REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-25)
Health Savings Account Reform
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2024 Interim Meeting, the House of Delegates referred Resolution 803-I-24, "Health Care Savings Account Reform," which asked the American Medical Association (AMA) to:

> Advocate for the revision of Health Savings Accounts (HSAs) to: (1) permit contributions from family members, employers, or other designated individuals, not limiting contributions to only those on high deductible health insurance plans; (2) permit contributions to the accounts of dependents, including children and spouses; (3) permit contributions from Medicare and Medicaid enrollees; (4) permit the payment of health, dental, and vision insurance premiums from HSAs; (5) permit the money spent by an employer on health insurance to be directed, in part, into an employee HSA, at the employee's discretion; (6) prioritize permitting the transfer of funds between HSAs, including between spouses and family members; and (7) ensure that the expansion of the role and functions of HSAs is complementary to and does not replace health insurance.

Additionally, a proposed amendment was referred with this resolution which asked the AMA to support expanding choice and competition on Affordable Care Act (ACA) Marketplaces by automatically placing leftover ACA premium tax credits into an HSA when a selected plan's premium is lower than the premium tax credit.

An HSA pairs with an HSA-eligible high-deductible health plan (HDHP) and is a tax-advantaged way to save money for qualified medical expenses. HSAs are closely tied to United States tax code and have many guidelines and regulations they must follow as a result. In 2023, there were 36 million active HSA accounts that reported holding over $116 billion in assets. An individual can contribute to an HSA if: 1) they are not enrolled in a health plan sponsored by their spouse or parent that is not an HSA-eligible health plan; 2) they have no other health coverage (with some exceptions); 3) they are not enrolled in Medicare; and 4) they cannot be claimed as a dependent on someone else's tax return. As long as HSA funds are used for qualified medical expenses, an individual will not owe taxes on the money when it is taken out of the account. Employers can contribute to employees' HSAs, and like a 401(k) account, the money remains with the employee, even if they leave their job. Investing HSA funds is also possible and can help build a nest egg for health expenses later in life when needs may be greater.

Council on Medical Service Report 1-I-25 examines each of the proposed clauses and makes several policy recommendations to improve usability and flexibility for those who have HSAs but does not encourage or incentivize replacing other forms of health coverage with these accounts. The report recommends supporting HSA contributions from family members, employers, or other designated individuals; supporting continued contributions to HSAs by Medicare enrollees, with further study on appropriate guardrails for using those funds; amending AMA policy to include dental, vision, and hearing insurance premiums as qualified medical expenses; supporting external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and family members; supporting ACA premium tax credit design that allows unused or residual tax credits be placed in an HSA; amending AMA policy to support individual market bronze and silver plans being treated as HSA-qualified HDHPs; and supporting education on the use of HSAs, specifically to Medicare enrollees and those interested in bronze or silver plans on the ACA marketplace.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-25

Subject: Health Savings Account Reform

Presented by: Betty Chu, MD, MBA, Chair

Referred to: Reference Committee J

At the 2024 Interim Meeting, the House of Delegates referred Resolution 803-I-24, "Health Care Savings Account Reform," which was sponsored by the New England Delegation and asked the American Medical Association (AMA) to:

> Advocate for the revision of Health Savings Accounts (HSAs) to: (1) permit contributions from family members, employers, or other designated individuals, not limiting contributions to only those on high deductible health insurance plans; (2) permit contributions to the accounts of dependents, including children and spouses; (3) permit contributions from Medicare and Medicaid enrollees; (4) permit the payment of health, dental, and vision insurance premiums from HSAs; (5) permit the money spent by an employer on health insurance to be directed, in part, into an employee HSA, at the employee's discretion; (6) prioritize permitting the transfer of funds between HSAs, including between spouses and family members; and (7) ensure that the expansion of the role and functions of HSAs is complementary to and does not replace health insurance.

Additionally, a proposed amendment was referred with this resolution. The amendment asked the AMA to support expanding choice and competition on Affordable Care Act (ACA) Marketplaces by automatically placing leftover ACA premium tax credits into an HSA when a selected plan's premium is lower than the premium tax credit.

This report considers the referred, proposed changes to HSAs; summarizes relevant AMA policy; and makes several new policy recommendations.

