FSA or HRA on September 21, 2006 or the date of distribution.[43] 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.[44]

In addition, a qualified HSA distribution must be contributed directly to the HSA trustee by the employer.[45] 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")[46] 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.[47] 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.[48]

Description of Proposal

The proposal 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 proposal, 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.

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

[44] 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.

[45] Sec. 106(e).

[46] 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.

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

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

Under the proposal, the aggregate amount of qualified HSA distributions may not exceed the total annual limit on FSA contributions ($3,050 in 2023)[49] or twice this amount in the case of an eligible individual who has family coverage under an HDHP. The proposal 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.[50]

The proposal 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 proposal provides that the amount of any qualified HSA distribution is to be included on the information to be reported on Form W-2.[51]

Effective Date

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

[49] Sec. 125(i).

[50] 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).

[51] Sec. 6051(a).