United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE 115th CONGRESS, FIRST SESSION

Vol. 163 WASHINGTON, FRIDAY, MARCH 24, 2017 *No. 52*

Senate

The Senate was not in session today. Its next meeting will be held on Monday, March 27, 2017, at 3 p.m.

House of Representatives

FRIDAY, MARCH 24, 2017

The House met at 9 a.m. and was called to order by the Speaker.

PRAYER

The Chaplain, the Reverend Patrick J. Conroy, offered the following prayer:

Dear Lord, we give You thanks for giving us another day.

We are at the end of a difficult week filled with long days of work on legislation of great import for all Americans.

May Your peace descend upon this assembly. May wisdom and good faith rule the day, and may each Member proceed, with the help of Your grace, on the day's proceedings.

We all thank You that we have the privilege to serve in the people's House.

May all that is done this day be for Your greater honor and glory.

Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

Mr. THOMPSON of Pennsylvania. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER. The question is on the Speaker's approval of the Journal.

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

Mr. THOMPSON of Pennsylvania. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

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

The point of no quorum is considered withdrawn.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Michigan (Mr. KILDEE) come forward and lead the House in the Pledge of Allegiance.

Mr. KILDEE led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The Chair will entertain up to five requests for 1-minute speeches on each side of the aisle.

REMEMBERING TOM FRIEDKIN

(Mr. OLSON asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. OLSON. Mr. Speaker, a man loved throughout Houston, throughout Texas, throughout America, and throughout our world, Tom Friedkin put on his angel wings and flew to Heaven last week.

Tom was the force behind Houston's largest private company, Gulf States Toyota. Tom put an ''open for business'' sign up in 1969. Thirty years later, Tom was inducted into the Texas Business Hall of Fame.

Tom's brain made him a billionaire, but his heart was worth much, much more. Tom took that heart to Tanzania to protect elephants from being poached and killed. Tom's foundation signed a 30-year agreement with Tanzania to make it a better country.

A legend Texans love, Bum Phillips, would say this about Tom Friedkin: Tom, you may not be in a class by yourself, but whatever class you are in, it don't take long to call the roll.

God bless you, Tom.

HEALTHCARE BILL OUGHT TO BE REJECTED

(Mr. KILDEE asked and was given permission to address the House for 1 minute.)

Mr. KILDEE. Mr. Speaker, well, here we are. Today is the day when this House will vote on whether or not access to health care is a fundamental right in this country or should be limited to those of means who can afford it, whether access to lifesaving preventative care is something that Americans ought to be able to depend upon.

Now, we haven't seen the final language of the bill—it is still being worked on—although we are voting on it today, but here is what we know:

It will result in higher costs.

It will force families to pay higher premiums and higher out-of-pocket costs.

It will provide less coverage; and, in fact, just in the last couple of days,

even less coverage, by eliminating essential health benefits like preventative care, like hospitalization, like prescription drugs. Somebody might have a healthcare card, but it won't provide them health care when they need it.

It will have a crushing age tax. If you are 50 to 64 years of age, get ready. You will pay enormously higher costs as a result of this ill-conceived piece of legislation.

This steals from Medicare, undoes the promise.

This is a bad piece of legislation. It ought to be rejected.

THANKING ANDY LEUNG FOR HIS SERVICE

(Mr. THOMPSON of Pennsylvania asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. THOMPSON of Pennsylvania. Mr. Speaker, I rise today to thank a very special member of my team, Andy Leung, who is an intern in my office.

Andy comes to us through the Congressional Internship Program for Individuals with Intellectual Disabilities. This is a unique program designed to give students with varying intellectual disabilities an opportunity to gain congressional work experience. It is part of George Mason University's LIFE Program. To date, 150 congressional offices from the House and Senate have participated in this wonderful program.

Mr. Speaker, Andy is a part of our team, and we look forward to the hours he spends with us each week. He quickly settled into the office, and he is always in great spirits.

Andy is hardworking and curious. He is interested in the projects the full-time staff are working on. He loves picking up the flags from the Capitol, and we are truly fortunate to have such a dedicated intern.

I would like to thank Andy for his service and thank his employment assistant and the Congressional Internship Program for Individuals with Intellectual Disabilities for making this possible.

TRUMPCARE IS A PRESCRIPTION FOR DISASTER

(Ms. MCCOLLUM asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. MCCOLLUM. Mr. Speaker, TrumpCare is a disaster for children, families, seniors, and people with disabilities.

The bill we are considering today has been strong-armed through this House with no public hearings. Today as we vote, we don't have an updated estimated cost from the Congressional Budget Office, but here is what we do know:

Under TrumpCare, families will pay more for their insurance premiums and their deductibles.

Under TrumpCare, older Americans will be forced to pay higher insurance premiums, five times higher than what others pay.

Under TrumpCare, health care for vulnerable children, seniors, and people with disabilities will be rationed.

Unbelievably, TrumpCare even attacks the solvency of Medicare. It will be weakened by giving big tax breaks to billionaires.

TrumpCare was made even worse overnight. Now insurance companies will be able to sell policies that exclude basic health care like cancer screening and preventative care and even some hospitalizations.

Mr. Speaker, this is not a healthcare bill. It is a prescription for disaster. I urge my colleagues to strongly oppose TrumpCare.

AMERICAN HEALTH CARE ACT IS A WAY FORWARD

(Mr. LAMALFA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LAMALFA. Mr. Speaker, as we contemplate the American Health Care Act, here are a few things we do know:

The Affordable Care Act, as it is called, has driven premiums for working families up and up each year. There are fewer choices of plans, especially in rural America, and 8 million and rising people are choosing not to opt to be enrolled at all, paying the penalty instead.

Premiums will keep going up, as projected. Even more will drop out, and more will pay the penalty instead. More will become uninsured.

This death spiral is not choice; it is not an American value.

Mr. Speaker, as the American Health Care Act moves forward, we know the Democrats will not be helpful, as they are clinging to the failing ACA at all costs. We know that middle-income families are begging us for relief and more choices. We know this bill represents the best chance to achieve cost relief, actual choices, while also keeping the commitment under Medicaid to children in need with reauthorizing the bipartisan SCHIP later this year.

More affordable options come about with unshackling what the ACA has wrought. It is this or that.

Mr. Speaker, we must keep this dialogue, this option, this bill, the American Health Care Act, as a way forward to bring choices and relief to Americans who have worked for the American Dream and are feeling like they are losing it.

Let's keep our pledge and help President Trump keep his pledge by taking this one of three important steps with the American Health Care Act.

TAX CUTS FOR MILLIONAIRES

(Mr. HASTINGS asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. HASTINGS. Mr. Speaker, I say good morning to America.

This is not a health bill that we are readying ourselves to vote on. It is a tax bill for wealthy people.

I just left the Committee on Rules. We started our session there at 7 this morning. I have in hand a closed rule that will allow for 4 hours of debate. Later on this afternoon, the Republicans will accomplish what they set out to do.

The bill provides $274.9 billion in tax cuts for the highest income Americans. Over half of the tax cuts in the bill go to millionaires. In the year 2020, 61 percent of the cuts go to those earning more than a million dollars.

At the same time, Republicans cut Medicaid by more than $880 billion. That is money for poor people that will not have those benefits. Republicans cut Medicaid by that amount for working families.

Donald Trump's people and his Cabinet will do very well.

AMERICA CAN DO BETTER

(Mr. LEVIN asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, this is the Republican bill: a trillion dollars in lost health care for millions; at the same time, a trillion dollars in tax breaks, mostly for the very wealthy and corporations.

The Republican majority says their bill is to provide patient-centered health care, but for patients there is no healthcare center when there is no insurance.

The Republican bill robs millions of needed insurance for their health and, in many cases, would rob them of their life.

The Republican plan would create death panels for numerous unknown Americans.

This is not our America. America can do better. We must.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 1628, AMERICAN HEALTH CARE ACT OF 2017

Mr. SESSIONS, from the Committee on Rules, submitted a privileged report (Rept. No. 115–58) on the resolution (H. Res. 228) providing for consideration of the bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017, which was referred to the House Calendar and ordered to be printed.

PROVIDING FOR CONSIDERATION OF H.R. 1628, AMERICAN HEALTH CARE ACT OF 2017

Mr. SESSIONS. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 228 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 228

Resolved, That upon adoption of this resolution it shall be in order to consider in the House the bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017. All points of order against consideration of the bill are waived. The amendments specified in section 2 of this resolution shall be considered as adopted. The bill, as amended, shall be considered as read. All points of order against provisions in the bill, as amended, are waived. The previous question shall be considered as ordered on the bill, as amended, and on any further amendment thereto, to final passage without intervening motion except: (1) four hours of debate equally divided and controlled by the chair and ranking minority member of the Committee on the Budget or their respective designees; and (2) one motion to recommit with or without instructions.

SEC. 2. The amendments referred to in the first section of this resolution are as follows:

(a) The amendment printed in part A of the report of the Committee on Rules accompanying this resolution modified by the amendment printed in part B of that report.

(b) The amendment printed in part C of the report of the Committee on Rules accompanying this resolution modified by the amendments printed in part D and part E of that report.

The SPEAKER pro tempore (Mr. WOMACK). The gentleman from Texas is recognized for 1 hour.

Mr. SESSIONS. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), my friend, pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

GENERAL LEAVE

Mr. SESSIONS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

□ 0915

Mr. SESSIONS. Mr. Speaker, I rise in support of this rule and the underlying legislation.

This rule is a fair rule that adequately provides both sides of the aisle with ample time to debate the merits of the underlying legislation. In fact, the Rules Committee thought it was so important that ample time be provided to this debate, that we are provided 4 hours of general debate on the underlying bill.

Mr. Speaker, in honor of our former President, Ronald Reagan, I wear brown today. The former President, when he was President, believed that wearing brown was good luck to him and good luck for the things which he was undertaking. So, in honor of Ronald Reagan, I, too, wear my brown jacket today.

Mr. Speaker, it has become abundantly clear that ObamaCare has failed the American people. Our Nation's healthcare system today is broken and only getting worse under the current law, known as the Affordable Care Act, or ObamaCare.

Simply put, ObamaCare is collapsing, and it is collapsing fast. Options and choices are disappearing for consumers, and an anticompetitive marketplace has been created that firmly harms patients.

How bad is it? Nearly one-third of all U.S. counties currently have only one insurer offering plans on their State's exchanges. That is a government-created monopoly, Mr. Speaker, and that kills the free market, meaning no choices for the American people and higher costs are what the American consumer and the healthcare market are finding.

And it is only continuing to get worse. As more and more insurers leave the marketplace, prices will continue to rise, forcing healthy individuals to make economic decisions not to purchase health care, creating a self-defeating spiral of rising costs and less options. That is why we must act, and act today, which is what we are doing.

