I announce my support for this resolution, along with the two previous resolutions, and look forward to its immediate passage.

Mr. Speaker, I yield back the balance of my time.

Ms. CHENEY. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I thank my colleague, Mr. GARAMENDI from California, for his support of these resolutions and for his time focusing on them today on the floor.

I also want to thank my colleague from Oklahoma. There is no stronger supporter of our men and women in uniform that I know of in this body than Mr. RUSSELL from Oklahoma. He understands, I would say, more than most because of his own service that what we do in this body and what we do on this floor has a direct impact on the levels of risk, on the safety, and on the effectiveness of our men and women in uniform.

Mr. Speaker, this resolution highlights the damage that we have seen to the readiness of the United States Army over 9 years of continuing resolutions, sequestration, and overall budget dysfunction.

I want to echo the remarks of my colleague from Oklahoma. Let's change that. Let's make this a new start. Let's make this the year that we don't hold military funding hostage and we pass a clean Defense Appropriations bill. We have done it here in the House. We know they can do it in the Senate. We need to get the bill, take it up, and pass it.

All these other arguments and discussions are important. They are important for the future of the Nation. They are important for our economy. But we should not force our men and women in uniform to have to wait, to have stand by and watch, not knowing whether we are going to be able to pass the bills that they need for the funding they need to continue to keep us all safe.

We did our job for fiscal year 2018, although we were too slow, but we have now appropriated the $700 billion for that fiscal year. Let's do it this year on time, with sufficient funding, and with a level of accountability, and also making sure that our men and women in uniform know that those funds are coming to them.

It is going to take us more than a single year to get ourselves out of the crisis we face, Mr. Speaker. We have made a good start. But I think we should all come together, both sides of the aisle and, frankly, on both sides of Capitol Hill, to say: Look, this is an issue on which we are going to agree.

The security of the Nation is an issue that ought to cross party lines. The support that we are seeing for this resolution and for all the resolutions we have done for our services demonstrates that. Let's make this the year that we do it differently and we do it right, Mr. Speaker.

With that, I thank everyone who has participated in this effort. I thank Chairman THORNBERRY and Chairman GRANGER for their important efforts.

Mr. Speaker, I urge adoption of this resolution, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Wyoming (Ms. CHENEY) that the House suspend the rules and agree to the resolution, H.R. 1007.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

RESTORING ACCESS TO MEDICATION ACT OF 2018

Ms. JENKINS of Kansas. Mr. Speaker, pursuant to House Resolution 1012, I call up the bill (H.R. 6199) to amend the Internal Revenue Code of 1986 to include certain over-the-counter medical products as qualified medical expenses, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 1012, in lieu of the amendment in the nature of a substitute recommended by the Committee on Ways and Means printed in the bill, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 115–82 is adopted, and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 6199

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. FIRST DOLLAR COVERAGE FLEXIBILITY FOR HIGH DEDUCTIBLE HEALTH PLANS.

(a) IN GENERAL.—Section 223(c)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(E) FIRST DOLLAR COVERAGE FLEXIBILITY.—

''(i) IN GENERAL.—A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for not more than $250 of specified services for self-only coverage (twice such amount in the case of family coverage) during a plan year.

''(ii) SPECIFIED SERVICES.—For purposes of this subparagraph, the term 'specified services' means, with respect to a plan, services other than preventive care (within the meaning of subparagraph (C)) identified under the terms of the plan as being services to which clause (i) applies.''.

(b) 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)(2)(A), and (c)(2)(E)'', and

(2) in subparagraph (B)—

(A) by striking ''such taxable year'' in the matter preceding clause (i) and inserting ''the taxable year (plan year in the case of the dollar amount in subsection (c)(2)(E))'', and

(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)(2)(E) for plan years beginning in calendar years after 2019, 'calendar year 2018'.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to plan years beginning after December 31, 2018.

SEC. 3. 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 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, as amended by section 2(b), is amended—

(1) by inserting ''(c)(1)(D)(ii)(II),'' after ''(b)(2),'' each place it appears, and

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

''(iv) 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.

SEC. 4. CERTAIN EMPLOYMENT RELATED SERVICES NOT TREATED AS DISQUALIFYING COVERAGE FOR PURPOSES OF HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(1) of the Internal Revenue Code of 1986, as amended by section 3(a), is amended by adding at the end the following new subparagraph:

''(E) SPECIAL RULE FOR QUALIFIED ITEMS AND SERVICES.—

''(i) IN GENERAL.—An individual shall not be treated as covered under a health plan for purposes of subparagraph (A)(ii) merely because the individual, in connection with the employment of the individual or the individual's spouse, receives (or is eligible to receive) qualified items and services at—

''(I) a healthcare facility located at a facility owned or leased by the employer of the individual (or of the individual's spouse), or operated primarily for the benefit of such employer's employees, or

''(II) a healthcare facility located within a supermarket, pharmacy, or similar retail establishment.

''(ii) QUALIFIED ITEMS AND SERVICES DEFINED.—For purposes of this subparagraph, the term 'qualified items and services' means the following:

''(I) Physical examinations.

''(II) Immunizations, including injections of antigens provided by employees.

''(III) Drugs other than a prescribed drug (as such term is defined in section 213(d)(3)).

''(IV) Treatment for injuries occurring in the course of employment.

''(V) Drug testing, if required as a condition of employment.

''(VI) Hearing or vision screenings.

''(VII) Other similar items and services that do not provide significant benefits in the nature of medical care.

''(iii) AGGREGATION.—For purposes of clause (i)(I), all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.''.

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

SEC. 5. CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ACCOUNT.

(a) CONTRIBUTIONS PERMITTED IF SPOUSE HAS A HEALTH FLEXIBLE SPENDING ACCOUNT.—Section 223(c)(1)(B) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by inserting after clause (iii) the following new clause:

''(iv) coverage under a health flexible spending arrangement of the spouse of the individual for any plan year of such arrangement if the aggregate reimbursements under such arrangement for such year do not exceed the aggregate expenses which would be eligible for reimbursement under such arrangement if such expenses were determined without regard to any expenses paid or incurred with respect to such individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to plan years beginning after December 31, 2018.