BACKGROUND

An HSA pairs with an HSA-eligible health plan (typically a high-deductible health plan [HDHP]) and is a tax-advantaged way to save money for qualified medical expenses. HSAs are closely tied to United States tax code and have many guidelines and regulations they must follow as a result. Pre-tax dollars can be saved in an HSA and the funds can be used at any time in a person's life to pay for co-pays, prescriptions, dental care, contacts and eyeglasses, bandages, x-rays, and other qualified medical expenses as defined by the Internal Revenue Service (IRS).[1] Notably, insurance premiums are not considered qualified medical expenses (with the exception of Medicare premiums after age 65).[2] As long as the funds are used for qualified expenses, an individual will not owe taxes on the money when it is taken out of the account. Employers can contribute to employees' HSAs, and like a 401(k) account, the money remains with the employee, even if they leave their job. Investing HSA funds is also possible and can help build a nest egg for health expenses later in life when needs may be greater. In 2023, there were 36 million active HSA

accounts that reported holding over $116 billion in assets. This represents a 500 percent increase since 2013.[3]

Starting at age 65, there is no penalty for withdrawing HSA funds for non-qualified medical expenses, but income taxes will be owed on the amount withdrawn. Before the age of 65, income taxes plus a 20 percent penalty must be paid on withdrawals not used for qualified medical expenses.

An individual can contribute to an HSA if: 1) they are not enrolled in a health plan sponsored by their spouse or parent that is not an HSA-eligible health plan; 2) they have no other health coverage (with some exceptions); 3) they are not enrolled in Medicare; and 4) they cannot be claimed as a dependent on someone else's tax return.[4,5]

There are several advantages to an HSA:

- Contributions can be deducted from your taxes.
- Employers can contribute to employee HSAs, similar to 401(k) accounts.
- HSA funds can be invested to grow more wealth. Interest and other earnings on the account are tax free.
- HSA accounts belong to an individual, not an employer, and remain with the individual even if they leave their job.
- Starting at age 65 there is no penalty for using HSA funds for non-qualified medical expenses.
- HSAs can help bridge the gap to Medicare coverage for those who retire before the age of 65.
- HSAs can be used to pay Medicare premiums and long-term care insurance policies.
- HSA funds can be passed to spouses and heirs after death.

Conversely, HSAs are considered regressive because the financial advantages they offer increase as the owner of the account's income and tax rate rises.[6] Tax exemptions for health spending are regressive for at least three reasons: higher income people are more likely to use the accounts, are more likely to exempt larger amounts, and have higher marginal tax rates. HSAs also provide an advantage to those with higher incomes since they are more likely able to navigate complex tax rules to maximum advantage.[7] An analysis of 2017 IRS data found that tax returns exceeding $500,000 in adjusted gross income were the most likely to report individual HSA contributions and returns between $200,000 and $1 million were the most likely to report employer HSA contributions. HSA contributions declined as income declined and only a small percentage of low-income tax returns showed contributions to an HSA.[8]

Another characteristic, and possible disadvantage, of HSAs is that they are only available to those that have qualifying HDHPs. Over the years, HDHPs have become a more common employer-sponsored health insurance offering. Among workers with HDHPs, 52 percent had plans with HSAs while eight percent participated in plans with Health Reimbursement Arrangements (HRAs), figures that varied considerably between high and low wage employees. Among workers in the lowest 25 percent wage category, 32 percent had plans with HSAs and 12 percent had HRAs. Among workers in the highest 25 percent wage category, 66 percent had plans with HSAs and seven percent had HRAs.[9] More workers are now covered by HDHPs, which typically have higher deductibles and lower premiums when compared to traditional plans. Such plans generally require patients to pay the full cost of health services and medications until deductibles are met; however, most HDHPs exclude a variety of preventive services from the deductible. Although an HDHP's lower premium may be attractive to some people, the responsibility for out-of-pocket expenses

becomes problematic when deductibles are too high for enrollees to afford and patients are unable to cover their costs when they need access to care.[10]

HSAs are often not a viable option for those who are uninsured and cannot afford coverage and are often out of reach for people with low and moderate incomes.[11] The arrangement is much more feasible for high earners. A 2024 study in *Health Affairs* found that there are racial and ethnic wealth disparities between families with private insurance and those in HDHPs – with or without an associated HSA.[12] Research shows that HSAs are distributed unevenly across race and ethnicity. Latino and Black individuals are about half as likely to have HSAs than are white and Asian individuals.[13] Additionally, HSAs tend to benefit patients that are overall healthy compared to those that have chronic care needs or other large medical expenses. HSAs must be paired with a qualifying HDHP, which can also impact patients' medical decision-making. According to a literature review conducted by *Health Affairs* in 2017, HDHPs did achieve policymakers' goal of reducing health care costs but also had an adverse effect on patient use of preventive services, screenings, and medication adherence.[14]