It is no wonder that in such a government-controlled system that premiums have increased by an average of 25 percent on the ObamaCare exchanges this year alone. And it is no wonder that some 19.2 million taxpayers chose to outright pay the individual mandate penalty or claimed an exemption. What this means is that ObamaCare is not a good option to these 19.2 million people.

Mr. Speaker, the American people, I believe, sent us to Washington, D.C., to fix this issue. They are telling us directly: this must be fixed now. And people certainly outside of Washington resent the Federal Government telling them how to purchase health care and what that healthcare marketplace would look like. But we really do not have to tolerate this. We do not have to agree that we will accept the status quo.

Mr. Speaker, I believe the American people are smart. I believe the American people want independence, they love freedom, and they want to know that they can make their own choices, because they believe they make better choices than a one-size-fits-all plan out of Washington, D.C.

What brings us here today, however, most assuredly, is a broken system. So, Republicans offer today H.R. 1628, the American Health Care Act of 2017, which will eliminate Washington's one-size-fits-all healthcare policy for the American people. It dismantles the disastrous ObamaCare taxes that are strangling the working middle class and diminishing America's economic prowess. We will end this with the opportunity to vote today to change the status quo.

It eliminates the onerous employer and individual mandates. It prohibits health insurers from denying coverage and helps young adults access health care by getting back into the marketplace while stabilizing and restoring the free market opportunities for all Americans.

Mr. Speaker, the American people are counting on Washington getting it right this time. What does getting it right mean? Getting it right means giving them the opportunity to exit a bad system and to have a better chance at a new system.

This rule provides House Republicans with the opportunity to restore exactly that—a better healthcare plan to provide the middle class and low-income families who have been left behind on either side of the aisle, and it gives them an opportunity to have tax advantages in the employer marketplace.

Mr. Speaker, today, we will be dissecting this into three separate areas. We will have Members of the Republican majority here to explain that and the bill.

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

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

(Mr. MCGOVERN asked and was given permission to revise and extend his remarks.)

Mr. MCGOVERN. Mr. Speaker, I want to thank the gentleman from Texas (Mr. SESSIONS), my friend, for yielding me the customary 30 minutes.

Mr. Speaker, the majority is rushing to congratulate itself for finally having a bill to repeal the Affordable Care Act. For 7 years, Republicans had nothing to actually replace the law with, but that didn't stop them from making one empty political promise after another.

And after all that, what do we have in front of us today? This bill will take away health care from 24 million hard-working Americans. It forces families to pay higher premiums and deductibles, increasing out-of-pocket costs. It is a crushing age tax, forcing Americans age 50 to 64 to pay premiums five times higher than what others pay for health coverage, no matter how healthy they are. Not to mention the $880 billion cut to Medicaid or the fact that it steals from Medicare, shortening the life of the Medicare trust fund by 3 years and ransacking funds that seniors depend on to get the long-term care they need.

I don't see anything there to be excited about. But then again, I come from the old-fashioned school of thought that we should actually take care of our fellow citizens as they grow older, rather than tossing them off the ship without a life preserver.

It is no wonder that after developing such an ill-conceived and far-reaching bill on the fly, the majority has had to try and jam this legislation through our Chamber.

First, they rushed this bill through the committee process without holding a single hearing, and without the benefit of a nonpartisan Congressional Budget Office score outlining its costs and impacts.

Then the majority came out of a back room somewhere and filed four managers' amendments in the dark of

night to try to appease the conservative and moderate holdouts, including the infamous Buffalo bribe. The Republican leadership has been trying to strong-arm their conference into voting for this bill all week, and nobody knows how today's vote will go. The only thing we do know is that this is a terrible bill that is only getting worse, not better.

This thing has been a mess from beginning to end. Now, I know our President prides himself on his negotiating skills, but this seems more like the art of no deal to me, no matter what the final vote tally looks like.

That brings us to this early morning, when we met at 7 a.m. in the Rules Committee to report out this rule, which rewrites the bill to make it far worse.

Last night, we were presented with a provision, concocted in some back room, that boggles the mind with its cynicism. So what is this mysterious grand bargain that will appease the Republican Conference and finally buy Speaker RYAN enough votes to pass this disaster of a bill? Well, Mr. Speaker, it is so cartoonishly malicious that I can picture someone twirling their mustache as they drafted it in their secret Capitol lair last night.

Republicans are killing the requirements that insurance plans cover essential health benefits—essential health benefits. Now, perhaps you are wondering: What are these so-called essential benefits? Well, I will give you a partial list: emergency room trips, maternity care, mental health care and substance abuse treatment, and prescription drugs. These are the types of exotic, extravagant benefits that Republicans apparently don't think are important for working Americans to be able to afford.

It would be literally unbelievable if we weren't here considering it right now, Mr. Speaker. Now, I have been awake since before dawn—thanks to our Rules Committee meeting—so I know that this isn't a nightmare. We are actually voting on a bill with a backroom deal, made in the dark of night, that would take away any guarantee that plans would cover these basic essential benefits.

And, of course, we have no idea what the costs will be or how many people it will affect. We can't know those things until we get an analysis from the nonpartisan Congressional Budget Office, which, obviously, we will not have before we vote on this reckless legislation.

And that is the real problem. Because every time you come out of a back room, this bill gets worse. For the sake of our country, maybe we should consider putting locks on the back rooms you huddle in.

President Trump keeps talking about crowd size. My colleagues across the aisle keep talking about page size. This morning, in the Rules Committee, Republicans kept saying that the fifth manager's amendment is only 4 pages long. How bad could it be?

Well, they need to stop worrying about size and pay more attention to how this bill will affect regular, working Americans. These 4 pages are the worse 4 pages on this planet because of the terrible consequences it will have on real people. It will be devastating for millions and millions of Americans.

So, Mr. Speaker, instead of rushing this horrendous bill, patched together with backroom deals, to the floor and voting on it just hours after seeing the final product, we should be working together in a bipartisan way to improve people's lives, and certainly not putting them at risk. My colleagues seem too concerned about winning at any cost to stop and think about the consequences for millions upon millions of Americans. This is a lousy bill.

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

Mr. SESSIONS. Mr. Speaker, I yield 10 minutes to the gentleman from Lewisville, Texas (Mr. BURGESS), a distinguished member of the Rules Committee, a gentleman who sits on both the Energy and Commerce and the Rules Committee. He is quite literally the most knowledgeable person on health care in the United States Congress.

Mr. BURGESS. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, we all know why we are here—the problems that exist within the Affordable Care Act. It is simply not working for the American people—limited choice, costs going up, and millions without access to care. Unfortunately, these are not just talking points, but real issues affecting real Americans.

The Affordable Care Act has damaged the individual market. It has driven insurers away from offering coverage. Now, we are seeing one-third of all United States counties with only one insurer. And among the plans that have chosen to remain in the markets, there have been widespread, double-digit premium increases.

The individual markets are a death spiral and are failing to live up to the promises made 7 years ago—that Americans would be able to receive affordable health care. As we knew then, and we know now, this was an empty promise that has left an estimated 19.2 million Americans without coverage. What is worse, these individuals are forced to pay the individual mandate penalty or seek a hardship exemption because of the costs to purchase and use health insurance.

Nine months ago, Mr. Speaker, we began our Better Way plan to save the Nation's healthcare system and to bring relief to the American people. This plan, which served as the blueprint for the American Health Care Act, laid out the policies to stabilize the collapsing insurance markets and to repeal the more burdensome Affordable Care Act taxes and mandates that have hindered innovation and limited access to care. So let's take a look at what the American Health Care Act does.

First and foremost, it provides immediate relief to the State insurance markets. As Republicans, we know that one-size-fits-all works for no one and certainly did not work for the individual markets. The States should have the flexibility to support their insurance markets and ensure that plans can continue to provide options for coverage.

To do this, we relaxed two of the egregious market regulations that were imposed under the Affordable Care Act: the mandate that premiums cannot vary for younger and older Americans by more than a 3-to-1 ratio, and the mandate creating fixed actuarial values for plans.

The mandate limiting a plan's ability to set premiums by age has driven up the cost for coverage for younger and healthier Americans and has pushed away those seeking coverage by the millions. Of the 19.2 million Americans who have sidestepped the individual mandate, it estimated that as many as 45 percent of these individuals are under the age of 35. Without these younger Americans seeking coverage, the markets have further plunged into death spirals, as insurers hike up premiums year after year.

To change this, we are relaxing the ratio to 5-to-1. It will lower premium costs and provide necessary opportunities to stabilize the markets.

Additionally, we are repealing the actuarial values mandate to provide insurers with additional flexibility to offer more coverage options.

□ 0930

To further supplement these efforts, we are establishing the Patient and State Stability Fund. This fund provides States with $100 billion over 10 years to promote innovative solutions to lower cost and increase access to health care for unique patient populations in each State. The goal is simple: to provide States with maximum flexibility as to how they address the cost of care for their citizens.

The Congressional Budget Office estimated that a combination of the Stability Fund and other proposed changes to the market would reduce premiums by 10 percent by calendar year 2026. We all want patients to have access to high-quality, affordably priced coverage. The Patient and State Stability Fund can help to lower costs.

In Medicaid, in addition to supporting the insurance market, the American Health Care Act provides needed reforms to the Medicaid program. Without changes, the Medicaid expansion alone is expected to cost $1 trillion over the next decade. Medicaid desperately needs reform so that States can continue to provide coverage to children, people with disabilities, and other vulnerable groups.

To address these concerns, the American Health Care Act first phases out the Medicaid expansion, the expansion that has crippled State budgets and limited States' ability to ensure that

resources will continue to be available for those vulnerable populations.

Additionally, our bill helps further bend the Medicaid cost curve by shifting programs toward per capita allotments. The per capita allotments, an idea that originated during the Clinton administration, will set limits on the annual cost for growth for per capita expenditures for which the States will receive matching funds from the Federal Government.

The American Health Care Act increases the amount of flexibility that States have in managing their Medicaid programs. The bill scales back the Affordable Care Act mandates that have limited a State's ability to tailor their plans to the needs of their beneficiaries. States can and should be trusted to manage the needs of their beneficiaries, and this bill allows States to do that.

Additionally, the bill before us today furthers the goal of providing the States with greater flexibility in managing their Medicaid programs by providing States with the option to implement two additional opportunities: work requirement and block grants for Medicaid.

This time around we chose to engage our State counterparts in the discussion and listen—listen—to their input as we designed this bill. At the top of their list were the desire to see the work requirement built in and the opportunity to work with Medicaid as a block grant.

We don't tell them what to do. They are given the permission to do what they feel is best for their citizens. Republicans trust the States and trust the Governors and the elected leaders in those States.

Finally, the American Health Care Act provides additional resources to bolster State safety net providers. The bill provides increases in the community health center funding, offers enhanced funding to support safety net providers in States that did not expand Medicaid, and ends the cuts to the disproportionate share hospital payments.