SEC. 6. FSA AND HRA TERMINATIONS OR CONVERSIONS TO FUND HSAS.

(a) IN GENERAL.—Section 106(e)(2) of the Internal Revenue Code of 1986 is amended to read as follows:

''(2) QUALIFIED HSA DISTRIBUTION.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'qualified HSA distribution' means, with respect to any employee, a distribution from a health flexible spending arrangement or health reimbursement arrangement of such employee directly to a health savings account of such employee if—

''(i) such distribution is made in connection with such employee establishing coverage under a high deductible health plan (as defined in section 223(c)(2)) after a significant period of not having such coverage, and

''(ii) such arrangement is described in section 223(c)(1)(B)(iii) with respect to the portion of the plan year after such distribution is made.

''(B) DOLLAR LIMITATION.—The aggregate amount of distributions from health flexible spending arrangements and health reimbursement arrangements of any employee which may be treated as qualified HSA distributions in connection with an establishment of coverage described in subparagraph (A)(i) shall not exceed the dollar amount in effect under section 125(i)(1) (twice such amount in the case of coverage which is described in section 223(b)(2)(B)).''.

(b) PARTIAL REDUCTION OF LIMITATION ON DEDUCTIBLE HSA CONTRIBUTIONS.—Section 223(b)(4) of such Code is amended by striking ''and'' at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting '', and'', and by inserting after subparagraph (C) the following new subparagraph:

''(D) so much of any qualified HSA distribution (as defined in section 106(e)(2)) made to a health savings account of such individual during the taxable year as does not exceed the aggregate increases in the balance of the arrangement from which such distribution is made which occur during the portion of the plan year which precedes such distribution (other than any balance carried over to such plan year and determined without regard to any decrease in such balance during such portion of the plan year).''.

(c) CONVERSION TO HSA-COMPATIBLE ARRANGEMENT FOR REMAINDER OF PLAN YEAR.—Section 223(c)(1)(B)(iii) of such Code, as amended by section 5(a), is amended to read as follows:

''(iii) coverage under a health flexible spending arrangement or health reimbursement arrangement for the portion of the plan year after a qualified HSA distribution (as defined in section 106(e)(2) determined without regard to subparagraph (A)(ii) thereof) is made, if the terms of such arrangement which apply for such portion of the plan year are such that, if such terms applied for the entire plan year, then such arrangement would not be taken into account under subparagraph (A)(ii) of this paragraph for such plan year, and''.

(d) INCLUSION OF QUALIFIED HSA DISTRIBUTIONS ON W–2.—

(1) IN GENERAL.—Section 6051(a) of such Code, as amended by section 3(d), is amended by striking ''and'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting '', and'', and by inserting after paragraph (18) the following new paragraph:

''(19) the amount of any qualified HSA distribution (as defined in section 106(e)(2)) with respect to such employee.''.

(2) CONFORMING AMENDMENT.—Section 6051(a)(12) of such Code is amended by inserting ''(other than any qualified HSA distribution, as defined in section 106(e)(2))'' before the comma at the end.

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

SEC. 7. INCLUSION OF CERTAIN OVER-THE-COUNTER MEDICAL PRODUCTS AS QUALIFIED MEDICAL EXPENSES.

(a) HSAS.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended—

(1) by striking the last sentence of subparagraph (A) and inserting the following: ''For purposes of this subparagraph, amounts paid for menstrual care products shall be treated as paid for medical care.'', and

(2) by adding at the end the following new subparagraph:

''(D) MENSTRUAL CARE PRODUCT.—For purposes of this paragraph, the term 'menstrual care product' means a tampon, pad, liner, cup, sponge, or similar product used by women with respect to menstruation or other genital-tract secretions.''.

(b) ARCHER MSAS.—Section 220(d)(2)(A) of such Code is amended by striking the last sentence and inserting the following: ''For purposes of this subparagraph, amounts paid for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as paid for medical care.''.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by striking subsection (f) and inserting the following new subsection:

''(f) REIMBURSEMENTS FOR MENSTRUAL CARE PRODUCTS.—For purposes of this section and section 105, expenses incurred for menstrual care products (as defined in section 223(d)(2)(D)) shall be treated as incurred for medical care.''.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM HEALTH SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid after December 31, 2018.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred after December 31, 2018.

SEC. 8. CERTAIN AMOUNTS PAID FOR PHYSICAL ACTIVITY, FITNESS, AND EXERCISE TREATED AS AMOUNTS PAID FOR MEDICAL CARE.

(a) IN GENERAL.—Section 213(d)(1) of the Internal Revenue Code of 1986 is amended by striking ''or'' at the end of subparagraph (C), by striking the period at the end of subparagraph (D) and inserting '', or'', and by adding at the end the following new subparagraph:

''(E) for qualified sports and fitness expenses.''.

(b) QUALIFIED SPORTS AND FITNESS EXPENSES.—Section 213(d) of such Code is amended by adding at the end the following paragraph:

''(12) QUALIFIED SPORTS AND FITNESS EXPENSES.—

''(A) IN GENERAL.—The term 'qualified sports and fitness expenses' means amounts paid for—

''(i) membership at a fitness facility,

''(ii) participation or instruction in a program of qualified physical activity, or

''(iii) safety equipment for use in a program (including a self-directed program) of qualified physical activity.

''(B) LIMITATIONS.—

''(i) OVERALL DOLLAR LIMITATION.—The aggregate amount treated as qualified sports and

fitness expenses with respect to any taxpayer for any taxable year shall not exceed $500 (twice such amount in the case of a joint return or a head of household (as defined in section 2(b))).

''(ii) DOLLAR LIMITATION ON SAFETY EQUIPMENT.—The amount treated as qualified sports and fitness expenses with respect to any item of safety equipment described in subparagraph (A)(iii) shall not exceed $250.

''(iii) EXCLUSION OF EXERCISE VIDEOS, ETC.—Qualified sports and fitness expenses shall not include videos, books, or similar materials.

''(C) QUALIFIED PHYSICAL ACTIVITY.—For purposes of this paragraph—

''(i) IN GENERAL.—Except as provided in clause (ii), the term 'qualified physical activity' means any physical exercise or physical activity.

