115TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
115–852

THE "PRIMARY CARE ENHANCEMENT ACT OF 2018"

JULY 19, 2018.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BRADY of Texas, from the Committee on Ways and Means, submitted the following

R E P O R T

[To accompany H.R. 6317]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6317) to amend the Internal Revenue Code of 1986 to provide that direct primary care service arrangements do not disqualify deductible health savings account contributions, and for other purposes, report favorably thereon with an amendment and recommend that the bill as amended do pass.

79–006

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together with

MINORITY VIEWS

[To accompany H.R. 6317]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6317) to amend the Internal Revenue Code of 1986 to provide that direct primary care service arrangements do not disqualify deductible health savings account contributions, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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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 "Primary Care Enhancement Act of 2018".

SEC. 2. TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.

(a) IN GENERAL.—Section 223(c)(1) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(D) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—

"(i) IN GENERAL.—A direct primary care service arrangement shall not be treated as a health plan for purposes of subparagraph (A)(ii).

"(ii) DIRECT PRIMARY CARE SERVICE ARRANGEMENT.—For purposes of this paragraph—

"(I) IN GENERAL.—The term 'direct primary care service arrangement' means, with respect to any individual, an arrangement under which such individual is provided medical care (as defined in section 213(d)) consisting solely of primary care services (as defined in section 1833(x)(2)(B) of the Social Security Act) provided by primary care practitioners (as defined in section 1833(x)(2)(A) of the Social Security Act, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee.

"(II) LIMITATION.—With respect to any individual for any month, such term shall not include any arrangement if the aggregate fees for all direct primary care service arrangements (determined without regard to this subclause) with respect to such individual for such month exceed $150 (twice such dollar amount in the case of an individual with any direct primary care service arrangement (as so determined) that covers more than one individual).

"(iii) CERTAIN SERVICES SPECIFICALLY EXCLUDED FROM TREATMENT AS PRIMARY CARE SERVICES.—For purposes of this paragraph, the term 'primary care services' shall not include—

"(I) procedures that require the use of general anesthesia,

"(II) prescription drugs (other than vaccines), and

"(III) laboratory services not typically administered in an ambulatory primary care setting.

The Secretary, after consultation with the Secretary of Health and Human Services, shall issue regulations or other guidance regarding the application of this clause.".

(b) DIRECT PRIMARY CARE SERVICE ARRANGEMENT FEES TREATED AS MEDICAL EXPENSES.—Section 223(d)(2)(C) is amended by striking "or" at the end of clause (iii), by striking the period at the end of clause (iv) and inserting ", or", and by adding at the end the following new clause:

"(v) any direct primary care service arrangement.".

(c) INFLATION ADJUSTMENT.—Section 223(g)(1) of such Code is amended—

(1) by striking "and (c)(2)(A)" each place it appears and inserting ", (c)(1)(D)(ii)(II), and (c)(2)(A)", and

(2) in subparagraph (B), by striking "clause (ii)" and inserting "clauses (ii) and (iii)" in clause (i), by striking "and" at the end of clause (i), by striking the period at the end of clause (ii) and inserting ", and", and by inserting after clause (ii) the following new clause:

"(iii) in the case of the dollar amount in subsection (c)(1)(D)(ii)(II) for taxable years beginning in calendar years after 2019, 'calendar year 2018'."

(d) REPORTING OF DIRECT PRIMARY CARE SERVICE ARRANGEMENT FEES ON W–2.—Section 6051(a) of such Code is amended by striking "and" at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting ", and", and by inserting after paragraph (17) the following new paragraph: .

"(18) in the case of a direct primary care service arrangement (as defined in section 223(c)(1)(D)(ii)) which is provided in connection with employment, the aggregate fees for such arrangement for such employee.".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2018, in taxable years ending after such date.

I. SUMMARY AND BACKGROUND

A. Purpose and Summary

The bill H.R. 6317, as reported by the Committee on Ways and Means, allows Health Savings Account (HSA)-eligible individuals that participate in a direct primary care (DPC) arrangement not to lose their HSA eligibility merely because of their participation in a DPC. In addition, it allows DPC provider fees to be paid for out of HSAs.

B. Background and Need for Legislation

Individuals eligible for HSAs must have a high deductible health plan (HDHP) and no other health plan that provides coverage for any benefit which is covered under the high deductible health plan. Various types of coverage are disregarded for this purpose, including coverage for accidents, dental care, and vision care.