We are committed, Mr. Speaker, to ensuring that our local providers can continue to deliver lifesaving care. The American Health Care Act turns this commitment into action. For millions of Americans in rural and medically underserved areas, these actions will provide needed relief that was undercut by the Affordable Care Act.

Let me just say, Mr. Speaker, it has been an interesting process. We had a 27½-hour markup in the Energy and Commerce Committee. We have had over 15 or 16 hours in the Rules Committee. This bill has been almost talked to death. I want to just acknowledge that I appreciate the input of the administration. I appreciate the fact that the directive to us last night was to put our pencils down and turn our papers in. It is time, Mr. Speaker.

This is a good bill. The rule deserves our support. The underlying bill deserves our support.

Mr. MCGOVERN. Mr. Speaker, I include in the RECORD a letter from the AARP; a letter from the National Rural Health Association; a letter from the American Society of Addiction Medicine; and a letter from the American Medical Association—all strongly opposed to the Republican bill.

AARP,
March 7, 2017.

Hon. GREG WALDEN,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.
Hon. KEVIN BRADY,
Chairman, Committee on Ways and Means, House of Representatives, Washington, DC.
Hon. FRANK PALLONE,
Ranking Member, Committee on Energy and Commerce, House of Representatives, Washington, DC.
Hon. RICHARD NEAL,
Ranking Member, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR CHAIRMEN AND RANKING MEMBERS: AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to consumers and families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

We write today to express our opposition to the American Health Care Act. This bill would weaken Medicare's fiscal sustainability, dramatically increase health care costs for Americans aged 50–64, and put at risk the health care of millions of children and adults with disabilities, and poor seniors who depend on the Medicaid program for long-term services and supports and other benefits.

MEDICARE

Our members and older Americans believe that Medicare must be protected and strengthened for today's seniors and future generations. We strongly oppose any changes to current law that could result in cuts to benefits, increased costs, or reduced coverage for older Americans. According to the 2016 Medicare Trustees report, the Medicare Part A Trust Fund is solvent until 2028 (11 years longer than pre-Affordable Care Act (ACA)), due in large part to changes made in the ACA. We have serious concerns that the American Health Care Act repeals provisions in current law that have strengthened Medicare's fiscal outlook, specifically, the repeal of the additional 0.9 percent payroll tax on higher-income workers. Repealing this provision could hasten the insolvency of Medicare by up to 4 years and diminish Medicare's ability to pay for services in the future.

PRESCRIPTION DRUGS

Older Americans use prescription drugs more than any other segment of the U.S. population, typically on a chronic basis. We are pleased that the bill does not repeal the Medicare Part D coverage gap (''donut hole'') protections created under the ACA. Since the enactment of the law, more than 11.8 million Medicare beneficiaries have saved over $26.8 billion on prescription drugs. We do have strong concerns that the American Health Care Act repeals the fee on manufacturers and importers of branded prescription drugs, which currently is projected to add $25 billion to the Part B trust fund between 2017 and 2026. AARP believes Congress must do more to reduce the burden of high prescription drug costs on consumers and taxpayers and is willing to work with you on bipartisan solutions.

INDIVIDUAL PRIVATE INSURANCE MARKET

About 6.1 million older Americans age 50–64 currently purchase insurance in the non-group market, and nearly 3.2 million are currently eligible to receive subsidies for health insurance coverage through either the federal health benefits exchange or a state-based exchange (exchange). We have seen a significant reduction in the number of uninsured since passage of the ACA, with the number of 50–64 year old Americans who are uninsured dropping by half.

Affordability of both premiums and cost-sharing is critical to older Americans and their ability to obtain and access health care. A typical senior seeking coverage through an exchange has a median annual income of under $25,000 and already pays significant out-of-pocket costs for health care. We have serious concerns that the bill under consideration will dramatically increase health care costs for 50–64 year olds who purchase health care through an exchange due both to the changes in age rating from 3:1 (already a compromise that requires uninsured older Americans to pay three times more than younger individuals) to 5:1 and reductions in current subsidies for older Americans.

Age rating plus premium increases equal an unaffordable age tax. Our previous estimates on the age-rating change showed that premiums for current coverage could increase by up to $3,200 for a 64-year-old, while reducing premiums by only about $700 for a younger enrollee. Significant premium increases for older consumers will make insurance less affordable, will not address their expressed concern of rising premiums, and will only encourage a small increase in enrollment numbers for younger persons. In addition, the bill proposes to change current subsidies based on income and premium levels to a flatter tax credit. The change in structure will dramatically increase premiums for older consumers. We estimate that the bill's changes to current law's tax credits could increase premium costs for a 55-year-old earning $25,000 by more than $2,300 a year. For a 64-year-old earning $25,000 that increase rises to more than $4,400 a year, and more than $5,800 for a 64-year-old earning $15,000. When we examined the impact of both the tax credit changes and 5:1 age rating, our estimates find that, taken together, premiums for older adults could increase by as much as $3,600 for a 55-year-old earning $25,000 a year, $7,000 for a 64-year-old earning $25,000 a year and up to $8,400 for a 64-year-old earning $15,000 a year. In addition to these skyrocketing premiums, out-of-pocket costs could significantly increase under the bill with the elimination of cost sharing assistance in current law. The cost sharing assistance has provided relief on out-of-pocket costs (like deductibles and certain benefits) for low-income individuals who are some of the most financially vulnerable marketplace participants.

MEDICAID AND LONG-TERM SERVICES AND SUPPORTS

AARP opposes the provisions of the American Health Care Act that create a per capita cap financing structure in the Medicaid program. We are concerned that these provisions could endanger the health, safety, and care of millions of individuals who depend on the essential services provided through Medicaid. Medicaid is a vital safety net and intergenerational lifeline for millions of individuals, including over 17.4 million low-income seniors and children and adults with disabilities who rely on the program for critical health care and long-term services and supports (LTSS, i.e., assistance with daily

activities such as eating, bathing, dressing, managing medications, and transportation).

Of these 17.4 million individuals: 6.9 million are ages 65 and older (which equals more than 1 in every 7 elderly Medicare beneficiaries); 10.5 million are children and adults living with disabilities; and about 10.8 million are so poor or have a disability that they qualify for both Medicare and Medicaid (dual eligibles). Dual eligibles account for almost 33 percent of Medicaid spending. While they comprise a relatively small percentage of enrollees, they account for a disproportionate share of total Medicare and Medicaid spending.

Individuals with disabilities of all ages and older adults rely on critical Medicaid services, including home and community based services (HCBS) for assistance with daily activities such as eating, bathing, dressing, and home modifications; nursing home care; and other benefits such as hearing aids and eyeglasses. People with disabilities of all ages also rely on Medicaid for access to comprehensive acute health care services. For working adults, Medicaid can help them continue to work; for children, it allows them to stay with their families and receive the help they need at home or in their community. Individuals may have low incomes, face high medical costs, or already spent through their resources paying out-of-pocket for LTSS, and need these critical services. For these individuals, Medicaid is a program of last resort.

In providing a fixed amount of federal funding per person, this approach to financing would likely result in overwhelming cost shifts to states, state taxpayers, and families unable to shoulder the costs of care without sufficient federal support. This would result in cuts to program eligibility, services, or both—ultimately harming some of our nation's most vulnerable citizens. In terms of seniors, we have serious concerns about setting caps at a time when per-beneficiary spending for poor seniors is likely to increase in future years. By 2026, when Boomers start to turn age 80 and older, they will likely need much higher levels of service—including HCBS and nursing home—moving them into the highest cost group of all seniors. As this group continues to age, their level of need will increase as well as their overall costs. We are also concerned that caps will not accurately reflect the cost of care for individuals in each state, including for children and adults with disabilities and seniors, especially those living with the most severe disabling conditions.

AARP is also opposed to the repeal of the six percent enhanced federal Medicaid match for states that take up the Community First Choice (CFC) Option. CFC provides states with a financial incentive to offer HCBS to help older adults and people with disabilities live in their homes and communities where they want to be. About 90 percent of older adults want to remain in their own homes and communities for as long as possible. HCBS are also cost effective. On average, in Medicaid, the cost of HCBS per person is one-third the cost of institutional care. Taking away the enhanced match could disrupt services for older adults and people with disabilities in the states that are already providing services under CFC.

AARP has concerns with the removal of the state option in Medicaid to increase the home equity limit above the federal minimum. This takes away flexibility for states to adjust a Medicaid eligibility criterion based on the specific circumstances of each state and its residents beyond a federal minimum standard.

Although we cannot support the American Health Care Act, we are pleased that the bill does not repeal some of the critical consumer protections included in the Affordable Care Act, such as guaranteed issue, prohibitions on preexisting condition exclusions, bans on annual and lifetime coverage limits and allowing families to keep children on their policies until the age of 26. Also, AARP does support restoring the 7.5 percent threshold for the medical expense deduction which will directly help older Americans struggling to pay for health care, particularly the high cost of nursing homes and other long-term services and supports.

We look forward to working with you to ensure that we maintain a strong health care system that ensures robust insurance market protections, controls costs, improves quality, and provides affordable coverage to all Americans.

Sincerely,

JOYCE A. ROGERS,
Senior Vice President,
Government Affairs.

VOTE NO TO THE AMERICAN HEALTH CARE ACT

The National Rural Health Association urges a NO vote on the American Health Care Act (AHCA).

Rural Americans are older, poorer and sicker than other populations. In fact, a January 2017 CDC report pronounced that life expectancies for rural Americans have declined and the top five chronic diseases are worse in rural America. The AHCA does nothing to improve the health care crisis in rural America, and will lead to poorer rural health outcomes, more uninsured and an increase in the rural hospital closure crisis.

Though some provisions in the modified AHCA bill will improve the base bill, including increased tax credits for Americans between the ages of 50 and 64 who would have seen their premiums skyrocket under the current plan, the National Rural Health Association is concerned that the bill still falls woefully short in improving access and affordability of health care for rural Americans. Additionally, the new amendments to freeze Medicaid expansion enrollment as of Jan. 1, 2018, and reduce the Medicaid per-capita growth rate will disproportionately harm rural America.

The AHCA will hurt vulnerable populations in rural Americans, leaving millions of the sickest, most underserved populations in our nation without coverage, and further escalating the rural hospital closure crisis. According to the Wall Street Journal, the ''GOP health plan would hit rural areas hard . . . Poor, older Americans would see the largest increase in insurance-coverage costs.'' The LA Times reports ''Americans who swept President Trump to victory—lower-income, older voters in conservative, rural parts of the country—stand to lose the most in federal healthcare aid under a Republican plan to repeal and replace the Affordable Care Act.''