''(ii) EXCLUSIONS.—The Secretary, after consultation with the Secretary of Health and Human Services, shall issue guidance to determine for purposes of this paragraph what does not constitute a qualified physical activity, including golf, hunting, sailing, horseback riding, and other similar activities.

''(D) FITNESS FACILITY DEFINED.—For purposes of subparagraph (A)(i), the term 'fitness facility' means a facility—

''(i) providing instruction in a program of qualified physical activity or facilities for qualified physical activity,

''(ii) which is not a private club owned and operated by its members,

''(iii) whose health or fitness facility is not incidental to its overall function and purpose, and

''(iv) which is fully compliant with applicable State and Federal anti-discrimination laws.

''(E) PROGRAMS WHICH INCLUDE COMPONENTS OTHER QUALIFIED PHYSICAL ACTIVITY.—Rules similar to the rules of paragraph (6) shall apply in the case of any program or facility that includes qualified physical activity (or facilities therefore) and also other components. For purposes of the preceding sentence, travel and accommodations shall be treated as an other component.

''(F) INFLATION ADJUSTMENT.—In the case of any taxable year beginning in a calendar year after 2019, the $500 amount in subparagraph (B)(i) and the $250 amount in subparagraph (B)(ii) shall each be increased by an amount equal to—

''(i) such dollar amount, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins, determined by substituting 'calendar year 2018' for 'calendar year 2016' in subparagraph (A)(ii) thereof.

If any increase determined under the preceding sentence is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2018.

The SPEAKER pro tempore. The bill, as amended, shall be debatable for 1 hour equally divided and controlled by the chair and ranking minority member of the Committee on Ways and Means.

The gentlewoman from Kansas (Ms. JENKINS) and the gentleman from Oregon (Mr. BLUMENAUER) each will control 30 minutes.

The Chair recognizes the gentlewoman from Kansas.

GENERAL LEAVE

Ms. JENKINS of Kansas. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous materials on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Kansas?

There was no objection.

Ms. JENKINS of Kansas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased to come to the floor today to speak in support of the Restoring Access to Medication and Modernizing Health Savings Account Act of 2018.

This legislation makes a variety of simple but much-need changes to health savings accounts, or HSAs, rules to ensure that folks have more access and choice when using their HSAs.

This bill contains five separate bipartisan pieces of legislation that passed the Ways and Means Committee earlier this month. It includes a bipartisan policy by Mr. ROSKAM and Mr. THOMPSON that would allow HSA-eligible plans to offer a certain amount of first-dollar coverage in their plan design without losing their HSA-eligibility. This allows HSA plans to offer coverage for valuable services like telehealth or primary care appointments without a deductible.

The bill permits patients with HSAs to access the innovative and patient-centered direct primary care arrangements with HSA plans, provisions championed by the bipartisan team of Mr. PAULSEN and Mr. BLUMENAUER.

The bill also allows coverage for certain medical services from a retail or onsite clinic and permits contributions to an HSA if their spouse has a health FSA, which is prohibited today.

Another commonsense provision in the bill allows rollovers from other tax-advantaged health accounts to be able to fund HSAs. These proposals were included in Mr. KELLY and Mr. BLUMENAUER's bipartisan legislation.

Additionally, this bill contains the PHIT Act, introduced in a bipartisan manner by Mr. JASON SMITH and Mr. KIND, that would allow certain qualified fitness expenses to be eligible items that can be paid for with tax-advantaged dollars, offsetting a portion of their costs and promoting healthy activity.

Lastly, this legislation repeals the Affordable Care Act's unnecessary barriers when it comes to using tax-advantaged health accounts to purchase over-the-counter medicines, something that I have been pleased to work on with my good friend Congressman KIND for the last several years, and I am encouraged that the bipartisan duo of Representatives MENG and PAULSEN have also joined us in introducing the underlying legislation.

In addition to expanding access for over-the-counter medication, the bill also allows for feminine hygiene products to be considered a qualified medical expense.

Since the passage of the Affordable Care Act, Americans have had to seek prescriptions in order to use their health savings and flexible spending accounts on safe and effective over-the-counter medicines. This legislation would end the need for those prescriptions.

It doesn't make any sense to require the millions of American families that use HSAs and FSAs to manage their healthcare needs to go to the doctor in order to access over-the-counter medicines for things like basic pain management and cold and allergy symptoms.

Nobody benefits from this nonsensical policy that requires consumers to jump through unnecessary hoops and increases the burdens on the healthcare system, all while providing no medical benefit. Over-the-counter medicines are often the frontline treatment for many common illnesses and for maintenance of chronic diseases, and they should be treated as medically reimbursable healthcare therapies, just as prescription medications.

Mr. Speaker, I am pleased the House is considering H.R. 6199, which gives individuals and families more control over their healthcare spending and increases their options when it comes to health savings accounts.

Today marks a nice opportunity to pass bipartisan legislation to simply make it easier for consumers to meet their basic medical needs. These are commonsense, simple, bipartisan solutions, and I urge my colleagues to support this legislation.

Mr. Speaker, I reserve the balance of my time.

Mr. BLUMENAUER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am pleased to be here with Ms. JENKINS, moving forward on this legislation. It represents an opportunity for us to deal with a series of, as she mentioned, bipartisan ideas, relatively simple, to enhance service delivery.

I state from the outset that I am troubled that we were not able to provide opportunities to pay for these. They carry a cost. In committee, even though I thought they were a good idea, I voted against some of them because they were rather expensive.

In the aggregate, these are things, moving forward, that will improve healthcare, and I am hopeful that, as we move along the process, we can find some ways to offset the costs involved.

Some of us have philosophical questions about the role of HSAs and how it fits overall, but this legislation will make key consumer-friendly improvements to our existing system. Direct primary care medical homes are an important example of successful delivery reforms that will become easier to access under this legislation.

DPC arrangements offer individuals access to comprehensive primary care and prevention services in a medical home setting for a flat monthly fee, as opposed to concierge services that some people have in mind. Most of these practices typically charge a low monthly fee, perhaps $50 to $100, in most cases, and they serve low- and

moderate-income patients. These fees support the delivery of high-quality, coordinated care by providing better healthcare upfront in primary care settings.