The final language of the 2025 Federal Budget Reconciliation Bill (commonly known as the "One Big Beautiful Bill Act [OBBBA]") allows individual market bronze and catastrophic plans to be treated as HSA-eligible HDHPs. This will go into effect on January 1, 2026, and will allow individuals who opt for these higher deductible marketplace plans to pair their coverage with an HSA and take advantage of the tax and savings benefits.

Additionally, the legislation expands the definition of a qualified medical expense to include Direct Primary Care (DPC) arrangements. DPCs are health care models where a patient pays a recurring (often annual or monthly) fee directly to a primary care physician to cover a broad range of primary care services, such as annual wellness exams and communication with the physician. The OBBBA passed by the Senate allows individuals to use HSA funds to cover DPC services as a qualified medical expense. There are exceptions for services that require general anesthesia, prescription drugs (except for vaccines) and laboratory services not typically administered in an ambulatory primary care setting. This change aligns with AMA policy.

While the legal limitation is clear under current law, any future policy change to allow unused premium tax credits to fund HSAs or similar accounts would need to be carefully designed to avoid exacerbating coverage disparities. Subsidy overages are more likely among individuals who are younger, healthier, or select lower-premium plans. Redirecting these funds could incentivize underinsurance or plan gaming, undermining the ACA's foundational principle that subsidies are tied to actual coverage purchases. Such an approach must be evaluated through an equity lens to ensure it does not disproportionately benefit those least in need of subsidization or erode access to comprehensive coverage for others.

PROPOSED CHANGES TO HSAs

Contributions from family members, employers, or other designated individuals, not limiting contributions to only those on HDHPs

According to the IRS (Publication 969) any eligible individual can contribute to an HSA. For an employee's HSA, the employee, employer, or both may contribute to the employee's HSA in the same year. For an HSA established by a self-employed or unemployed individual, the individual can contribute to the account. Family members or any other person may also make contributions on behalf of an eligible individual.[15]

Contributions to the accounts of dependents, including children and spouses

There is no prohibition from contributing to a spouse's HSA if they are individually eligible and have an account of their own. As long as the annual limit has not been met, an individual can contribute to their spouse's HSA. There are no general prohibitions against someone else making a contribution on behalf of an eligible individual. However, dependent minor children generally cannot have their own HSAs as they are not individually eligible because they are dependents claimed on someone else's tax return.

Contributions from Medicare and Medicaid enrollees

The proposal to allow contributions from individuals enrolled in Medicare would require a change to Section 223 of the United States tax code. Under 26 U.S.C. § 223(c)(1)(A)(ii), individuals are ineligible to contribute to an HSA if they are enrolled in any part of Medicare. IRS guidance (Notice 2004-50, Q&A) further clarifies that enrollment in Part A alone disqualifies an individual, even if they are otherwise covered by a HDHP. Under current law, once seniors become eligible for Medicare, they are no longer able to make deposits into HSAs since these funds can be used to pay Medicare premiums. Allowing contributions would mean decoupling HSA eligibility from HDHP enrollment. If seniors could make tax-deductible contributions to an HSA and then use those funds to pay for Medicare premiums, it would essentially allow retirees to deduct their Medicare premiums from their taxes. At this time, Congress has been unwilling to provide this benefit to Medicare enrollees, although it has been suggested.[16]

In 2023, Congress considered H.R. 5687, HSA Modernization Act of 2023. Under this proposal, it was assumed that people enrolled in HDHPs would no longer lose the tax preference for HSA contributions when they enroll in Medicare at age 65. As a result, the Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) expected that some beneficiaries who under current law would have dropped their HDHP coverage would instead have retained that coverage and make Medicare their secondary payer. At that time of consideration of this proposal, CBO and JCT estimated that allowing Medicare enrollees to contribute to HSAs would reduce revenues by $8.5 billion and cause Medicare overlays to decline an additional $2.7 billion over the next decade (2024-2033).[17]

More recently, in the House-passed version of H.R. 1, text included a change to allow people who are 65 or older and enrolled in Medicare Part A only to contribute to an individual HSA. If that individual is eligible to continue to contribute to an HSA, they may not use distributions to pay for health insurance and funds not used for qualified medical expenses would be subject to an additional 20 percent tax.[18] Because the provision to allow HSA contributions from Medicare enrollees was not included in the final version of the OBBBA, it was not specifically assigned an updated score by CBO and JCT.