Let's be clear—many provisions in the ACA failed rural America. The lack of plan competition in rural markets, exorbitant premiums, deductibles and co-pays, the co-op collapses, lack of Medicaid expansion, and devastating Medicare cuts to rural providers—all collided to create a health care crisis in rural America. However, it's beyond frustrating that an opportunity to fix these problems is squandered, and instead, a greater health care crisis will be created in rural America.

Congress has long recognized the importance of the rural health care safety net and has steadfastly worked to protect it. And now, much of the protections created to maintain access to care for the 62 million who live in rural America are in jeopardy. We implore Congress to continue its fight to protect rural patients' access to care. Three improvements are critical for rural patients and providers:

1. Medicaid—Though most rural residents are in non-expansion states, a higher proportion of rural residents are covered by Medicaid (21% vs. 16%).

Congress and the states have long recognized that rural is different and thus requires different programs to succeed. Rural payment programs for hospitals and providers are not 'bonus' payments, but rather alternative, cost-effective and targeted payment formulas that maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country. Any federal health care reform must protect a state's ability to protect its rural safety net providers. The federal government must not abdicate its moral, legal, and financial responsibilities to rural, Medicaid eligible populations by ensuring access to care.

Any federal health care reform proposal must protect access to care in Rural America, and must provide an option to a state to receive an enhanced reimbursement included in a matching rate or a per capita cap, specifically targeted to create stability among rural providers to maintain access to care for rural communities. Enhancements must be equivalent to the cost of providing care for rural safety net providers, a safeguard that ensures the enhanced reimbursement is provided to the safety net provider to allow for continued access to care. Rural safety net providers include, but not limited to, Critical Access Hospitals, Rural Prospective Payment Hospitals, Rural Health Clinics, Indian Health Service providers, and individual rural providers.

2. Market Reform—Forty-one percent of rural marketplace enrollees have only a single option of insurer, representing 70 percent of counties that have only one option. This lack of competition in the marketplace means higher premiums. Rural residents average per month cost exceeds urban ($569.34 for small town rural vs. $415.85 for metropolitan).

Rural Americans are more likely to have obesity, diabetes, cancer, and traumatic injury; they are more likely to participate in high risk health behaviors including smoking, poor diet, physical inactivity, and substance abuse. Rural Americans are more likely to be uninsured or underinsured and less likely to receive employer sponsored health insurance. Rural communities have fewer health care providers for insurers to contract with to provide an adequate network to serve the community.

Any federal health care reform proposal must address the fact that insurance providers are withdrawing from rural markets. Despite record profit levels, insurance companies are permitted to cherry pick profitable markets for participation and are currently not obliged to provide service to markets with less advantageous risk pools. Demographic realities of the rural population make the market less profitable, and thus less desirable for an insurance company with no incentive to take on such exposure. In the same way that financial service institutions are required to provide services to underserved neighborhoods, profitable insurance companies should be required to provide services in underserved communities.

3. Stop Bad Debt Cuts to Rural Hospitals—Rural hospitals serve more Medicare patients (46% rural vs. 40.9% urban), thus across-the-board Medicare cuts do not have across the board impacts. A goal of the ACA was to have hospital bad debt decrease significantly. However, because of unaffordable health plans in rural areas, rural patients still cannot afford health care. Bad debt among rural hospitals has actually increased

50% since the ACA was passed. According to MedPAC ''Average Medicare margins are negative, and under current law they are expected to decline in 2016'' has led to 7% gains in median profit margins for urban providers while rural providers have experienced a median loss of 6%.

If Congress does not act, all the decades of efforts to protect rural patients' access to care, could rapidly be undone. The National Rural Health Association implores Congress to act now to protect rural health care across the nation.

AMERICAN SOCIETY OF ADDICTION MEDICINE,
Rockville, MD, March 8, 2017.

Hon. KEVIN BRADY,
Chairman, Committee on Ways and Means, House of Representatives, Washington, DC.
Hon. RICHARD NEAL,
Ranking Member, Committee on Ways and Means, House of Representatives, Washington, DC.
Hon. GREG WALDEN,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.
Hon. FRANK PALLONE,
Ranking Member, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR CHAIRMAN BRADY, CHAIRMAN WALDEN, RANKING MEMBER NEAL AND RANKING MEMBER PALLONE: On behalf of the American Society of Addiction Medicine (ASAM), the nation's oldest and largest medical specialty society representing more than 4,300 physicians and allied health professionals who specialize in the treatment of addiction, I am writing to share our views on the American Health Care Act (AHCA) that is being considered by the Ways and Means and Energy and Commerce committees.

ASAM is very concerned that the AHCA's proposed changes to our health care system will result in reductions in health care coverage, particularly for vulnerable populations including those suffering from the chronic disease of addiction, and we cannot support the bill in its current form.

More than 20 million Americans currently have health care coverage due to the Affordable Care Act (ACA), including millions of Americans with addiction. This coverage is a critical lifeline for persons with addiction, many of whom were unable to access effective treatment before the ACA's expansion of Medicaid eligibility to low-income adults, and its requirement that Medicaid expansion plans and plans sold in the individual and small group market provide essential health benefits (EHB) including addiction treatment services at parity with medical and surgical services.

We are concerned that rolling back the Medicaid expansion, sunsetting the EHB requirements for Medicaid expansion plans, and capping federal support for Medicaid beneficiaries will reduce coverage for and access to addiction treatment services, changes that will be particularly painful in the midst of the ongoing opioid epidemic. Moreover, while the AHCA retains the EHB requirements for private plans, it repeals the ACA's actuarial value requirements for those plans. We are concerned that this could result in insurers offering addiction treatment benefits in name only due to higher costs and/or less robust benefits.

The Medicaid expansion in particular has led to significant increases in coverage and treatment access for persons with addiction. In states that expanded Medicaid, the share of people with addiction or mental illness who were hospitalized but uninsured fell from about 20 percent in 2013 to 5 percent by mid-2015 and Medicaid expansion has been associated with an 18.3 percent reduction in unmet need for addiction treatment services among low-income adults. Rolling back the Medicaid expansion and fundamentally changing Medicaid's financing structure to cap spending on health care services will certainly reduce access to evidence-based addiction treatment and reverse much or all progress made on the opioid crisis last year.

To be sure, ASAM supports flexibility in the Medicaid program and has supported several states' applications for 1115 waivers to transform their addiction treatment systems to offer all levels of care described by The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. However, ASAM has seen for decades how states underfund addiction treatment services and waste federal dollars on inefficient and ineffective care when they are left to decide how to manage their federal Medicaid dollars without mandates for parity and accountability to cover appropriate care. Based on this experience, we commended the Congress for requiring accountability for the $1 billion in funding sent to the states to combat the opioid epidemic authorized by 21st Century Cures. This funding is an additional lifeline to suffering communities, but it will come to an end while patients will continue to need treatment for the chronic disease of addiction. When it does, the Medicaid program must continue to fund appropriate addiction treatment at parity with medical and surgical services.

ASAM has long advocated for broad access to high-quality, evidence-based, individualized and compassionate treatment services for persons suffering from the chronic disease of addiction. The critical need for access to this type of care has been heightened and highlighted by our nation's ongoing epidemic of opioid addiction and related overdose deaths. The ACA's Medicaid expansion, EHB requirements for addiction treatment coverage, and extension of parity protections to the individual and small group market have surely reduced the burden of this epidemic and saved lives. As you consider this legislation, we hope that parity protections will continue to apply individual, small and large group plans as well as Medicaid plans through the transition. Finally, throughout this process, we implore you to keep in mind how your decisions will affect the millions of Americans suffering from addiction who may lose their health care coverage entirely or see reductions in benefits that impede access to needed treatment.

Sincerely,

R. JEFFREY GOLDSMITH, MD, DLFAPA, DFASAM,
President, American Society of Addiction Medicine.

AMERICAN MEDICAL ASSOCIATION,
Chicago, IL, March 22, 2017.

Hon. PAUL RYAN,
Speaker, House of Representatives, Washington, DC.
Hon. NANCY PELOSI,
Democratic Leader, House of Representatives, Washington, DC.

DEAR SPEAKER RYAN AND LEADER PELOSI: Due to projections that enactment of the American Health Care Act (AHCA) will result in millions of Americans losing health insurance coverage, the American Medical Association (AMA) must express our opposition to the proposal currently before the House of Representatives. The need to stabilize the individual insurance market and make other improvements in the Affordable Care Act is well understood. However, as physicians, we also know that individuals who lack health insurance coverage live sicker and die younger than those with adequate coverage. We encourage all members of Congress to engage in an inclusive and thorough dialogue on appropriate remedies. We cannot, however, support legislation that would leave health insurance coverage further out of reach for millions of Americans.

Earlier this year, we shared with Congress key health reform objectives that we believe are critical to improving the health of the nation. Among these objectives are ensuring that those currently covered do not lose their coverage, maintaining market reforms, stabilizing and strengthening the individual insurance market, ensuring that low and moderate-income patients are able to secure affordable and adequate coverage, and ensuring that Medicaid and other critical safety net programs are maintained and adequately funded. While we appreciate that the bill's authors have made efforts to maintain some market reforms and that regulatory efforts are underway to strengthen the individual insurance market, as a whole the legislation falls short of the principles we previously outlined.

Health insurance coverage is critically important. Without it, millions of American families could be just one serious illness or accident away from losing their home, business, or life savings. The AMA has long supported the availability of advanceable and refundable tax credits, inversely related to income, as a means to assist individuals and families to purchase health insurance. The credits proposed under the AHCA are significantly less generous for those with the greatest need than provided under current law. The reduced purchasing power with the AHCA tax credits will put insurance coverage out of reach for millions of Americans.

We also remain deeply concerned with the reduction of federal support for the Medicaid program and the resulting significant loss of coverage. Medicaid expansion has provided access to critical services, including mental health and substance abuse treatment, for millions. Not only will the AHCA force many states to roll back coverage to these millions of previously ineligible individuals, but the significant reduction in federal support for the program will inevitably have serious implications for all Medicaid beneficiaries, including the elderly, disabled, children, and pregnant women, as well.

We also continue to be concerned about provisions that eliminate important investments in public health, and those that inappropriately insert the federal government into personal decisions about where Americans are allowed to access covered health care services.

We continue to stand ready to work with Congress on proposals that will increase the number of Americans with quality, affordable health insurance coverage but for the reasons cited above, urge members to oppose the American Health Care Act.

Sincerely,

JAMES L. MADARA, MD.

Mr. MCGOVERN. Mr. Speaker, I just want to say to my colleague from Texas, he said this bill was talked to death. It was talked to death by politicians. There were no hearings on this bill, so no experts came to testify, and none of these people who are now writing to us in opposition had the opportunity to be able to come before us and tell us how awful this bill is.

Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. HASTINGS), a distinguished member of the Rules Committee.

Mr. HASTINGS. Mr. Speaker, today is a sad day for this institution.