DPC practices reduce unnecessary hospital and specialty care, as well as administrative expenses. This empowers the doctor-patient relationship, enabling providers to resist financial incentives that distort the decision-making process in primary care.

It also reduces the conveyor belt process, where people are typically shuttled into the office in 8-minute increments. This is not the case in direct primary care. It is not uncommon for appointments to last half an hour or even an hour. So they build a better relationship with patients, and they are able to better understand and address healthcare needs.

By offering a high level of access to primary care, evidence shows that direct primary care medical homes improve health outcomes and reduce costs. Today, DPC medical homes serve individuals of all ages and income in at least 47 States.

This legislation simplifies existing IRS regulations and clarifies that direct primary care medical homes are qualified health expenses—medical services—and not health plans.

I personally question the IRS ruling. We have debated with them, but we have lost that. We fix it with this legislation.

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As more individuals and employers seek to utilize the direct primary care delivery model, it is important that this outdated tax barrier not get in the way of patients accessing this successful model.

The legislation will allow HSA plans to cover onsite employee clinics. Think for a moment about the nursing stations that we have here in the House of Representatives to provide that service. They can offer physical exams, immunization, over-the-counter drugs, drug testing, hearing and vision screening, and other minor primary care preventive services to help employers assemble a benefits package for their employees that is both practical and can give them a competitive edge.

Allowing employees to access this basic healthcare service at work means it doesn't disrupt the worksite. It is more convenient for them; it is better for the employer.

Another key consumer change made by this bill is to recognize that employees change jobs. This bill allows individuals to streamline the conversion of a medical savings account, flexible savings account, or HSA so they won't lose savings when they change jobs. These reasonable changes will help consumers make the most of their employer-sponsored coverage.

Now—make no mistake—while this legislation will certainly help some consumers, it doesn't atone for the systematic sabotage that we have seen of the Affordable Care Act by the administration and some of my Republican colleagues. By zeroing out the mandate penalty, estimates are that insurance premiums will rise 15 percent. None of these bills before us today undo that premium hike that is visited upon our constituents unnecessarily.

These premium increases are coming after Republicans gave insurance companies billions in tax cuts in their tax bills. Republican attempts to expand HSAs is no replacement for the Affordable Care Act's financial assistance. Attempts to expand HSAs are a continuation of a platform of shifting families into health plans which provide fewer health benefits and higher out-of-pocket costs, while providing greater tax benefits for those who need them least.

HSAs and high-deductible healthcare plans shift costs to consumers without bending the cost curve or addressing underlying costs of medical care in the United States. I think we can and should do better.

For instance, the President has promised action on lowering prescription drug costs. These bills today do nothing to lower the cost of drugs consumers buy, and seek to move more people into plans that provide only catastrophic coverage, exposing more people to pay the full freight of drug price hikes.

Now, we have legislation before our committees that could move forward to do something about this, and I am saddened, despite Trump's talking about it, that we have really not taken action to do so. And we could, on a bipartisan basis, if we were enabled to do so.

The collection of bills on the floor this week will reduce Federal revenues by about $90 billion and will do nothing to reduce the number of uninsured people that will increase as a result of policy changes my Republican friends have done in this Congress. Their sabotage efforts under the Trump administration have caused millions of people to lose coverage, and millions more will do so in the future.

Now we are seeing, in the budget proposal, my Republican friends proposing to cut Medicare and Medicaid by nearly $1 trillion to try and pay for the deficits that have been exaggerated by tax cuts they have enacted. The bills that we will be considering, especially the next one, will only add fuel to that fire.

So, I am pleased that we have got some bipartisan pieces that we can move forward. I am hopeful that we don't abandon a sense of fiscal responsibility to be able to work together to pay for them, and I hope that we can encourage some of my friends on the other side of the aisle to dial back the assault on the Affordable Care Act, especially by the administration, so that we don't destabilize the system further, drive up costs, and increase the number of uninsured.

Mr. Speaker, I reserve the balance of my time.

Ms. JENKINS of Kansas. Mr. Speaker, I yield 3 minutes to the gentleman from South Carolina (Mr. RICE), a distinguished member of the House Ways and Means Committee.

Mr. RICE of South Carolina. Mr. Speaker, I am proud to stand before you today to discuss two bills that expand choice and offer lower cost. And lower cost and choice are what are needed in healthcare.

Back home in South Carolina, the average premium before ObamaCare, in 2013, in the individual market, was $233. In 2017—which the premiums were set before the President took office—before the ''assault'' on ObamaCare that my colleague was speaking of, the premium reached $512. That is a $279-per-month increase in 4 years, a 120 percent increase from 2013 to 2017.

Before ObamaCare, 85 percent of the people in the country were covered by health insurance. At the peak, under the Affordable Care Act, 91 percent were covered. So we covered 6 percent more people, and that is a good thing. But what was the cost of that? To cover 6 percent more of our population, the other 85 percent, who were already covered, either by Medicare, Medicaid, or private insurance, had to pay another 120 percent on their premiums in South Carolina, 105 percent nationwide. And the premiums are going to go up double digits again this year.

We need lower cost, and we need choice. In South Carolina, all of the insurance companies have pulled out of the exchanges except for one. In fact, 40 percent of the counties in the country have only one choice for health insurance. That is no choice at all. It is either health insurance or nothing. You select from that one company, or you get nothing. We need lower cost, and we need choice.

These bills today, by allowing more liberal contributions to health savings accounts, by allowing easier access to health savings accounts, by allowing health savings accounts to be used for more purposes—like private family care or for nonprescription drugs, over-the-counter drugs—they are serving the exact causes, the exact purposes, that I hear the most complaints about back home.

My folks back home are saying: How can I afford these insurance policies? With the high deductibles that are being forced on us by these insurance companies, even if I have the insurance policy, I cannot afford to use it.

Mr. Speaker, I am proud to stand before you today to recommend these bills.