Medicaid enrollees typically do not have access to qualifying HDHPs. According to Medicaid.gov, Michigan, Indiana, and Arkansas have used Section 1115 demonstration waivers to implement programs to offer HSAs for Medicaid beneficiaries. Iowa and Pennsylvania are also exploring the possibilities of using Medicaid funds to enroll beneficiaries in these plans. States that have tried these programs have ended them after their trial periods due to low enrollment, cost, and additional administrative burdens.

Payment of health, dental, and vision insurance premiums from HSAs

Currently, health insurance premiums are not HSA-eligible expenses (26 U.S.C. § 223(d)(2)(B)), with the exception of Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance coverage and Medicare premiums, as well as some long-term care coverage premiums. For long-term care coverage, the amount of money that can be withdrawn tax free to cover these premiums depends on age. The older the individual, the more money that is able to be deducted to cover these costs. Unemployed individuals may qualify to withdraw funds from their HSA to cover health insurance premiums, but only if they are receiving federal or state unemployment benefits or are covered by COBRA. Allowing payment of health, dental, and vision insurance premiums from an HSA would require a statutory change but is something that has been proposed in past legislation on expanding HSAs.

Directing some or all of the money spent by an employer on health insurance into an employee HSA

Under 26 U.S.C. § 106(d)(1) employers can contribute to employees' HSAs with contributions generally excluded from employee gross income and not subject to federal income tax, Social Security, Medicare, or federal unemployment tax. For 2025, the HSA contribution limits are $4,300 for individual coverage and $8,550 for family coverage. Employers can make direct contributions or matching contributions, similar to retirement accounts. Employers can also make contributions tied to organizational wellness incentives and goals. Individual contribution limits must be adjusted based on employer contributions to ensure the total contribution cap is not exceeded.[19]

Permit the transfer of funds between HSAs, including between spouses and family members

According to current tax law (26 U.S.C. § 35 and 26 U.S.C. §223 (b)(5)), each eligible individual must open and own their own HSA. The account belongs to that individual and cannot be transferred unless the asset is divided during a divorce or if the account holder dies. There are specific rules laid out in each of the following scenarios, based on who is eligible for the account:

- Family HDHP Coverage – Both Spouses are Eligible: If one or both spouses have family HDHP coverage, the spouses may divide one maximum contribution amount for family coverage between their accounts, however they choose.
- Self-Only HDHP Coverage – Both Spouses are Eligible: If each spouse has self-only HDHP coverage, each is eligible to contribute up to the amount allowed for self-only coverage.
- Family HDHP Coverage – One Spouse is Eligible: The HSA account is owned by the eligible individual who can contribute up to the annual family contribution limit.
- Family HDHP Coverage – One or Both Spouses and Non-dependent Child are Eligible: An individual who is eligible to be claimed as a dependent on another individual's tax return is not eligible to open their own HSA. However, the ACA requires health plans to provide coverage to children until they reach age 26, even if the adult child is not eligible to be claimed as a dependent on the parent's income tax return. In this instance, the non-dependent child who is covered by their parents' family HDHP would be eligible to open their own HSA.
- Family HDHP Coverage and Single HDHP Coverage – Both Spouses are Eligible: If one spouse has family HDHP coverage and the other spouse has self-only HDHP coverage, the spouse with the self-only coverage may contribute up to the limit allowed for individual

> contribution. The spouse with the family HDHP coverage must reduce their contribution amount by the contribution amount made by the spouse with self-only coverage. The spouses' combined contribution amounts cannot exceed the amount allowed for family coverage.[20]

Care for dependent children would be paid out of the parents' account(s) and the total amount of money contributed could not exceed the cap for family coverage. Transfers between spouses and other family members are currently restricted, but spouses can inherit the HSA when the owner dies if the living spouse has been named a beneficiary to the account. In the case of divorce, an HSA is treated like any other asset and division of the asset is open to negotiation. Movement of all or part of an HSA to a former spouse as required by divorce decree is not a taxable transfer as long as the account remains an HSA. If the money is moved to a different type of account the money will be taxed at 20 percent. Notably, an HSA cannot be used to pay medical expenses for an ex-spouse tax-free, even if the court orders the ex-spouse to remain on the family insurance plan for a specific period following the divorce. If money is withdrawn to pay for the medical expenses of an ex-spouse, the money will be taxed at 20 percent. If there are children involved, either spouse can use money from the HSA to pay for a child's medical expenses, regardless of which parent claims the child as a dependent.