Why are we here? Well, after 13 hours at the Rules Committee on Wednesday,

did we report to the floor the Republicans' replacement to the Affordable Care Act? No.

And why not? Because the legislation was not extreme enough. It didn't hurt enough people. It didn't make enough people uninsured. It didn't give a large enough tax break to the wealthiest among us.

That 13-hour exercise yielded nothing except to reveal the callous depths of the Republican Party's attempt to deprive health care from 24 million people.

So after my friends on the other side of the aisle added yet another manager's amendment, bringing the total to five, and after stripping away essential health benefits, we are here this morning to push this extreme, dangerous, and callous bill under martial law.

But why are we really here? Is this bill actually about improving health care in this country? By my estimation, and by the analysis of virtually every healthcare group—Mr. MCGOVERN has introduced some of them: hospitals, medical organizations, and the nonpartisan Congressional Budget Office—the answer is a flat-out, resounding no.

Premiums are going to rise. Millions upon millions of people will lose health coverage. Essential benefits will be stripped away, and 400 of the wealthiest Americans will get a substantial tax cut, while Medicaid is being cut by $880 billion.

Mr. Speaker, during that 13-hour marathon meeting that yielded nothing but a rule allowing Republicans to continue to ram this measure through Congress, I quoted from Scripture, from the King James Bible, Matthew 25:45. It says:

> Then shall He answer them, saying, Verily, I say unto you, inasmuch as you did it not to one of the least of these, you did it not to me.

My friends on the other side of the aisle often cite Scripture in their legislative motivations. I ask them now: How does cutting the benefits from the least among us, while showering more wealth upon the wealthiest among us, square with these teachings?

In addition, Mr. Speaker, I noted to them that we hear from them all the time about liberty. So I noted that, in the Preamble to the Constitution, the document that guides our great Nation and that we all swear an oath to uphold, that we are entrusted to also, and I quote from the Preamble, ''promote the general welfare.'' I also note for you that this charge is placed before the first mention of the word ''liberty.''

Does stripping away of essential health benefits, which include maternity and newborn care, pediatric services, and emergency services, promote the general welfare?

Does cutting $880 billion from Medicaid promote the general welfare?

Does ensuring that, by 2026, 56 million people under the age of 64 will be left without coverage promote general welfare?

Finally, Mr. Speaker, in the debate at committee on this shameful bill, I answered the Republican charge that this bill was about freedom when I quoted a verse from Janis Joplin's ''Me and Bobby McGee.'' What she was saying is: ''Freedom's just another word for nothin' left to lose.''

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. MCGOVERN. Mr. Speaker, I yield an additional 30 seconds to the gentleman from Florida.

Mr. HASTINGS. Mr. Speaker, if this extreme bill becomes law, a bill which has been rushed through Congress, amended without care, brought before us without hearings, without a CBO score, without thoughtful consideration, without a Democratic amendment being approved, and without a clue, I fear—indeed, I know—that the American people will find themselves with nothing left to lose when it comes to their and their family's health care, which is the most perverse and wretched kind of freedom as you may have ever seen.

Mr. SESSIONS. Mr. Speaker, I yield myself such time as I may consume, and I thank the gentleman from Florida very much. In fact, the gentleman is correct. We had an opportunity to quote the Bible, Janis Joplin, and ZZ Top when we were doing our hearings. We had so much time with each other, and I enjoyed the hours and hours that we had to debate these essential items.

But the other side of the story is essential health benefits are not being done away with. They are being transferred entirely to States. States have asked for the ability to manage their own money, and manage their own people's benefits of what would be required in the States. So in no way should a person take away, well, we just did away with it. In fact, we transferred the authority and the responsibility of essential health benefits to the States because Governors have been asking for this.

Mr. Speaker, I want to take just a moment to explain what I believe is at the heart of the legislation and really, in reality, the key to fixing health care. It is the second part of this.

We heard the gentleman from Lewisville, Texas, Dr. BURGESS, speak about the Energy and Commerce portions. I now would like to take a minute to talk about the portions that come directly out of the Ways and Means Committee.

The gentleman, Mr. BRADY, from The Woodlands, Texas, today, spoke about many of these; but at the heart of it, 170 million Americans currently receive their health care through an employee-employer tax advantage or tax benefits, an untaxed benefit whereby people who have an employer who can provide their health care, it is not taxed—pretaxed to the employee, allowing them to have a good healthcare system. Well, all the while, millions of Americans pay higher premiums out of their pockets in the individual market. Those are people that do not have an employer who is able to help them. So that is not fair. That does not help these people.

What we are doing here is putting together an addition of, really, a great Republican idea; and it takes the important step to provide the same tax-free benefits for those employer-sponsored plans that we will give to regular employees, and it is called a tax credit. This tax credit is going to work because it allows every single American that does not receive the tax benefit at work to get it for themselves.

Who is this? Well, quite honestly, it is small-business owners; it is low-income workers; it is entrepreneurs. It includes, really, a lot of real estate agents and people that work for a small business, maybe heating and air-conditioning systems like we have all across this country. It will give their families an opportunity.

How much money? Well, we will provide them between $2,000 and $14,000 a year for their families to be able to have these opportunities to purchase a nongovernment healthcare plan, meaning that, as they would go to the marketplace, we are going to help these people through a tax credit available January 1, providing them with an opportunity to purchase health care on a benefit basis.

Why is this important? It saves money because what it does, it creates two things: a family then has an insurance plan, including a healthcare component that goes to the hospitalization; and secondly, it gives them an opportunity to have their own doctor or healthcare plan that they choose. This is important because many of these people end up in the hospital in the most expensive kind of way we can provide health care: at the emergency room.

So this gives these families parity in the marketplace. We believe that that is important and is another part of this Republican healthcare plan.

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

Mr. MCGOVERN. Mr. Speaker, I hear my friend talking about what came out of the Ways and Means Committee. I will tell you what came out of Ways and Means Committee: a $1 trillion tax cut for the wealthy.

Mr. Speaker, I yield 2 minutes to the gentleman from Colorado (Mr. POLIS), a distinguished member of the Rules Committee.

Mr. POLIS. Mr. Speaker, look, first of all, this rather outrageous Republican healthcare bill still will cost 24 million Americans their healthcare insurance; and if you are lucky enough not to be one of those 24 million Americans, the nonpartisan Congressional Budget Office, the head of which was appointed by a Republican, says it will also increase the cost by 15 or 20 percent for those who are lucky enough to keep their insurance.

In addition to that, it has a crushing age tax that forces people aged 50 to 64 to pay premiums five times higher than what other Americans pay for health care.

As if that age tax wasn't enough, in this new amendment, which most of us only saw for the first time at 6:30 this morning, they increased the Medicare tax for another 5 years by 1 percent, so Americans will have to pay even more in taxes.

The last manager's amendment, which we just got the information on, actually would increase the deficit by over $150 billion more than their original bill, somehow without covering even one additional American.

□ 0945

So what is going on here?

They are creating a bill that has more taxes with this manager's amendment, creating a bill that costs the American people more and reduces the deficit more, and then pawns off the hard decisions to the States, without giving them enough to maintain the essential benefits that Americans rely on, like prescription drugs, rehabilitative care, and mental health services.

They are not giving the States enough money to maintain those. And then they are saying: But you, States, be the bad guys and you guys make the cut so we in Washington can pat ourselves on the back and look good, even while we increase the deficit by more than $150 billion more than the original healthcare bill that was introduced last week and even though we maintain the age tax that forces people between the age of 50 and 64 to pay up to five times more than other Americans.

This is simply the wrong way to go. Sometimes you need to reboot, restart, get together, look at real ideas that Democrats and Republicans have put on the table to reduce costs and expand coverage. That is what this discussion should be about. Yet, to do that, we need to defeat this rule now and go back to the starting point.

Mr. SESSIONS. Mr. Speaker, I yield 2 minutes to the gentleman from Alabama (Mr. BYRNE), a distinguished member of the Rules Committee.

Mr. BYRNE. Mr. Speaker, 7 years ago yesterday, the Affordable Care Act, or ObamaCare, became law. Since then, this law has resulted in canceled plans, higher premiums, fewer choices, increased deductibles, and less freedom for the American people.

Don't just take my word for it. Former Democratic President Bill Clinton said this about ObamaCare:

'' . . . the people who are out there busting it, sometimes 60 hours a week, wind up with their premiums doubled and their coverage cut in half, and it's the craziest thing in the world.''

I tend to agree with President Clinton on this. ObamaCare is crazy. But for far too many Americans, it is the crazy reality they face every day.

So today is about a rescue mission. Today is about bringing relief to the families who are struggling under this failed law. Today it is about passing the American Health Care Act.

ObamaCare is on a collision course with disaster. If Congress were to sit back and do nothing, ObamaCare would implode. This would leave millions of Americans with no insurance and the overall insurance market in a dangerous condition for the rest of us. So Congress must act.

That is where the American Health Care Act comes into play. This bill repeals ObamaCare along with its costly taxes and burdensome mandates. By doing this, we can lower premiums for hardworking Americans.

Most importantly, this bill gives Americans the freedoms, choices, and control they desperately want and deserve.

So, Mr. Speaker, the vote today is for the family in Monroeville who can't afford their premiums. The vote is for the small-business owner in Daphne who had his plan canceled. The vote is for the mother in Mobile whose deductible is too high. The vote is for the people in southwest Alabama and across all of America who are struggling under ObamaCare.

This is our chance. This is the bill. We have got to get this done.

Mr. MCGOVERN. Mr. Speaker, I would respond to the gentleman from Alabama with the words of another Alabama Member, Congressman MO BROOKS, who this morning said:

This is one of the worst bills I've seen in my 30 years in Congress.

Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. KILDEE).

Mr. KILDEE. Mr. Speaker, today is the day. In hearing my friends on the other side of the aisle describe their efforts to improve health care, I just wonder if we have the right bill on the floor. Because looking at all the external analysis—the CBO, which I know you want to discount, but there are many other organizations—what do they say about this legislation?

It is a terrible bill. It increases costs that Americans will bear. Despite the fact that we hear about decreasing premiums, all the reports say that this will increase premiums and increase out-of-pocket costs that Americans will have to put out in order to protect themselves from disease.

It will provide less coverage. Twenty-four million Americans will lose coverage. But even for those who might be able to have health insurance without essential benefits assured, that will just be a health insurance card, but not access to an emergency room, not access to maternal care, not access to prescription drugs, not access to hospitalization. Basically you will be able to get diagnosed, but you won't get health care.

This is a terrible bill. We ought to reject it today.

Mr. SESSIONS. Mr. Speaker, I yield 5 minutes to the gentleman from Georgia (Mr. WOODALL), who will be describing the third piece of this, and that is the putting together of the piece from the Budget Committee.

Mr. WOODALL. Mr. Speaker, I appreciate all the hard work the Rules Committee chairman has done in this bill. Mr. Speaker, I have the great pleasure of serving on the Rules Committee, but I am the designee to the Budget Committee.