Mr. BLUMENAUER. Mr. Speaker, I yield 4 minutes to the gentleman from Wisconsin (Mr. KIND), a senior member of the Committee on Ways and Means, author of several of these reform provisions, and a champion of value over volume in healthcare, as well as fiscal restraint.

Mr. KIND. Mr. Speaker, I thank my friend and colleague from Oregon for yielding me this time. I agree with my colleague.

Mr. Speaker, I rise in opposition to this legislation, not because of the policy initiatives underlying these bills, but because of how fiscally irresponsible it is being done.

This week, out of the Ways and Means Committee, we have 10 bills to be debated and voted on on the House floor, at a total cost of roughly $90 billion. There was no effort made to try to find an offset or a pay-for in order to maintain some fiscal discipline in this place. That is problematic, because we keep digging the hole deeper.

But my name is on a few of these bills. Yesterday we had the repeal of the medical device tax, legislation that I had authored with my friend from Minnesota, ERIK PAULSEN. But that came at a cost of $20 billion. No offset. No pay-for. Just borrow more money from China and let future generations wrestle with it.

But it made sense policy-wise to try to repeal that in a fiscally responsible manner, because we were taxing these manufacturers whether they were making a profit or not. In fact, the pre-revenue companies were getting hit by the same tax. Policy-wise, it didn't make a lot of sense.

Today, I was happy to introduce legislation from our friend and colleague, Ms. JENKINS, on the Restoring Access to Medication Act. This will make it easier for patients to purchase over-the-counter medicine with their HSA and FSA account money without having to first run to their doctor to get a prescription. Just for the sake of efficiency and the cost savings, policy-wise, that makes sense; but the legislation comes with a cost, and there was no effort to pay for that.

Also part of this package is legislation I have introduced with our colleague, Mr. SMITH, called the Personal Health Investment Today Act, or the PHIT Act. This would allow HSA and FSA dollars to be used for physical exercise, for gym memberships, so that we are investing in the front end of wellness and keeping people healthy in their lives rather than the hundreds of billions of dollars we spend at the back end dealing with chronic disease management.

Policy-wise that makes sense, but the legislation, again, comes with a cost. No attempt to pay for it. I think that is fiscally irresponsible.

At the time when we worked on and passed the Affordable Care Act, President Obama had one major request, that all of it had to be paid for, all of it had to be offset. We worked hard to accomplish it, and, in fact, we did, and then some. We did not add one nickel to our budget deficit or to future budget debt forecasts because of how we dealt with that in a fiscally responsible manner.

All we are asking is that our colleagues on the other side who are in charge now and running this place try to practice some semblance of that fiscal discipline that we showed with the passage of the Affordable Care Act.

We ought to be working together, finding out what is working with the healthcare system and fixing what isn't.

What is not working is the elimination of cost-sharing reduction payments that help health insurance providers spread the risk in the health insurance exchanges. That is one of the reasons why premiums are being driven up right now.

What is not working is refusing to provide funding to the navigators, who help people make the choices with the health plans that they have available, or undercutting funding for any education outreach with patients, or the elimination of the individual responsibility component so that young and healthy people don't get to sit around and wait until they get sick or injured and then go out and acquire health insurance. That is not how insurance markets work.

What also doesn't work is an administration that is trying to undermine the protections that are in place under the Affordable Care Act for people with preexisting conditions. There is a lawsuit pending right now. This administration should be defending that preexisting condition exclusion, and they are refusing to do so. That will implicate millions of lives throughout our country.

There is a lot that we can and should be working on together to improve the healthcare system, to reduce healthcare costs for all Americans. This approach, this piecemeal approach, while policy-wise there is a lot of justification and explanation for what is happening, is being done in a very fiscally irresponsible manner, just piling on the debt.

The SPEAKER pro tempore (Mr. BOST). The time of the gentleman has expired.

Mr. BLUMENAUER. Mr. Speaker, I yield the gentleman from Wisconsin 1 additional minute.

Mr. KIND. Mr. Speaker, this comes, by the way, on the heels, in this session of Congress, of the passage of a major tax cut last year that will add over $2 trillion to our national debt over the next 10 years because, again, there was no attempt to pay for it. It comes on the heels of the passage of a 2-year budget that will increase spending by over half a trillion dollars, none of it paid for, none of it offset.

Just yesterday, President Trump just announced a $12 billion subsidy bailout program for our family farmers because of the adverse effects that they are feeling due to his tariffs. And that is going to be borrowed money from China, again, to pay our farmers because they can't now sell their product—guess where—into the Chinese market.

How crazy is this? I hope we are not in an era now where budget deficits and debt only matters when there is a Democrat in the White House. Over the last year and a half, that certainly seems to be the case in this Congress.

Ms. JENKINS of Kansas. Mr. Speaker, I appreciate my friend's point of view on the other side of the aisle. Mr. KIND and I have worked really hard on this legislation for many years. I want to, for the Record, just remind folks that this bill is simply allowing people to keep more of their hard-earned money.

Letting people keep their own money is not government spending that needs to be offset. Each of these bills contained in this package were authored with our Democratic colleagues without an offset. Each of these bills went through committee, with bipartisan support, without an offset. It is ironic that Democrats want to, all of a sudden, claim to be fiscally conservative.

This is the same Democratic Party that passed the stimulus in 2009. Remember, that bill added nearly $800 billion to the deficit.

Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. KELLY), a real leader on these issues on the House Committee on Ways and Means.

Mr. KELLY of Pennsylvania. Mr. Speaker, I thank the gentlewoman for including my bill, H.R. 6305, the Bipartisan HSA Improvement Act of 2018, in H.R. 6199, the Restoring Access to Medication and Modernizing Health Savings Accounts Act.

□ 1615

This important legislation expands access to and enhances the utility of health savings accounts, also known as HSAs.

My legislation gives employers more flexibility to offer quality healthcare in the setting that is best for them, like onsite or retail clinics. Employers around the country are offering innovative ways to deliver healthcare to their associates, and this provision makes sure that individual health savings accounts can utilize these same services.

It also fixes the spouse penalty by allowing individuals to make health savings account contributions if a spouse has a flexible spending account, while preventing double-dipping in tax benefits.