The tax code would need to be modified and careful guardrails would need to be established to accomplish this proposed change. There would also likely be pushback on efforts to more freely transfer funds tied to concerns about tax sheltering.

Expansion of the role and functions of HSAs

HSAs can be beneficial to some individuals but should not be considered a one size fits all approach, nor should they replace all other types of health insurance. The AMA supports patient freedom of choice when choosing a health plan and supports HDHPs paired with HSAs as one option for individuals to consider when making this decision.

Placing unused Affordable Care Act (ACA) premium tax credits in HSAs

Under current law, when an individual does not use their entire allotted ACA premium tax credit the unused, leftover premium tax credit goes away and the individual loses part of the benefit of the tax credit. For example, if an individual qualifies for a premium tax credit to cover a silver plan but instead chooses to enroll in a bronze plan where the premium is lower, the leftover premium tax credit disappears. If an individual is at 150 percent of the federal poverty level (FPL), is not eligible for Medicaid, and is enrolling in an ACA Marketplace plan, they would qualify for $4,662 per year of premium tax credits for a silver plan. However, if that individual instead chose to enroll in a bronze plan, they would receive $3,580 per year in premium tax credits, essentially leaving $1,082 of benefits on the table per year. This example was calculated using the KFF Health Insurance Marketplace Calculator for 2025 plans.

Furthermore, the OBBBA has changed the process for excess ACA premium tax credits. This scenario is slightly different than the one outlined above; however, prior to passage of the OBBBA, if an enrollee received excess premium tax credits because their estimated income was lower than their actual income, they had to repay the excess. For most enrollees there was a repayment cap based on household income and for those with a household income over 400 percent of the federal poverty level (FPL), there was no limit and the entirety of the excess tax credit had to be repaid. An individual with an income less than 200 percent FPL had a cap of $375 and families with a household income between 300 – 400 percent FPL had a cap of $3,150. Following the passage of

the OBBBA, beginning on January 1, 2026, all premium tax credit recipients must repay the full amount of excess, no matter their household income.[21]

Given both of these scenarios, it would be valuable for the AMA to support tax credits that are designed to allow individuals to contribute to an HSA through the application of unused or residual credit amounts. Doing so could encourage individuals to be proactive about saving for future health care needs and could potentially reduce medical debt in the face of unexpected medical expenses.

AMA POLICY

AMA has several policies that either directly or indirectly relate to the points raised by Resolution 803-I-24 and/or portions of the OBBBA passed into law.

Regarding contributions to HSAs from Medicare and Medicaid enrollees, Policy H-290.972 outlines principles for states to consider when deciding if they are going to offer HSA programs to Medicaid beneficiaries. These guidelines include, amongst other standards, making beneficiary participation voluntary, providing first-dollar coverage for preventive care, allowing payments to non-Medicaid providers by beneficiaries to count towards deductibles and out-of-pocket spending limits, and prohibiting the use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private health insurance, including the employee share of the premium for employer-sponsored coverage.

Policy H-165.852(7) states that legislation promoting the establishment of and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. The addition of dental and vision premiums as qualified medical expenses could be considered within this policy.

The AMA has policy on how HSAs fit into the larger health insurance landscape. Policy H-165.852(3) states that advocacy of HSAs continues to be incorporated prominently in AMA's campaign for health insurance market reform, indicating the organization's commitment to improving HSAs and Policy H-165.833 states that as part of the AMA's organizational goal of amending and improving the ACA, the AMA will advocate to expand the use of HSAs and a means to provide health insurance.

Policy H-165.828 states that the AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy and supports clear labeling of exchange plans that are eligible to be paired with an HSA with information on how to set up an HSA. Additionally, Policy H-165.865 states that tax credits should be applicable only for the purchase of health insurance, including all components of a qualified HSA, and not for out-of-pocket health expenditures.