This whole process that we are going through is a Budget Committee process. It is called reconciliation. And as folks have talked about it, they have talked about what the Ways and Means Committee has done and what the Energy and Commerce Committee did. But then those two bills come together in the Budget Committee, and we move the process forward.

I can't help but notice my colleagues' frustration with the amendments that have been made to this bill along the way. Generally, we celebrate amendments that are made along the way because they improve the work product. We do them together.

I point here, Mr. Speaker, to a tweet that the President sent out the day the healthcare bill was introduced. The President said:

''Our wonderful new HealthCare Bill is now out for review and negotiation.''

And that was true. It was out for review so everyone could read it, and it was out for negotiation so that everyone could improve it.

We did that in the Budget Committee. We had four motions to instruct that passed in the Budget Committee to provide Medicaid flexibility, to make sure the tax credits were targeted to the right populations, to ensure that able-bodied, working Americans had those incentives to both get health care and be able to go back to work.

Now, every committee didn't have that experience. As my colleagues have asked for a bipartisan process, you will remember that the Energy and Commerce Committee spent 10 hours debating the title of the bill. They spent 10 hours debating Democratic amendments to change the title of the bill. Folks, we have opportunity after opportunity to make things better, but it is incumbent upon us to choose that opportunity to make things better.

So often we get wrapped around the partisan action. Folks let that opportunity slip away. I am glad that we didn't do that.

Mr. Speaker, when I talk about what we did in the Budget Committee to make it better, I am talking about focusing on the real problems. There is not a member in this body that doesn't understand that what is contributing to the ObamaCare death spiral is that young people are not enrolling. Young people are not enrolling.

More Americans rejected ObamaCare and filed for an exemption or agreed to pay the penalty than enrolled in ObamaCare. I don't care how big your heart was when you passed the bill, you have to concede that wasn't what you intended. And we can do better.

My friends are talking about the essential health benefits plan today. Young people are particularly sensitive to that. They are price sensitive in that way. We are talking in the Budget Committee about how to preserve that flexibility for States to design plans that are right for them.

How many times today have we heard folks say that prices are going to increase for Americans between the age of 54 and 64?

I have heard it at least a dozen times. At the same time, my friends are demanding that every healthcare plan in the State of Georgia cover maternity benefits for those women between the age of 54 and 64. At the same time, my friends are demanding that every plan in Georgia cover pediatric benefits for those empty nesters between 54 and 64. That doesn't make sense. It doesn't make sense. We in Georgia know it doesn't make sense, and we can do better.

Mr. Speaker, 45 percent of the almost 20 million people who rejected the Affordable Care Act and agreed to pay the fine or file an exemption instead were under the age of 35. There is not a serious thinker in this room who believes we can solve the insurance crisis in this country without getting these folks back into the marketplace. And that is what we did in the Budget Committee. That is what we have done throughout this entire amendment process, and that is what the amendments we considered in the Rules Committee this morning did as well.

Mr. Speaker, since the passage of the Affordable Care Act, many States have had to pass a lot of legislation in order to conform their plans to new one-size-fits-all Federal mandates. But that is not the story. The story is that, at the same time, States were passing their own benefit mandates to serve their constituency better.

Mr. Speaker, Chairman SESSION's State of Texas passed a mandate that orally administered anticancer medication be covered. The gentleman from Texas has seen those groups in his office. He has seen those families struggling. And what Texas said is: To respond to our people, we are going to require every plan sold in the State of Texas cover these issues.

In my home State, Mr. Speaker, we created a commission to look at annually how to add more benefits, change those benefits, make sure we are being responsive to folks in the best way that we can.

The gentleman from Colorado, his State did the very same thing. They required coverage for acupuncture services. They required the selling of child-only plans. They required coverage for fetal alcohol syndrome. We do these things collaboratively, and we do these things together.

Mr. Speaker, I urge passage of the rule and passage of the underlying legislation.

Mr. MCGOVERN. Mr. Speaker, I notice the gentleman from Georgia relied on a tweet from Donald Trump for his facts in explaining the bill. I might suggest a more scholarly source, maybe, like, beginning with the Congressional Budget Office, which says that 24 million people will lose their health coverage as a result of the bill.

I will also point to the Quinnipiac poll that says only 17 percent of the American people approve of what my Republicans friends are doing. Seventeen percent is lower than Trump's rating. That is quite an accomplishment.

Mr. Speaker, I yield 1 minute to the gentlewoman from California (Mrs. DAVIS).

Mrs. DAVIS of California. Mr. Speaker, it has been hard keeping up with all the changes over the last 24 hours. This process has been far from transparent.

The CBO released a revised score last night that said that the changes made to appease the Freedom Caucus will cost about $200 billion more without doing or adding anything to increase coverage.

So how is that possible?

The latest edition to this healthcare disaster, the elimination of minimum essential benefits, is something that I want to focus on very briefly.

This change hits women especially hard. Insurance companies will no longer have to cover maternity care, provide direct access to an OB/GYN, or cover preventative services like cancer screening or birth control.

Mr. Speaker, do we call this a mommy tax? Is this a mommy tax to finance a millionaire tax cut?

I don't know.

Earlier this week, I gave my colleagues the opportunity to demonstrate their commitment to women's health in a related bill, and, Mr. Speaker, they didn't even allow a vote. I hear my colleagues claiming that these changes are about choice. Forcing women to pay more for the care they need is a choice I think we could do without.

Mr. Speaker, I urge opposition to this healthcare disaster.

Mr. SESSIONS. Mr. Speaker, I yield 2 minutes to the gentleman from Oklahoma (Mr. COLE), the vice chairman of the Rules Committee.

Mr. COLE. Mr. Speaker, I thank the gentleman from Texas for his remarkable leadership in this important debate.

Seven years ago, I was on this floor and I heard that, if you liked your plan, you could keep it. I heard, if you liked your doctor, you could keep that doctor. And I heard that healthcare costs were going to drop by $2,500 per family. None of it was true.

I sit here now and look at my State, and I know what is happening next year. The rates on the ObamaCare exchanges are going up by 69 percent. We are down to a single provider. That is what 7 years ago brought us.

Today we have a chance to do something different, and everybody from my State will do something different. They will vote for a plan that actually does what it says it is going to do. Number one, they will be able to actually have plans that are designed by Oklahomans, not by bureaucrats in Washington, D.C. They will be able to have a tax credit, if they are not already insured under Medicaid or Medicare or from their employer. They will be able to have an individual tax credit to purchase a plan that they design, that they like. They will be free of the mandates of ObamaCare, free to make their own decisions, free of the mandates that require them to buy insurance products that they simply don't need.

I have got a lot of people in my district that are in their fifties and sixties. Some of them might like to have children again, but they are not likely to have children again, and they mostly don't want maternity care.

So it is a pretty simple choice for us. It is a choice to be free and make our own decisions. It is a choice to design our own plans. It is a choice to have Federal assistance where we need it, but to be used under our direction. It is an easy choice.

I urge the passage of this rule, and I urge the passage of the underlying legislation.

□ 1000

Mr. MCGOVERN. Mr. Speaker, I include in the RECORD a statement from NETWORK, the lobby for Catholic Social Justice; a letter from the National Alliance on Mental Illness; a letter from the Mental Health Liaison Group; and an article in the New York Times entitled ''Late GOP Proposal Could Mean Plans That Cover Aromatherapy but Not Chemotherapy.''

DEAR REPRESENTATIVE: NETWORK Lobby for Catholic Social Justice urges you to vote NO on the American Health Care Act (AHCA). This legislation fails to protect access to quality, affordable healthcare for vulnerable communities. It would widen the gaps in our society by making massive cuts to Medicaid, giving large tax breaks to the very wealthiest families and corporations, and threatening the health security of American families.

Our faith teaches that access to healthcare is an essential human right that is necessary to protect the life and dignity of every person. The bill would drastically increase the number of people without health insurance—and I know that behind those numbers are millions of stories of families facing medical bankruptcy, forgoing treatment, and losing loved ones who could have been saved by preventative care.

The AHCA cuts Medicaid spending—an essential source of care for millions of children, seniors, people with disabilities, and people experiencing poverty in our nation—and a per-capita cap would force states to ration care. The legislation would also increase costs for older and sicker patients and burden low- and moderate-income families with much higher premiums by cutting $312 billion of financial assistance for people purchasing health insurance on the individual market. This is far from the Gospel mandate to care for our most vulnerable sisters and brothers.

For any replacement to the ACA to be sufficient, it must meet these 10 conditions—a Ten Commandments of Healthcare if you will—and the AHCA breaks nine of 10 commandments:

1. Thou shalt provide affordable insurance and the same benefits to all currently covered under the Affordable Care Act. AHCA fails.

2. Thou shalt continue to allow children under the age of 26 to be covered by their parents' insurance.

3. Thou shalt ensure that insurance premiums and cost sharing are truly affordable to all. AHCA fails.

4. Thou shalt expand Medicaid to better serve vulnerable people in our nation. AHCA fails.

5. Thou shalt not undercut the structure or undermine the purpose of Medicaid, Children's Health Insurance Program (CHIP), and Medicare funding. AHCA fails.

6. Thou shalt create effective mechanisms of accountability for insurance companies and not allow them to have annual or lifetime caps on expenditures. AHCA partial fail.

7. Thou shalt not allow insurance companies to discriminate against those with preexisting conditions. AHCA partial fail.

8. Thou shalt not allow insurance companies to discriminate against women, the elderly, and people in poverty. AHCA fails.

9. Thou shalt provide adequate assistance for people enrolling and using their health coverage. AHCA fails.

10. Thou shalt continue to ensure reasonable revenue is in the federal budget to pay for life-sustaining healthcare for all. AHCA fails.

At its heart, this bill has lost sight of community and the common good. Its biggest problem is that it lacks the awareness that it is community which makes healthcare effective. Healthcare is not just about the individual—it is a communal good. The hyper individualism evident in the AHCA is sucking the life out of our nation. Just focusing on one's individual self is contrary to our Catholic faith and contrary to our Constitution. We will track the vote and score it in our 2017 voting record.

This dangerous legislation is not the faithful way forward and must be rejected. Stand by Gospel principles and vote NO on the AHCA.

Sincerely,

SR. SIMONE CAMPBELL, SSS,
Executive Director, NETWORK Lobby for Catholic Social Justice.

NATIONAL ALLIANCE ON MENTAL ILLNESS,
Arlington, VA, March 8, 2017.

Re The American Health Care Act.

Hon. GREG WALDEN,
Chairman, House Energy and Commerce Committee, House of Representatives, Washington, DC.

Hon. FRANK PALLONE,
Ranking Member, House Energy and Commerce Committee, House of Representatives, Washington, DC.