Lastly, it makes it easier for people to save for their healthcare by streamlining the conversion of other tax-preferred accounts to health savings accounts.

Ultimately, this bill modernizes healthcare delivery and gives employers the freedom to innovate and improve their employees' health.

I am also very pleased to see that the PHIT Act was included in this package. I strongly support adding more of an emphasis on exercise and wellness to build a healthy American population.

We spend an incredible amount of money on healthcare but very little on maintenance, like exercise and wellness, before we get sick. The PHIT Act will better incentivize healthy lifestyles.

Mr. Speaker, we are trying to improve healthcare for all Americans.

This means giving consumers a choice in their healthcare by incentivizing wellness and exercise. This is a preemptive effort to build a healthier, stronger America and the freedom to design insurance products that work best for them.

If you want to keep healthcare costs down, let's just make sure people are healthier. That is the best way to do it.

And do you know what? I really like this debate because we talk about how the deficit has grown. And for my colleagues on the other side, I wasn't here at the time, but I watched the deficit grow in the beginning of the Obama administration from $9 trillion to $20 trillion, and I am glad that, finally, somebody has awakened to the fact that we are working with huge deficits.

Now, this bill was passed by the Ways and Means Committee in a bipartisan fashion, and I want to thank my friend EARL BLUMENAUER for working on this issue.

This issue is extremely important for the 175 million Americans who get their health insurance from their employer. I strongly urge my colleagues on both sides of the aisle to vote in favor of H.R. 6199.

Mr. BLUMENAUER. Mr. Speaker, I yield myself 1 minute just to respond briefly.

Mr. Speaker, I was here in 2009. The very month President Obama took office, there were 700,000 jobs lost. There was great fear that we were going to have a complete collapse of the auto industry. There was a whole range of things that we were in an emergency situation on, and the worst economic crisis since the Great Depression.

As it was, a major portion of that bill was tax cuts to try and stimulate the economy. I do point out that as we move forward, our healthcare bill was entirely paid for, and that is what we need to get back to.

Mr. Speaker, I yield 3 minutes to the gentleman from Illinois (Mr. DANNY K. DAVIS), a champion of healthcare, dealing with disparities in the healthcare system, a champion for balance and vision, and I appreciate him being here.

Mr. DANNY K. DAVIS of Illinois. Mr. Speaker, I thank my colleague who demonstrates with regularity the intensification of real care for the people.

Today, we take up another bill that does nothing to make up for the long-term Republican sabotage of the Affordable Care Act. Tens of millions of working families also see their healthcare costs skyrocket due to the repeated Republican efforts to undermine the healthcare system.

Tens of millions of Americans with preexisting conditions will still fear the loss of guaranteed health protections with the horrible choice of loss of health insurance or untenable premiums.

The Republicans' sabotage will cost a typical family of four in my congressional district $2,250 more in insurance premiums in 2019. The Republicans' sabotage will cost a typical 55-year-old couple in my congressional district $3,570 more in 2019.

The 2019 premium hikes follow an average 37 percent increase in 2018. These premium hikes are especially disturbing when contrasted with the billions in tax cuts the Republicans gave to insurance companies in their tax law.

H.R. 6199 makes a small change to health savings accounts used exclusively by the wealthy. Many of my constituents have trouble paying for basic living costs like heat, food, and housing. They ask me regularly for a few hundred dollars to help their kids stay in college.

The vast majority of my constituents can't set aside tens of thousands of dollars to pay for their medical care out of pocket in a health savings account. This legislation does nothing to increase coverage, improve affordability, or change the skyrocketing costs of healthcare.

I urge my colleagues to reject this bill, and I urge my Republican colleagues to bring up meaningful legislation to improve coverage and lower costs to help the tens of millions of Americans in need.

Ms. JENKINS of Kansas. Mr. Speaker, I yield 3 minutes to the gentleman from Kansas (Mr. ESTES), my friend and colleague.

Mr. ESTES of Kansas. Mr. Speaker, I rise to speak in support of two bills being considered today as part of our overall goal to improve healthcare for families across the country.

Currently, ObamaCare is broken. As I mentioned in an opinion piece, from 2010 to 2016, health insurance premiums increased by nearly $4,400 per family.

This year, health insurance costs rose about 30 percent and are expected to go up an additional 10 to 20 percent in 2019.

These skyrocketing costs are not due to some sabotage, as some folks have suggested. Instead, they are a product of a system that was designed and destined to fail.

Today, we all recognize that ObamaCare has failed to provide insurance for all Americans. Rather than create more government-run healthcare, we need competition and free market solutions like health savings accounts to put patients in control of their own healthcare. That is why I am proud to support H.R. 6199, the Restoring Access to Medication Act of 2018, sponsored by Representative LYNN JENKINS and Representative GRACE MENG.

H.R. 6199 repeals provisions of the Affordable Care Act that restrict health savings accounts, medical savings accounts, health flexible spending arrangements, and health reimbursement arrangements to only be used for prescription drugs or insulin. Removing these restrictions will allow people to use such accounts for over-the-counter drugs.

I am also proud to support H.R. 6311, the Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018, sponsored by Representatives PETER ROSKAM and MICHAEL BURGESS.

H.R. 6311 provides relief from ObamaCare's rising premiums and limited choices by allowing the premium tax credit to be used for plans offered outside of ObamaCare exchanges. The bill also expands access to the lowest premium plans for people purchasing coverage in the individual market and allows the premium tax credit to be used to offset the cost of such plans. These measures increase competition for consumers and seek to drive down the cost of health insurance.

I want to thank the Ways and Means Committee for bringing forward thoughtful healthcare solutions that will help American families. I urge my colleagues to support both bills.

Mr. BLUMENAUER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I take modest exception to the notion that somehow the Affordable Care Act failed. It represents the largest expansion of healthcare that we have seen in decades. It is so popular and important that, when my Republican friends attempted to repeal it, something they have been working on for 7 years, it blew up in their face. Even President Trump said their bill was mean. And it continues, even though they are working to dismantle it bolt by bolt.

I would hope that we will return to sanity to be able to work to be able to move forward on things like some of the elements in this bill here today that we agree upon that could move us forward rather than the continued battle over the notion that the Affordable Care Act is something that needs to be destroyed. The American people deserve better.