DPC offers patients, employers, and health plans direct access to primary care and prevention services through a fixed fee. This coordinated, patient-centered care setting affords the patient more time with their provider and allows providers the time to better understand their patients' health needs. Under current law, DPC arrangements are viewed as other insurance coverage and thus disqualify members from contributing to an HSA. This legislation would allow individuals to enroll in both DPC arrangements and HDHPs with HSAs.

C. Legislative History

Background

H.R. 6317 was introduced on July 10, 2018 and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up H.R. 6317, the "Primary Care Enhancement Act", on July 12, 2018, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

The policy issues associated with Health Savings Accounts (HSAs) and need for legislative response were discussed at the following Ways and Means hearings during the 114th and 115th Congresses:

- Full Committee Hearing on the Tax Treatment of Health Care (April 14, 2016)
- Subcommittee on Health Member Day Hearing on Tax-Related Proposals to Improve Health Care (May 17, 2016)
- Subcommittee on Health Hearing on Rising Health Insurance Premiums Under the Affordable Care Act (July 12, 2016)
- Subcommittee on Health Hearing on Lowering Costs and Expanding Access to Health Care through Consumer-Directed Health Plans (June 6, 2018)

II. EXPLANATION OF THE BILL

A. Treatment of Direct Primary Care Service Arrangements

PRESENT LAW

Health savings accounts

An individual may establish 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. 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,[1] contributions to an HSA made by or on behalf of an eligible individual are deductible by the individual. Contributions to an HSA are excludible from income and employment taxes if made by the employer. Earnings 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 or disability, or after the individual attains the age of Medicare eligibility (age 65).

High deductible health plans

A high deductible health plan is a health plan that has a minimum annual deductible of $1,350 (for 2018) for self-only coverage and 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 $6,650 (for 2018) for self-only coverage and twice this amount for family coverage.[2] These dollar thresholds are subject to inflation adjustment, based on chained CPI.[3]

An individual who is covered under a high deductible health plan is eligible to establish an HSA, provided that while such individual is covered under the high deductible health plan, the individual is not covered under any health plan that (1) is not a high deductible health plan and (2) provides coverage for any benefit (subject to certain exceptions) covered under the high deductible health plan.[4]

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 cer-

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[1] For 2018, the basic limit on annual contributions that can be made to an HSA is $3,450 in the case of self-only coverage and $6,900 in the case of family coverage. (The 2018 limitation for family coverage was revised by the IRS to permit taxpayers to disregard the $6,850 limitation under the modified inflation adjustment of Pub. L. No. 115–97. Rev. Rul. 2018–27, 2018–20 I.R.B. 591, May 14, 2018.) 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).

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

[3] Sec. 223(g).

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

tain limited coverage through health flexible savings accounts.[5] Permitted insurance means insurance under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, or such other similar liabilities as specified by the Secretary under regulations. Permitted insurance also means insurance for a specified disease or illness, and insurance paying a fixed amount per day (or other period) of hospitalization.[6]

Individuals eligible

Individuals eligible for HSAs are individuals who are covered by a high deductible health plan and no other health plan that (1) is not a high deductible health plan and (2) provides coverage for any benefit which is covered under the high deductible health plan. After an individual has attained age 65 and becomes enrolled in Medicare benefits, contributions cannot be made to the individual's HSA.[7]

Direct primary care service arrangements

A direct primary care service arrangement is an arrangement under which an individual only pays a monthly fee for direct primary care services rather than paying a doctor's fee for each visit. A direct primary care service arrangement is considered other coverage or insurance for purposes of a high deductible health plan, and so an individual covered by such a plan and such an arrangement is not eligible to contribute to an HSA.

A direct primary care service arrangement is distinguished from a concierge service arrangement under which patients also pay a monthly fee which may cover some or all primary care services. Under a concierge service arrangement, patients may have to pay for additional medical care, and the practice may submit claims to insurance and receive reimbursement from insurance for its services. (Under a direct primary care service arrangement, the practice cannot submit claims to insurance or receive reimbursement from insurance for its services.) A concierge service arrangement also is treated as other coverage or insurance for purposes of a high deductible plan, so an individual covered by such a plan and such an arrangement is not eligible to contribute to an HSA.

REASONS FOR CHANGE

The Committee believes connecting consumers to their health care dollars through consumer-directed health plans, including high deductible health plans, reduces health care costs. The Committee further believes that HSAs are an important tool used in conjunction with high deductible health plans to permit consumers to set-aside funds and provide such consumers the choice on how to spend those funds to pay for medical care.