DEAR CHAIRMAN WALDEN AND RANKING MEMBER PALLONE: NAMI is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. On behalf of our nonprofit, nonpartisan organization, I am writing to express our views on the American Health Care Act (AHCA), which seeks to repeal and replace the Affordable Care Act (ACA).

The mental health crisis in our nation is well documented. Half of all Americans with mental illness go without treatment. Last year, Congress passed significant bipartisan legislation to address the crisis in our nation's mental health system. However, addressing the mental health needs in our country relies on a foundation of affordable, quality health coverage with fair and equal coverage of mental health and substance use conditions. Thus, the importance of Medicaid and insurance safeguards for individuals living with mental illness cannot be overstated. Unfortunately, the proposed reforms in the AHCA threaten to undermine the historic progress being made to improve mental health and substance use care.

RESTRUCTURING MEDICAID THREATENS MENTAL HEALTH CARE

Medicaid is the single largest payer of mental health and substance use services in the United States. Medicaid is also the largest funding source for the country's public mental health system. One in five of Medicaid's nearly 70 million beneficiaries have a mental health or substance use disorder diagnosis.

NAMI is deeply concerned with proposed provisions to convert Medicaid financing into a per capita cap model. This would limit federal funding to a lump sum for all enrollees and, instead of providing more flexibility, would shift financial risk for health care costs—including unexpected costs, such as promising new innovations in treatment—to states. Current estimates are that the per capita cap provisions would shift an alarming $370 billion in Medicaid costs to states over the next ten years. In the face of budget shortfalls, states will be forced to cut people from coverage, reduce health benefits and access to care, and/or reduce already low provider payments, escalating our nation's healthcare workforce crisis.

The AHCA would set per capita caps for Medicaid at current funding levels, adjusted for medical inflation. Funding for mental health and substance use services is already inadequate in Medicaid programs and, under this model, could not be improved without cutting other health care. Further, the deep reductions in federal Medicaid funding would mean that people with mental illness will face even more desperate circumstances when trying to access critical mental health care.

FREEZING MEDICAID EXPANSION PUTS LIVES AT RISK

Nearly 1 out of 3 people covered by Medicaid expansion lives with a mental health or substance use condition. Medicaid expansion has proven to be a lifeline that helps people with mental illness who typically fall through the cracks. Medicaid expansion provides coverage to people with mental health conditions who are too sick to navigate the traditional Medicaid application process, who are just stable enough not to qualify for disability (often because they are coming out of a psychiatric hospital), or who have first symptoms of a serious mental illness.

NAMI strongly urges the Committee to take further steps to preserve enrollment in Medicaid expansion, rather than the proposed end to new enrollment in 2020. Expanded eligibility has brought mental health treatment and the hope of recovery to millions affected by mental illness. It is helping keep people healthier and productive in their communities. Congress should not abandon this important means of improving coverage for and access to critical mental health treatment.

NAMI also urges the Committee to reject provisions in the AHCA that would lock enrollees out of Medicaid expansion should they experience a lapse of coverage of more than one month. This is a high price to pay for forgetting to pay a premium while in the hospital or experiencing severe symptoms of mental illness. Denying coverage only serves to further de-stabilize lives with costly consequences for individuals, families and communities.

Finally, NAMI is very concerned that the AHCA removes the requirement for Medicaid expansion plans to cover essential health benefits, including mental health and substance use treatment. Congress' significant commitment to mental health and substance use services in recent legislation should not be jeopardized by making these vital services optional in Medicaid. Our country can ill afford to weaken coverage at a time when the need for mental health and substance use treatment is so high.

CONTINUING INSURANCE SUBSIDIES AND PROTECTIONS

To help Americans afford quality health insurance, NAMI strongly urges the Committee to continue current levels of federal support, tied to income, to purchase health care coverage. Without assistance tied to income, more people with mental illness will be unable to afford coverage for mental health care. This threatens their overall health, resulting in more costly and difficult-to-treat conditions and denying people the chance to reach and maintain recovery and a stable life in the community.

NAMI appreciates that the Committee included essential insurance safeguards in the AHCA. These safeguards include protecting Americans from losing or being denied coverage because of pre-existing health conditions. This also includes continuing to allow young adults to remain on their parent's health insurance plans to age 26 and banning annual and lifetime caps for insurance coverage.

Cutting corners in health coverage will keep people from getting the treatment they need and will push people with mental illness into costly emergency rooms, hospitals and jails. Making the investment early in affordable, quality mental health care promotes recovery and reduces the high long-term financial burden to taxpayers in avoidable disability, criminal justice involvement and hospital care.

NAMI urges the Committee to maintain coverage and services for people with mental illness by preserving financial help based on income, removing the proposed per capita cap financing model for Medicaid and protecting expanded Medicaid eligibility. We appreciate the challenges in reforming America's health coverage and look forward to working with you to improve mental health coverage and care for children and adults throughout our nation.

Sincerely,

MARY GILIBERTI, J.D.,
Chief Executive Officer, NAMI.

MENTAL HEALTH LIAISON GROUP,
March 17, 2017.

Hon. PAUL RYAN,
Speaker, House of Representatives, Washington, DC.

Hon. NANCY PELOSI,
House Minority Leader, House of Representatives, Washington, DC.

DEAR SPEAKER RYAN AND DEMOCRATIC LEADER PELOSI: The Mental Health Liaison Group (MHLG) wishes to express our serious concerns about the provisions of the American Health Care Act (AHCA) that would restructure the Medicaid program and end the Medicaid expansion, as well as provisions of that legislation that would significantly reduce the Federal premium assistance that enrollees receive from the Federal government to maintain continuous insurance coverage, and impose a significant penalty for not maintaining continuous coverage. We are also very concerned that the legislation would eliminate required coverage for prevention and treatment of mental illness and substance use disorders under state Medicaid managed care and alternative benefit programs, as Medicaid is the major source of Federal funding in every state for mental health and substance use services.

The MHLG is a coalition of dozens of national organizations representing consumers, family members, mental health and substance use treatment providers, state behavioral health agencies, advocates, payers, and other stakeholders committed to strengthening Americans' access to mental health and substance use services and programs.

The elimination of Medicaid expansion under the AHCA would leave without coverage the 1.3 million childless, non-pregnant adults with serious mental illness who were able, for the first time, to gain coverage under Medicaid expansion. It would also leave uncovered the 2.8 million childless, non-pregnant adults with substance use disorders who also gained coverage under expansion for the first time. These are populations that Congress promised and worked to serve with the passage of 21st Century Cures and the Comprehensive Addiction and Recovery Act (CARA) of 2016, respectively. And it is important to remember that untreated mental health and substance use disorders intensify and serve to increase the number of co-morbid medical conditions in those populations, thereby multiplying total Medicaid program costs.

Medicaid is the single largest payer for behavioral health services in the United States, accounting for about 26 percent of behavioral health spending, and is the largest source of funding for the country's public mental health system. The Congressional Budget Office estimates the Medicaid provisions of the AHCA would reduce Medicaid funding over 10 years by $880 billion, or about 25 percent. With an estimated 14 million people—one in five of Medicaid's 70 million enrollees—living with mental illness or substance use disorders and depending heavily on Medicaid services, allowing states to determine whether those services should be covered could very well leave many low-income Americans without access to medically necessary prevention and treatment services.

Medicaid covers a broad range of behavioral health services at low or no cost, including but not limited to psychiatric hospital care, case management, day treatment, evaluation and testing, psychosocial rehabilitation, medication management, as well as individual, group and family therapy. In three dozen states, Medicaid covers essential peer support services to help sustain recovery. Additionally, because people with behavioral health disorders experience a higher rate of chronic physical conditions than the general population, Medicaid's coverage of primary care is critical to help this population receive needed treatment for both their behavioral health and physical health conditions.

In states that have expanded Medicaid and which have been particularly hard hit by the opioid crisis, such as Kentucky, Maine, Pennsylvania, Ohio, and West Virginia, Medicaid pays between 35 to 50 percent of medication-assisted treatment for substance use disorders. CARA and 21st Century Cures were to increase payment for those services, but the elimination of mandated coverage under Medicaid would likely result in state cost shifting, so that CARA moneys (should they be appropriated) and moneys provided under 21st Century Cures for prescription opioid addiction prevention and treatment services would supplant, rather than supplement, the existing Medicaid coverage of services in the states.

Similarly, converting Medicaid into a per capita cap block grant program or a simple block grant program will shift significant costs to states over time. Ultimately, states will be forced to reduce their Medicaid rolls, benefits, and already low payment rates to an already scarce workforce of behavioral health providers. Mental health and substance use disorder treatments and programs will be at high risk because, even though they are cost-effective, they are intensive and expensive. Furthermore, the elimination of the ACA's required Medicaid managed care coverage of mental health and substance use disorder services and the long-term reduction of real funding dollars will leave states and managed care plans no alternative but to reduce or eliminate services in order to balance state Medicaid budgets and operate within managed care organizations' capitated rates.

In addition, these cuts will hit children with serious emotional disorders, as well as adults with mental illness. Fifty percent of Medicaid beneficiaries are children. Seventy-five percent of mental conditions emerge by late adolescence. The loss of Medicaid-covered mental and substance use disorder services for adults would result in more family disruption and out-of-home placements for children, significant trauma which has its own long-term health effects, and a further burden on a child welfare system that is struggling to meet the current demand for foster home capacity. In addition, we estimate $4 to $5 billion in Medicaid assistance will be lost by schools for specialized instructional support services, including mental and behavioral health services.

More directly, the rollback of the maximum eligibility level for children ages 6 to 19 from 133 percent of the Federal Poverty Level to 100 percent FPL will undoubtedly have the result of reducing access to mental health and substance use disorder services, and critical Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, for those older children. This is a particularly problematic change since 5 percent (1.2 million) of adolescents between the ages of 12 and 17 had substance use disorders in 2015 and EPSDT screening is the most effective early identifier for emergent mental health issues.

AHCA CHANGES TO PRIVATE INSURANCE COVERAGE

If Medicaid is not to provide the avenue for recovery for individuals with mental illness or substance use disorders, then the private insurance market may have to serve as an alternative, but the $2,000 to $4,000 refundable tax credits provided under the AHCA to subsidize insurance premiums constitute a significant reduction in the advance premium tax credits paid under the ACA, which averaged 72 percent of gross premiums. Further, the 30 percent premium surcharge required under AHCA to be imposed for a failure to maintain continuous coverage will likely hit hardest the lowest-income enrollees who will be struggling to maintain premium payments for coverage. It will be particularly destructive for those enrollees whose serious mental illness or substance use disorders may render them cognitively impaired and thus unable to maintain premium payment schedules until they recover, when the sizeable surcharge will leave them unable to pick up coverage. For the foregoing reasons, these provisions of the AHCA leave us very concerned for the continued well-being of the individuals with serious mental illness and substance use disorders we have been better able to serve since the implementation of the ACA's expanded coverage.