Policy D-165.954 states that the AMA will monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

Policy D-165.962 states that the AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.

Policy H-165.863 states that along with efforts to liberalize the Health Savings Account rules, the AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.

Policy H-385.912 is addressed in the final language of the OBBBA and states that it is AMA policy that the use of an HSA to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense. Furthermore, the policy states that the AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for DPC and to enter DPC periodic-fee agreements without IRS interference or penalty.

DISCUSSION

With appropriate guardrails in place, expanded use of HSAs can allow for more flexibility for consumers' medical spending. The recommendations from the Council improve usability and flexibility for those who have HSAs, but are not intended to encourage or incentivize replacing other forms of health coverage with these accounts. Notably, many of the changes proposed in Resolution 803-I-24 and the Council's corresponding recommendations would require changes to U.S. tax code and would potentially come with a hefty price tag.

The tax code currently allows family members and/or others to contribute to an individual's HSA, as long as the total amount does not exceed the annual contribution limit. This allows an individual to receive financial support from their community in the event of a medical emergency. Similarly, an individual can contribute to the accounts of their spouse or children if they have their own individually eligible HDHP paired with an HSA.

The Council believes it is reasonable to support continued contributions to an HSA once an individual has reached 65 years of age and is eligible for Medicare. Many individuals live decades past eligibility for Medicare, and allowing continued contributions to an HSA can help those individuals continue to prepare for the medical costs associated with aging, especially since funds from an HSA can be used to pay for long-term care premiums. However, in order to follow the current tax laws, guardrails would need to be in place to ensure this benefit does not further strain the Medicare program and can be accessed fairly among Medicare beneficiaries, regardless of socioeconomic status. The Council believes that further study from tax experts and others is warranted to develop the specific guardrails but recommends that Medicare enrollees be allowed to continue to contribute to an HSA. Regarding Medicaid, the AMA has extensive policy outlining principles for states considering offering HSA-like accounts to their Medicaid populations. Notably, most states that have attempted to do so have ended these programs due to low use, expense, and/or associated administrative burdens.

Under Policy H-165.852, the AMA supports the use of HSA funds to pay for health and long-term care insurance premiums. The Council believes it is appropriate to expand this to include the payment of dental, vision, and hearing premiums as well. This strengthens AMA policy and can provide additional benefits to those with HSAs.

The proposed policy in Resolution 803-I-24 addressing employer contributions is not clear and the Council has chosen not to include a recommendation regarding employer contributions to HSAs. Currently, employers are able to contribute to employees' HSAs and many choose to do so as a benefit of employment.

The Council appreciates the intent of transferring HSA funds between spouses and family members but believes there needs to be additional study on the feasibility and tax implications. This change would make an HSA akin to a 529 account used for educational purposes; however, the two are treated differently in U.S. tax code. An external study and/or demonstration project could be done to examine the intricacies and implications of making such a change. For example, this study could explore supporting narrowly tailored exceptions allowing spousal transfers during joint filing years or transfers to legally dependent children for qualified expenses while opposing broader unrestricted portability that risks gaming the tax system.

Long-standing AMA policy supports freedom of choice when it comes to health insurance for patients and the Council believes expanded use of HSAs allows for more freedom and flexibility for individuals who wish to utilize these accounts. However, expanded use of HSAs should be complementary to health insurance and not be used as a replacement.

The Council discussed the referred amendment and agrees that placing unused ACA premium tax credits into an HSA when a plan's premium is lower than the tax credit would help strengthen ACA benefits. The Council notes that the feasibility of this may be limited at this time, especially with the provision in the OBBBA stating that unused premium tax credits will be paid back to the government regardless of income and the expiration of enhanced premium tax credit program by the end of 2025.

Finally, the OBBBA included provisions strengthening HSAs that warrant corresponding AMA policy. The Council supports allowing those who enroll in high-deductible bronze plans to contribute to an HSA. Policy H-165.828 encourages the development of demonstration projects to test this concept. The Council believes continued demonstration projects already included in the policy are necessary and thus recommends updating the policy with a new clause that aligns with the federal policy change. The Council also believes that silver plans should also be considered HSA-eligible HDHPs to prevent incentivizing people to enroll in bronze plans, which often offer less coverage and have higher out-of-pocket costs. Second, the OBBBA changes the law to allow HSA funds to pay for DPC services. Policy H-385.912 states that the use of an HSA to access DPC providers and/or receive care from a DPC medical home constitutes a bona fide medical expense. Therefore, the Council recommends that Policy H-385.912 be reaffirmed. Additional text included in the House-passed version of the bill looked to significantly expand the use of HSAs and could be informative as to where Congress and the Trump Administration could potentially be open to exploring additional changes.