Mr. Speaker, I reserve the balance of my time.

Ms. JENKINS of Kansas. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. ROSKAM), who has provided great leadership in this area.

Mr. ROSKAM. Mr. Speaker, I am pleased to see the inclusion of the Promoting High-Value Health Care Through Flexibility for Deductible Health Plans in this bill today. This is legislation that is bipartisan that I introduced, along with the Congressman from California (Mr. THOMPSON), that gives consumers the choice and flexibility that they need to be engaged in their healthcare.

In a nutshell, the bill allows plans to offer coverage for high-value, low-cost services like telehealth, chronic disease management such as diabetic testing strips, or primary care visits below the deductible. In a nutshell, what we are trying to do is give patients more choices, more capacity to be more demonstrative about navigating through their own healthcare needs.

This is a good bipartisan approach. I thank the gentlewoman for including it, and I thank her for the time. I urge its passage.

Mr. BLUMENAUER. Mr. Speaker, I reserve the balance of my time.

Ms. JENKINS of Kansas. Mr. Speaker, I yield 2 minutes to the gentleman from Minnesota (Mr. PAULSEN), who has worked tirelessly in this area.

Mr. PAULSEN. Mr. Speaker, I thank the chairwoman for yielding.

Mr. Speaker, as an advocate for giving consumers more choice in healthcare and lowering costs, I support this bill, which also gives more flexibility for those who have healthcare savings accounts, as well as some of the other provisions that were already just previously mentioned.

I want to highlight my support for one of the provisions in this bill that will allow people to use their healthcare savings account to pay for direct primary care and those arrangements.

The concept of direct primary care is simple, and it is supported by a lot of family doctors, a lot of primary care doctors. People pay a monthly fee to see their physician in this area anytime they choose, over the phone, through telemedicine, or in person, and then they get a whole host of services. It is really important for strengthening the doctor-patient relationship, and it means that more people will have access to primary care services instead of just going to the emergency room in order to get care.

But, unfortunately, the IRS has stated that direct primary care arrangements are essentially health insurance, and they categorize them in this way so you cannot use your HSAs and those funds to pay for direct primary care. That is why Congressman BLUMENAUER and I authored legislation to fix this and to allow HSAs, health savings accounts, to be used for direct primary care, and I am pleased that it is included in this bill.

Another important reform will allow employers to offer direct primary care arrangements to employees that have an HSA, also. This will let more people have access to direct primary care through their healthcare savings accounts, allowing family practice doctors like Dr. Julie Anderson in Minnesota to expand their practice without having to worry about the headache of filling out mountains of paperwork and excessive insurance forms, because direct primary care let's the doctor work directly with the patient and you don't have to go through extensive billing services and insurance.

Healthcare savings accounts, Mr. Speaker, have already been proven to help lower healthcare costs; and expanding them, giving consumers more flexibility and more choices, will mean families are also going to be better off.

So let's allow healthcare savings accounts to be used for direct primary care and support the underlying bill.

Mr. BLUMENAUER. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, I appreciate the opportunity for us to have this discussion. It has been fun working with the gentleman from Minnesota (Mr. PAULSEN) on this notion of direct primary care. It is a simple notion that runs athwart IRS regulations. I still don't fully understand why these should be classified as ''health plan'' rather than ''payment for service.''

But, nonetheless, we were able to work together on a bipartisan basis to move this forward. It is not expensive. The score is less than $2 billion out of $90 billion that we are tossing around here, and I personally believe that it will result in substantial savings in order to provide more efficient coverage.

But I must say that I am a little troubled by the continuing assault on what we are doing with the fiscal future of this country.

□ 1630

We just saw the latest reports that because of what my Republican friends have done with the budget and with the tax bill, we have doubled the deficit this year. It is doubled.

Now, there were complaints from my friend from Kansas about deficit spending when President Obama took office. Remember, he was only President for one-third of that month and lost 700,000 jobs. The economy was in free fall. Absolutely we took steps: cutting taxes and moving in areas to try and strengthen parts of the economy that was posing huge problems for people across the board. And this was broadly supported by people in business. Economic experts actually agree that probably we didn't do enough, and that slowed the economic recovery. But the economy has recovered.

We have seen 9 consecutive years of private sector job growth. That is what Trump inherited: over 7 years of job growth. The economy was strong. It wasn't in free fall. Yet, in that strong position, we are doubling the deficit this year. We are looking at trillion dollar deficits as far as the eye can see.

And we just had the President announce that he wants to spend $12 billion more, not because we are in economic free fall, but because his ruinous trade policies have resulted in losses to the farming sector. They are going to provide extra government bailout, not because farmers want it, but because they are being injured by these ruinous trade policies.

There was a time when most of my Republican friends would rise up in opposition. It is certain that if these were offered by Bill Clinton or Barack Obama, they would be screaming at the top of their lungs. Most of them are strangely silent now, but it is another $12 billion to try to fix a problem that Trump has created by starting trade wars with our friends, trying to punish China, and, in fact, we are punishing our allies. And somehow auto imports are national security.

This is embarrassing that we are in this situation. But it is not just embarrassing, it is dangerous. We are weakening ourselves economically, while we pick fights with our allies, like Canada and the European Union.

Mr. Speaker, on top of all of this, we are going to advance legislation today that have some nuggets of positive things. I have worked with my colleagues on some of them. There are important advances, but they are coming at a price of $90 billion added to the deficit, without even an attempt to work with us to offset. I think we could have offset the direct primary care piece that we are talking about here. It is relatively small potatoes compared to $90 billion, and compared to $12 billion for tariff relief for a trade war we didn't need.

Mr. Speaker, I enjoy the conversation about some of these items. I think it is important to spotlight them. But I am hopeful that we are able to return to fiscal stability, not having bailouts for farmers that they don't want and wouldn't need if we had a rational tariff policy. I am hopeful that we are not going to have a parade of other things that undermine the Affordable Care Act and add unnecessary costs to the deficit.

Mr. Speaker, I yield back the balance of my time.

Ms. JENKINS of Kansas. Mr. Speaker, I yield myself the remainder of my time.