HSA-qualified high deductible health plans may cover certain "preventive services" before the deductible is met without disqualifying HSA participation. However, participating in a direct primary

[5] Sec. 223(c)(1)(B).
[6] Sec. 223(c)(3).
[7] See sec. 223(b)(7), as interpreted by Notice 2004–2, 2004–2 I.R.B. 269 (December 22, 2003), corrected by Announcement 2004–67, 2004–36 I.R.B. 459 (September 7, 2004).

care service arrangement that provides certain medical care for a fixed fee currently prevents a participant from contributing to their HSA or paying the fixed fee from his or her HSA. The Committee believes that the rules for HSAs should be expanded to permit individuals who participate in high deductible health plans to participate in direct primary care service arrangements that meet certain requirements without impacting those individuals' ability to contribute to HSAs or to pay the fixed fees (up to limited monthly caps) for such direct primary care services from their HSA accounts.

EXPLANATION OF PROVISION

Under the provision, a direct primary care service arrangement that meets the relevant requirements is not treated as a health plan that would cause an individual to be ineligible to contribute to an HSA. For this purpose, a direct primary care service arrangement means, with respect to any individual, an arrangement under which such individual is provided medical care consisting solely of primary care services, as defined in the Social Security Act (SSA),[8] provided by primary care practitioners, as defined in the SSA[9] 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 (in the case of an individual with any such arrangement that covers more than one individual, twice such dollar amount, or $300). These dollar amounts are to be adjusted annually for inflation. 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 for which the Secretary of Treasury, after consultation with the Secretary of Health and Human Services, shall issue regulations or other guidance.

Fees paid for such direct primary care service arrangements will be treated as medical expenses (and not the payment of insurance). The aggregate fees for direct primary care service arrangements provided to an employee in connection with employment will be reported on Form W–2.

Concierge service arrangements that charge amounts to patients in addition to the monthly fee and/or submit claims to insurance and receive reimbursement from insurance for such services are not treated as meeting the relevant requirements for a direct primary care service arrangement and therefore HDHP covered persons who participate in such concierge service arrangements are not individuals eligible to contribute to an HSA under the provision.

EFFECTIVE DATE

The provision applies to months beginning after December 31, 2018, in taxable years ending after such date.

[8] Sec. 1833(x)(2)(B), 42 U.S.C. 13951.
[9] Sec. 1833(x)(2)(A), 42 U.S.C. 13951 (without regard to clause (ii) thereof).

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 6317, the "Primary Care Enhancement Act," on July 12, 2018.

H.R. 6317 was ordered favorably reported to the House of Representatives as amended by an amendment in the nature of a substitute offered by Chairman Brady by a roll call vote of 26 yeas to 12 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson	X			Mr. Levin		X	
Mr. Nunes				Mr. Lewis		X	
Mr. Reichert	X			Mr. Doggett		X	
Mr. Roskam	X			Mr. Thompson		X	
Mr. Buchanan	X			Mr. Larson		X	
Mr. Smith (NE)	X			Mr. Blumenauer	X		
Ms. Jenkins				Mr. Kind	X		
Mr. Paulsen	X			Mr. Pascrell		X	
Mr. Marchant	X			Mr. Crowley		X	
Ms. Black	X			Mr. Davis		X	
Mr. Reed	X			Ms. Sanchez		X	
Mr. Kelly	X			Mr. Higgins		X	
Mr. Renacci	X			Ms. Sewell	X		
Ms. Noem	X			Ms. DelBene	X		
Mr. Holding	X			Ms. Chu		X	
Mr. Smith (MO)	X						
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						
Mr. LaHood	X						
Mr. Wenstrup	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. 6317, as reported.

The bill, as reported, is estimated to have the following effect on Federal fiscal year budget receipts for the period 2019–2028:

	FISCAL YEARS [Millions of Dollars]											
Item	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019–23	2019–28
Permit Direct Primary Care Service Arrangements[1]	−46	−69	−78	−93	−115	−144	−185	−258	−349	−471	−402	−1,810

NOTE: Details do not add to totals due to rounding.

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019–23	2019–28
[1] Estimate includes the following off-budget effects	−12	−17	−19	−23	−28	−36	−46	−60	−80	−108	−99	−429

Pursuant to clause 8 of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the bill amending the Internal Revenue Code of 1986: The gross budgetary effect (before incorporating macroeconomic effects) in any fiscal year is less than 0.25 percent of the current projected gross domestic product of the United States for that fiscal year; therefore, the bill is not "major legislation" for purposes of requiring that the estimate include the budgetary effects of changes in economic output, employment, capital stock and other macroeconomic variables.

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. The Committee further states that the revenue-reducing tax provision involves no new tax expenditure.

C. Cost Estimate Prepared by the Congressional Budget Office

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. 6138, as reported. As of the filing of this report, the Committee had not received an estimate prepared by the Congressional Budget Office (CBO).

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

A. Committee Oversight Findings and Recommendations

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated into the description portions of 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 contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding 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. Applicability of House Rule XXI 5(b)

Rule XXI 5(b) of the Rules of the House of Representatives provides, in part, that "A bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the bill and states that the bill does not involve any Federal income tax rate increases within the meaning of the rule.

E. Tax Complexity Analysis

Section 4022(b) of the Internal Revenue Service Restructuring and Reform Act of 1998 ("IRS Reform Act") requires the staff of the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Treasury Department) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code of 1986 and has widespread applicability to individuals or small businesses.

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. 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.

G. Duplication of Federal Programs

In compliance with Sec. 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 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. Disclosure of Directed Rule Makings

In compliance with Sec. 3(i) of H. Res. 5 (115th Congress), the following statement is made concerning directed rule makings: The Committee advises that the bill requires no directed rule makings within the meaning of such section.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

B. CHANGES IN EXISTING LAW PROPOSED BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed 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 italic, existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE 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 italic, and existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

* * * * * * *

Subtitle A—Income Taxes

* * * * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * * * *

Subchapter B—Computation of Taxable Income

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PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

* * * * * * *

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:

For taxable years beginning in:	The additional contribution amount is:
2004	$500
2005	$600
2006	$700
2007	$800
2008	$900
2009 and thereafter	$1,000.

(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, or long-term 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) TREATMENT OF DIRECT PRIMARY CARE SERVICE ARRANGEMENTS.—

(i) IN GENERAL.—A direct primary care service arrangement shall not be treated as a health plan for purposes of subparagraph (A)(ii).

(ii) DIRECT PRIMARY CARE SERVICE ARRANGEMENT.—For purposes of this paragraph—

(I) IN GENERAL.—The term "direct primary care service arrangement" means, with respect to any individual, an arrangement under which such individual is provided medical care (as defined in section 213(d)) consisting solely of primary care services (as defined in section 1833(x)(2)(B) of the Social Security Act) provided by primary care practitioners (as defined in section 1833(x)(2)(A) of

the Social Security Act, determined without regard to clause (ii) thereof), if the sole compensation for such care is a fixed periodic fee.

(II) LIMITATION.—With respect to any individual for any month, such term shall not include any arrangement if the aggregate fees for all direct primary care service arrangements (determined without regard to this subclause) with respect to such individual for such month exceed $150 (twice such dollar amount in the case of an individual with any direct primary care service arrangement (as so determined) that covers more than one individual).

(iii) CERTAIN SERVICES SPECIFICALLY EXCLUDED FROM TREATMENT AS PRIMARY CARE SERVICES.—For purposes of this paragraph, the term "primary care services" shall not include—

(I) procedures that require the use of general anesthesia,

(II) prescription drugs (other than vaccines), and

(III) laboratory services not typically administered in an ambulatory primary care setting.

The Secretary, after consultation with the Secretary of Health and Human Services, shall issue regulations or other guidance regarding the application of this clause.

(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).

(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. Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(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)[.], *or*

(v) any direct primary care service arrangement.

(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)], *(c)(1)(D)(ii)(II), 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)] *clauses (ii) and (iii)*, "calendar year 1997", [and]

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

(iii) in the case of the dollar amount in subsection (c)(1)(D)(ii)(II) for taxable years beginning in calendar years after 2019, "calendar year 2018".

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)], *(c)(1)(D)(ii)(II), 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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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart C—Information Regarding Wages Paid Employees

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SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

(1) the name of such person,

(2) the name of the employee (and an identifying number for the employee if wages as defined in section 3121(a) have been paid),

(3) the total amount of wages as defined in section 3401(a),

(4) the total amount deducted and withheld as tax under section 3402,

(5) the total amount of wages as defined in section 3121(a),

(6) the total amount deducted and withheld as tax under section 3101,

(8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),

(9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),

(10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned in-

come as determined for purposes of section 32 (relating to earned income credit),

(11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,

(12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse,

(13) the total amount of deferrals for the year under a nonqualified deferred compensation plan (within the meaning of section 409A(d)),

(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

(A) coverage to which paragraphs (11) and (12) apply, or

(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125),

(15) the total amount of permitted benefit (as defined in section 9831(d)(3)(C)) for the year under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2)) with respect to the employee,

(16) the amount includible in gross income under subparagraph (A) of section 83(i)(1) with respect to an event described in subparagraph (B) of such section which occurs in such calendar year, **[**and**]**

(17) the aggregate amount of income which is being deferred pursuant to elections under section 83(i), determined as of the close of the calendar year**[**.**]***, and*

(18) in the case of a direct primary care service arrangement (as defined in section 223(c)(1)(D)(ii)) which is provided in connection with employment, the aggregate fees for such arrangement for such employee.

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts required to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member

of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) ADDITIONAL REQUIREMENTS.—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) STATEMENTS TO CONSTITUTE INFORMATION RETURNS.—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) RAILROAD EMPLOYEES.—

(1) ADDITIONAL REQUIREMENT.—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) INFORMATION TO BE SUPPLIED TO EMPLOYEES.—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201, and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.—

(1) STATEMENTS REQUIRED FROM PAYOR.—

(A) IN GENERAL.—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

(i) the name and, if there is withholding under section 3402(o), the social security number of such employee,

(ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and

(iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term "third-party sick pay" means any sick pay (as defined in section 3402(o)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(o)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

(A) the information shown on the statement furnished under paragraph (1)(A), and

(B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable.

To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

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MINORITY VIEWS

H.R. 6317 Direct Primary Care

H.R. 6317 (Paulsen, R–MN and Blumenauer, D–OR) allows individuals to contribute to Health Savings Accounts (HSAs) and also participate in direct primary care arrangements, which is limited in scope of services and capped at $150 per month.

High Deductible Health Plans (HDHPs) and HSAs do not promote healthy behavior. This legislation, which allows consumers to have a capitated payment for just primary care, in addition to an HDHP, demonstrates why high-deductible health plans in their current form do not allow consumers to see value in their health insurance. It is widely acknowledged that HSAs and HDHPs lead consumers to delay care. They do not encourage individuals to make better health care decisions, as Republicans' "skin in the game" talking points assert. Decades of research show that exposure to high out-of-pocket costs leads consumers to delay or forgo both necessary and unnecessary care. Delaying care and increasing costs run counter to Democratic policy goals of better coordinated, high-value affordable care for American families.

According to the American Hospital Association, "Hospitals and health systems report that increased enrollment in HDHPs over the past several years has reduced access to care and subjected patients to costs they cannot afford. In addition, patients enrolled in HDHPs appear to delay care until they have reached their deductible or are in an emergency situation, which could lead to poorer health outcomes."

H.R. 6317 does not undo sabotage, premium hikes, and benefit cuts Republicans have caused over the past 18 months. This bill was one in a series of 11 bills the Committee marked up that Republicans claim will help lower health care costs for consumers. This legislation does not undo the disruption and sabotage Republicans have continued to inflict on the American health care system. Instead of focusing on expansion of HSAs and HDHPs, Democrats encourage the Committee to redirect its attention to legislation that could actually ensure that uninsured, low-income, and vulnerable people have real access to care. For example H.R. 5155, sponsored by Reps. Pallone, Neal, and Scott would protect people with pre-existing conditions, help lower premiums for Americans, and improve affordability of health coverage.

Legislation busts the deficit to benefit the wealthy, again. Altogether the 11 bills the Committee were marked up would add another $92 billion in unoffset tax cuts to the deficit. Attempts to expand HSAs (and encourage more enrollment in plans with high deductibles, covering very few up-front health costs) represent a continuation of Republicans' platform of shifting families into health plans that provide fewer health benefits and higher out-of-

pocket costs—while providing greater tax benefits for higher income individuals and corporate special interests. According to 2014 Treasury data, only five percent of families with adjusted gross income of under $100,000 held money in an HSA, and those users' average account balances were $1,700.

HSAs mostly benefit high-income taxpayers while doing little to help moderate-income families or the uninsured. High-income people can best afford to save for health care expenses and are therefore the most likely to contribute to HSAs. Higher income filers are much more likely to establish HSAs than lower income filers—70 percent of HSA contributions come from households with incomes over $100,000, according to the Joint Commission on Taxation (JCT)—and they are also likelier to max out their contributions. Additionally, high-income individuals receive the biggest tax benefit for each dollar contributed to an HSA, because the value of a tax deduction rises with an individual's tax bracket. More than 44 percent of Americans can't afford a $400 emergency visit. For these families, it is unlikely that they have excess income to devote to a tax preferred account.

JCT estimates the cost of this bill to be $1.8 billion over 10 years. With this bill, Republicans are adding more tax cuts and increasing the deficit. Republicans are using the deficit, which they keep making larger with cuts for the wealthy, to justify their deep cuts to Medicare and Medicaid. Republicans are already proposing to cut Medicare and Medicaid by nearly a trillion dollars to try to pay tax cuts they have already enacted. This bill will only add fuel to the fire.

RICHARD E. NEAL,
Ranking Member.

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