In considering these proposals, the AMA's guiding framework remains rooted in promoting access to high-quality, affordable coverage; minimizing administrative complexity; and avoiding regressive tax policies. Any HSA reforms must be consistent with these principles and should avoid subsidizing underinsurance or exacerbating inequalities.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 803-I-24 and the remainder of the report be filed:

1) That our American Medical Association (AMA) support permitting health savings account (HSA) contributions from family members, employers, or other designated individuals and not limiting HSA contributions to the owner of the high-deductible health plan, provided that annual Internal Revenue Service contribution limits are not exceeded. (New HOD Policy)

2) That our AMA support contributions to HSAs by individuals who are Medicare enrollees with support for external research and/or demonstration projects to determine how best those distributions can be spent, with special consideration for low-resource Medicare enrollees. (New HOD Policy)

3) That our AMA amend Policy H-165.852 by addition to read as follows:

HEALTH SAVINGS ACCOUNTS, H-165.852
It is the policy of the AMA that:

(7) legislation promoting the establishment and the use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health, dental, vision, hearing, and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. (Modify Current HOD Policy)

4) That our AMA support external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and other family members. (New HOD Policy)

5) That our AMA support Affordable Care Act (ACA) premium tax credits designed to allow individuals to contribute to HSAs through the application of unused or residual credit amounts. (New HOD Policy)

6) That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

HEALTH INSURANCE AFFORDABILITY, H-165.828

(3) Our AMA (i) encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and (ii) supports individual market bronze and silver plans, regardless of actual deductible amount, being treated as HSA-qualified high-deductible health plans, with appropriate guardrails in place (e.g., safe harbor provisions) to ensure low-income enrollees in these plans do not suffer financial hardships.
(Modify Current HOD Policy)

7) That our AMA support education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans, including those purchasing bronze plans and how that plan compares to purchasing a silver plan with subsidies. (New HOD Policy)

8) That our AMA support the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance such as ACA premium tax credits. (New HOD Policy)

9) That our AMA reaffirm Policy H-290.972, Health Savings Accounts in the Medicaid Program, which outlines several principles for states considering offering beneficiaries HSAs. (Reaffirm HOD Policy)

10) That our AMA reaffirm Policy H-165.833, Amend the Patient Protection and Affordable Care Act, which states that as part of the AMA's organizational goal of amending and improving the Affordable Care Act, the AMA will advocate to expand the use of HSAs as a means to provide health insurance. (Reaffirm HOD Policy)

11) That our AMA reaffirm Policy H-385.912, Direct Primary Care, which states that the use of a health savings account to access direct primary care (DPC) providers and/or to receive care from a direct primary care medical home constitutes and bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for DPC and DPC medical home models as a qualified medical expense. Furthermore, H-385.912 states that the AMA will seek federal legislation or regulation to amend appropriate sections of the IRS code to specify that DPC access or DPC medical homes are not health "plans" and that the use of HSA funds to pay for DPC provider services in such setting constitutes a qualified medical expense, enabling patients to use HSAs to help pay for DPC and to enter DPC periodic-fee agreements without IRS interference or penalty. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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[21] *Supra.* Item 18

Council on Medical Service Report 1-I-25
Health Savings Account Reform
Policy Appendix

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans, D-165.954
Our AMA will: (1) educate physicians about health insurance plan practices that may impact physician billing and collection of payment from patients with Health Savings Accounts (HSAs), health reimbursement arrangements (HRAs), and other forms of consumer-driven health care; and (2) monitor and support rigorous research on the impact of HSAs and HRAs on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.
(CMS Rep. 3, I-05; Modified: CMS Rep. 1, A-15)

Health Savings Accounts for Older Americans, D-165.962
Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals.
(Sub. Res. 702, A-04; Reaffirmation: A-10; Reaffirmed: BOT Rep. 04, A-20)

Flexible Spending Accounts (FSAs), H-165.863
1. Along with other efforts to liberalize Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account.
2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending Accounts.
(Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmation: A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 5, and 7, I-99; Appended by Res. 220, A-00; Reaffirmation: I-00; Res. 120, A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation: A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation: I-03; Reaffirmation: A-04; Consolidated: CMS Rep. 7, I-05; Appended: Res. 121, A-15; Modified: CMS Rep. 1, A-15)

Health Savings Accounts, H-165.852
It is the policy of the AMA that:
(1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
(2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
(3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
(4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
(5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
(6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs;
(7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

(CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation: A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation: I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation: I-00; Reaffirmed Res. 109 & Reaffirmation: A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation: A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation: I-03; CMS Rep. 6, A-04; Reaffirmation: A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation: A-07; Reaffirmation: A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 5, A-18)

Health Savings Accounts in the Medicaid Program, H-290.972
It is the policy of our AMA that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles:
A. Make beneficiary participation voluntary;
B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible;
C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health;
D. Set deductibles at 100% of account contributions, but no higher;
E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits;
F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible;
G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits;
H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online) and in multiple languages;
I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care;
J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage;
K. Monitor the impact on utilization and beneficiary financial burden;
L. Test broadening of eligibility to include currently ineligible beneficiary groups; and
M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian.
(CMS Rep. 1, I-06; Modified: CMS Rep. 01, A-16; Reaffirmation: A-18)

Increasing Accessibility to Incontinence Products, H-155.955
Our AMA supports increased access to incontinence products for children and adults, including the removal of sales tax, and ensuring eligibility of these products as medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs).
(Res. 908, I-18; Modified: Res. 231, A-22)

Health Insurance Affordability, H-165.828
1. Our American Medical Association supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life even for special enrollment in the health insurance marketplace.
(CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701 I-21; Reaffirmed: Res. 826, I-24)

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans, H-165.849
1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering case discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.
2. Our AMA will engage in a dialogue with health plan representatives (e.g., Americas Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.
(CMS Rep. 3, I-05; Reaffirmed: CMS Rep. 1, A-15; Appended: BOT Action in response to referred for decision Res. 805, I-16; Reaffirmed: CMS Rep. 09, A-19)

Transparency of Employer Sponsored Health Insurance, H-155.961
Our AMA encourages employers to inform employees as frequently as possible, preferably with each payment period (pay stub) but at least annually, of the total cost of health insurance benefits

paid on their behalf by the employer in the form of health insurance premiums, direct payments for services and deposits into health savings accounts.
(Res. 127, A-07; Reaffirmed: CMS 01, A-17)

Direct Primary Care, H-385.912
1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.
(Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res 102, A-19)

Principles for Structuring a Health Insurance Tax Credit, H-165.865
(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of the tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.
(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.
(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.
(CMS Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation, I-00; Reaffirmation: A-02; Reaffirmation: I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation: A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation: A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation: A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24)

Aligning Clinical and Financial Incentives for High-Value Care, D-185.979

1. Our American Medical Association supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of "clinical nuance," recognizing that
a. medical services may differ in the amount of health produced.
b. the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.
3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.
4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.
5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.
6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that:
a. preserves health plan coverage without patient cost-sharing for evidence-based preventive services.
b. allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.
8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.
(Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed in lieu of: Res. 101,
A-19; Reaffirmed: CMS Rep. 2, I-20; Reaffirmation: A-22)

Amend the Patient Protection and Affordable Care Act (PPACA), H-165.833
1. Our AMA continues to advocate to achieve needed reforms of the many defects of the federal Patient Protection and Affordable Care Act (PPACA) law so as to protect the primacy of the patient-physician relationship. These needed changes include but are not limited to:
- repeal of the Independent Payment Advisory Board (IPAB);
- study of the Medicare Cost/Quality Index;
- repeal of the non-physician provider non-discrimination provision;
- enactment of comprehensive medical liability reform;
- enactment of long term Medicare physician payment reform including permitting patients to privately contract with physicians not participating in the Medicare program;
- enactment of antitrust reform to permit independently practicing physicians to collectively negotiate with health insurance companies; and
- expanding the use of health savings accounts as a means to provide health insurance coverage.
2. Our AMA will vigorously work to change the PPACA to accurately represent our AMA policy.
(Res. 217, A-11; Reaffirmation: A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of Res. 215, A-15; Reaffirmed: Res. 206, A-19)