Mr. Speaker, we have heard my friends on the other side of the aisle suggest here, this afternoon, this bill might, in some way, hurt people with preexisting conditions. However, we know that is simply not true. This bill doesn't touch preexisting conditions. It doesn't raise costs or premiums on families. And it doesn't take away anyone's choice of a healthcare plan.

Millions of Americans use tax-advantage healthcare accounts to save and pay for healthcare expenses. In fact, there are twice as many Americans with an HSA than those who get coverage on the Affordable Care Act's exchanges. Almost 22 million people had an HSA in 2017, and there is only about 10 million people enrolled on the exchanges in 2018. Forty-four percent of all civilian workers had access to a health flexible spending arrangement in 2017.

The provisions in this bill allow more things to be paid for out of these accounts, like over-the-counter drugs, feminine products, and fitness activities. This means people are paying less because they are able to use pre-tax dollars or take a deduction for their contribution.

As a reminder, the policies in the bill are all bipartisan. We have worked together to write and advance them.

This bill helps middle class families afford their healthcare expenses, and I hope my colleagues will continue to support this legislation.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 1012, the previous question is ordered on the bill, as amended.

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BLUMENAUER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF CONFERENCE REPORT ON H.R. 5515, NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2019

Mr. BYRNE, from the Committee on Rules, submitted a privileged report (Rept. No. 115–875) on the resolution (H. Res. 1027) providing for consideration of the conference report to accompany the bill (H.R. 5515) to authorize appropriations for fiscal year 2019 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes, which was referred to the House Calendar and ordered to be printed.

INCREASING ACCESS TO LOWER PREMIUM PLANS AND EXPANDING HEALTH SAVINGS ACCOUNTS ACT OF 2018

Mr. ROSKAM. Mr. Speaker, pursuant to House Resolution 1011, I call up the bill (H.R. 6311) to amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to modify the definition of qualified health plan for purposes of the health insurance premium tax credit and to allow individuals purchasing health insurance in the individual market to purchase a lower premium copper plan, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore. Pursuant to House Resolution 1011, in lieu of the amendment in the nature of a substitute recommended by the Committee on Ways and Means, an amendment in the nature of a substitute consisting of the text of Rules Committee Print 115–83 is adopted, and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

H.R. 6311

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

SEC. 2. CARRYFORWARD OF HEALTH FLEXIBLE SPENDING ARRANGEMENT ACCOUNT BALANCES.

(a) IN GENERAL.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(h) CARRYFORWARD OF HEALTH FLEXIBLE SPENDING ARRANGEMENT ACCOUNT BALANCES.—A plan shall not fail to be treated as a health flexible spending arrangement under this section or section 105 merely because the lesser of—

''(1) such arrangement's account balance (or any portion thereof) determined as of the end of any plan year, or

''(2) the product of the dollar limitation in effect under section 125(i) for such plan year (determined without regard to paragraph (2) thereof) multiplied by 3,

may be carried forward to the succeeding plan year.''.

(b) COORDINATION WITH LIMITATION ON SALARY REDUCTION CONTRIBUTIONS.—

(1) IN GENERAL.—Section 125(i) of such Code is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

''(2) COORDINATION WITH CARRYFORWARD OF ACCOUNT BALANCES.—The dollar amount otherwise in effect under paragraph (1) for any plan year shall be reduced (but not below zero) by the excess (if any) of—

''(A) the amount of any account balance which is carried forward to such plan year from the preceding plan year, over

''(B) twice the dollar limitation in effect under paragraph (1) (determined without regard to this paragraph).''.

(2) CONFORMING AMENDMENTS.—Section 125(i) of such Code is amended by striking ''taxable year'' each place it appears in paragraphs (1) and (3) (as redesignated by paragraph (1) of this subsection) and inserting ''plan year''.

(c) COORDINATION WITH CAFETERIA PLAN LIMITATION ON DEFERRED COMPENSATION.—Section 125(d)(2) of such Code is amended by adding at the end the following new subparagraph:

''(E) EXCEPTION FOR HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—Subparagraph (A) shall not apply to a plan to the extent of amounts in a health flexible spending arrangement which may be carried forward as described in section 106(h).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning after December 31, 2018.

SEC. 3. INDIVIDUALS ENTITLED TO PART A OF MEDICARE BY REASON OF AGE ALLOWED TO CONTRIBUTE TO HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Section 223(c)(1)(B) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of clause (ii), by striking the period at the end of clause (iii) and inserting '', and'', and by adding at the end the following new clause:

''(iv) entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act by reason of section 226(a) of such Act.''.

(b) CONFORMING AMENDMENT.—Section 223(b)(7) of such Code is amended by inserting ''(other than an entitlement to benefits described in subsection (c)(1)(B)(v))'' after ''Social Security Act''.

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

SEC. 4. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

(a) SELF-ONLY COVERAGE.—Section 223(b)(2)(A) of the Internal Revenue Code of 1986 is amended by striking ''$2,250'' and inserting ''the amount in effect under subsection (c)(2)(A)(ii)(I)''.

(b) FAMILY COVERAGE.—Section 223(b)(2)(B) of such Code is amended by striking ''$4,500'' and inserting ''the amount in effect under subsection (c)(2)(A)(ii)(II)''.

(c) CONFORMING AMENDMENTS.—Section 223(g)(1) of such Code is amended—

(1) by striking ''subsections (b)(2) and'' both places it appears and inserting ''subsection'', and

(2) in subparagraph (B), by striking ''determined by'' and all that follows through '' 'calendar year 2003'.'' and inserting ''determined by substituting 'calendar year 2003' for 'calendar year 2016' in subparagraph (A)(ii) thereof.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2018.

SEC. 5. ALLOW BOTH SPOUSES TO MAKE CATCH-UP CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) of the Internal Revenue Code of 1986 is amended to read as follows:

''(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

''(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and either spouse has family coverage under a high deductible health plan as of the first day of any month—

''(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage of either spouse (and if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

''(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

''(iii) such limitation (after application of clauses (i) and (ii)) shall be divided equally between such spouses unless they agree on a different division.

''(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall