

**DESCRIPTION OF H.R. 6317,
A BILL 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**

Scheduled for Markup
by the
HOUSE COMMITTEE ON WAYS AND MEANS
on July 11, 2018

Prepared by the Staff
of the
JOINT COMMITTEE ON TAXATION



July 10, 2018
JCX-43-18

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INTRODUCTION

The House Committee on Ways and Means has scheduled a committee markup of H.R. 6317, a bill 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 on July 11, 2018 which provides that a direct primary care service arrangement will not be treated as a health plan that will make an individual ineligible to contribute to an health savings account. This document,¹ prepared by the staff of the Joint Committee on Taxation, provides a description of the bill.

¹ This document may be cited as follows: Joint Committee on Taxation, *Description of H.R. 6317, A Bill 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* (JCX-43-18), July 10, 2018. This document can also be found on the Joint Committee on Taxation website at www.jct.gov. All section references herein are to the Internal Revenue Code of 1986, as amended, unless otherwise stated.

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,² 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.³ These dollar thresholds are subject to inflation adjustment, based on chained CPI.⁴

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

² 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).

³ Sec. 223(c)(2).

⁴ Sec. 223(g).

and (2) provides coverage for any benefit (subject to certain exceptions) covered under the high deductible health plan.⁵

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

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.⁸

Direct primary care service arrangements

Under present law, a direct primary care service arrangement is other coverage or insurance, and therefore the HDHP covered person is not an eligible individual eligible to contribute to an HAS.

Description of Proposal

Under the proposal, a direct primary care service arrangement will not be treated as a health plan that will make an individual ineligible to contribute to an HSA. For this purpose, a direct primary care service arrangement means, with respect to any individual, an arrangement under which such individual is provided medical care consisting solely of such primary care services⁹ provided by primary care practitioners¹⁰ 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

⁵ Sec. 223(c)(1).

⁶ Sec. 223(c)(1)(B).

⁷ Sec. 223(c)(3).

⁸ 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).

⁹ As defined in sec. 1833(x)(2)(B) of the Social Security Act (SSA), 42 U.S.C. 13951.

¹⁰ As defined in sec. 1833(x)(2)(A) of the SSA, 42 U.S.C. 13951, without regard to clause (ii) thereof.

primary care service arrangements for such individual for such month cannot exceed \$150 per month (in the case of an individual with any such arrangement that covers more than one individual, twice such dollar amount, or \$300) which amounts are 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 any direct primary care service arrangement will be treated as medical expenses (and not the payment of insurance). The aggregate fees paid by the employer for direct primary care service arrangements provided to an employee in connection with employment will be reported on Form W-2.

Effective Date

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