We urge you to continue to protect these vulnerable Americans' access to and coverage of vital mental health and substance use disorder care and services, and to not reverse the recent progress made with the enactment of key mental health and substance use disorder prevention and treatment reforms under the 21st Century Cures Act and CARA.

Sincerely,

American Art Therapy Association, American Association of Child & Adolescent Psychiatry, American Association for Marriage and Family Therapy, American Association for Geriatric Psychiatry, American Association on Health and Disability, American Dance Therapy Association, American Foundation for Suicide Prevention, American Nurses Association, American Psychiatric Association, American Psychoanalytic Association (APsaA), American Psychological Association, American Society of Addiction Medicine, Anxiety and Depression Association of America, Association for Ambulatory Behavioral Healthcare, Association for Behavioral Health and Wellness, Bazelon Center for Mental Health Law, Campaign for Trauma-Informed Policy and Practice, Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD), Clinical Social Work Association, Clinical Social Work Guild 49–OPEIU.

Depression and Bi-Polar Support Alliance, Eating Disorders Coalition, EMDR International Association, Global Alliance for Behavioral Health and Social Justice, International Certification & Reciprocity Consortium (IC&RC), The Jewish Federations of North America, Mental Health America, National Association for Children's Behavioral Health, The National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD), The National Association for Rural Mental Health (NARMH), National Association of Social Workers, National Association of State Mental Health Program Directors (NASMHPD), National Alliance on the Mental Illness (NAMI), National Council for Behavioral Health, National Disability Rights Network, National Federation of Families for Children's Mental Health, National Health Care for the Homeless Council, National Register of Health Service Psychologists, No Health Without Mental Health (NHMH), School Social Work Association of America, Trinity Health of Livonia, Michigan, Young Invincibles.

[From the New York Times, Mar. 23, 2017]

LATE G.O.P. PROPOSAL COULD MEAN PLANS THAT COVER AROMATHERAPY BUT NOT CHEMOTHERAPY

(By Margot Sanger-Katz)

Most Republicans in Congress prefer the type of health insurance market in which everyone could ''choose the plan that's right for them.''

Why should a 60-year-old man have to buy a plan that includes maternity benefits he'll never use? (This is an example that comes up a lot.) In contrast, the Affordable Care Act includes a list of benefits that have to be in every plan, a reality that makes insurance comprehensive, but often costly.

Now, a group of conservative House members is trying to cut a deal to get those benefit requirements eliminated as part of the bill to repeal and replace the Affordable Care Act moving through Congress. (The vote in the House is expected later today.)

At first glance, this may sound like a wonderful policy. Why should that 60-year-old man have to pay for maternity benefits he will never use? If 60-year-old men don't need to pay for benefits they won't use, the price of insurance will come down, and more people will be able to afford that coverage, the thinking goes. And people who want fancy coverage with extra benefits can just pay a little more for the plan that's right for them.

But there are two main problems with stripping away minimum benefit rules. One is that the meaning of ''health insurance''

can start to become a little murky. The second is that, in a world in which no one has to offer maternity coverage, no insurance company wants to be the only one that offers it.

Here is the list of Essential Health Benefits that are required under the Affordable Care Act:

Ambulatory patient services (doctor's visits)

Emergency services

Hospitalization

Maternity and newborn care

Mental health and substance abuse disorder services, including behavioral health treatment

Prescription drugs

Rehabilitative and habilitative services and devices

Laboratory services

Preventive and wellness services, and chronic disease management

Pediatric services, including oral and vision care

The list reflects some lobbying of the members of Congress who wrote it. You may notice that dental services are required for children, but not adults, for example. But over all, the list was developed to make insurance for people who buy their own coverage look, roughly, like the kind of coverage people get through their employer. A plan without prescription drug coverage would probably be cheaper than one that covers it, but most people wouldn't think of that plan as very good insurance for people who have health care needs.

Under the Republican plan, the government would give people who buy their own insurance money to help them pay for it. A 20-year-old who doesn't get coverage from work or the government, for example, would get $2,000. If the essential health benefits go away, insurance companies would be allowed to sell health plans that don't cover, say, hospital care. Federal money would help buy these plans.

But history illustrates a potential problem.

In the 1990s, Congress created a tax credit that helped low-income people buy insurance for their children. Quickly, it became clear that unscrupulous entrepreneurs were creating cheap products that weren't very useful, and marketing them to people eligible for the credit. Congress quickly repealed the provision after investigations from the Government Accountability Office and the Ways and Means Committee uncovered fraud.

Mark Pauly, a professor of health care management at the Wharton School of the University of Pennsylvania, who tends to favor market solutions in health care, said that while the Obamacare rules are ''paternalistic,'' it would be problematic to offer subsidies without standards. ''If they're going to offer a tax credit for people who are buying insurance, well, what is insurance?'' he said, noting that you might end up with the government paying for plans that covered aromatherapy but not hospital care. ''You have to specify what's included.''

A proliferation of $1,995 plans that covered mostly aromatherapy could end up costing the federal government a lot more money than the current G.O.P. plan, since far more people would take advantage of tax credits to buy cheap products, even if they weren't very valuable.

There's another reason, besides avoiding fraud, that health economists say benefit rules are important. Obamacare requires insurers to offer health insurance to people who have pre-existing illnesses at the same price as they sell them to healthy people, and the Republican bill would keep this rule. But if an insurance company designs a plan that attracts a lot of sick people, it will be very expensive to cover them, and the insurance company will either lose money or end up charging extremely high prices that would drive away any healthy customers.

Sherry Glied, the dean of the Robert F. Wagner Graduate School of Public Service at New York University, who helped work on the essential health benefits in the Obama administration, raised the example of mental health benefits. Parents of adolescents with schizophrenia will be sure to buy insurance that covers only mental health services. Other parents won't care about that benefit.

The result: Any company offering such benefits will end up with a lot of customers requiring expensive hospitalizations, while its competitors that drop them will get healthier customers who are cheaper to insure. If mental health services are optional, no insurance company will want to offer them, lest all the families with sick children buy their product and put them out of business.

And then healthy people who develop mental illness, or drug addiction, will also learn that their illness isn't covered. The result could be a sort of market failure: ''If you don't require that these benefits are required, they often just get knocked out of the market altogether,'' she said.

Before Obamacare passed, there were few federal standards for health insurance bought by individuals, and it was not uncommon to find plans that didn't include prescription drug coverage, mental health services or maternity care. But plans tended to cover most of the other benefits. That was in a world where health insurers could discriminate against sick people. In that era, insurers in most states could simply tell the mother of a mentally ill child that she couldn't buy insurance. That made it less risky for insurers to offer mental health benefits to everyone else.

David Cutler, a professor at Harvard who helped advise the Obama administration on the Affordable Care Act, said he thinks the kind of insurance products that would be offered under the proposed mix of policies could become much more bare-bones than plans before Obamacare. He envisioned an environment in which a typical plan might cover only emergency care and basic preventive services, with everything else as an add-on product, costing almost exactly as much as it would cost to pay for a service out-of-pocket.

''Think of this as the if-you-have-rheumatoid-arthritis-you-should-pay-$30,000 provision,'' he said. Such a system would mean that Americans with costly problems—cancer, opioid addiction, H.I.V.—would end up paying a substantially higher share of their medical bills, while healthy people would pay lower prices for insurance that wouldn't cover as many treatments.

There is most likely a middle way. Republican lawmakers might be comfortable with a system that shifts more of the costs of care onto people who are sick, if it makes the average insurance plan less costly for the healthy. But making those choices would mean engaging in very real trade-offs, less simple than their talking point.

Mr. McGOVERN. Mr. Speaker, I yield 1 minute to the gentleman from Indiana (Mr. VISCLOSKY).

Mr. VISCLOSKY. Mr. Speaker, I rise in opposition to the rule and the underlying legislation.

I believe that the purpose of any healthcare legislation should be to improve the well-being of our Nation's citizens and to allow for access to quality and affordable health care for all. I think, particularly, the gentlemen from Massachusetts and Florida ably describe why today's legislation fails those tests. I would add that it will also jeopardize the healthcare coverage of over 429,000 Hoosiers currently enrolled in Indiana's expansion of Medicaid, the Healthy Indiana Plan.

Further, I believe it is disingenuous that, if this bill is successful, the House will have pushed numerous adverse consequences until after the next congressional election.

Congress should work to improve the Affordable Care Act. Congress should work to ensure affordable pharmaceutical products. Congress should act for the health concerns still facing ordinary Americans. But today's legislation does no such thing.

I find it unacceptable, and I urge my colleagues to oppose the legislation.

Mr. Speaker, I rise in strong opposition to the American Health Care Act.

I believe that the purpose of any health care legislation should be to improve the health and well-being of our nation's citizens, and to allow for access to quality and affordable health care for all.

That is why in the 111th Congress I was proud to support the Affordable Care Act. As a result of this landmark legislation, 19 million people in the United States now have health insurance coverage who did not before, and over nine-in-ten individuals in my home state of Indiana now have health insurance.

Regretfully, according to the nonpartisan Congressional Budget Office, the legislation we are considering today will leave approximately 14 million more Americans without health care insurance by 2018, and this number will continue to rise to an estimated 24 million by 2026.

I am especially concerned that the American Health Care Act will jeopardize the health care coverage of the over 429,000 Hoosiers currently enrolled in Indiana's expansion of Medicaid, also known as the Healthy Indiana Plan.

Further, I believe it is especially disingenuous that if this bill passes today, this institution will have pushed the financial cuts to programs like the Healthy Indiana Plan conveniently until after the next congressional election.

The Act before us also would negatively impact the health of millions of women and men who receive the medical services provided by Planned Parenthood. Additionally, it would not improve the well-being of our nation's elderly by allowing providers to charge older enrollees up to five times as much as younger individuals.

Finally, I would note with great concern that a provision was just added to the American Health Care Act today that would remove the requirement that insurers cover life-saving, essential health benefits, including maternal and pediatric services, rehabilitative therapy, and mental health and substance abuse treatment.

Congress should work to improve the Affordable Care Act and address important health concerns facing ordinary Americans, such as the rising cost of prescription drugs. But today's bill does no such thing.

It is unacceptable and I urge my colleagues to oppose this legislation.

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

Mr. MCGOVERN. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. MATSUI).

Ms. MATSUI. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, we have heard a lot of rhetoric about how this bill would supposedly fix our healthcare system. President Trump said that his plan would provide insurance for everybody. That is not the bill before us today.

The last-minute backroom changes have only made a bad bill worse. Republicans stuck in a provision to strip away essential health benefits for American families.

The list of services in jeopardy is long, devastating, and cruel, services like emergency services, hospitalization, prescription drugs, preventive care, and many other guarantees.

These are basic health services that every person in the country deserves, like my constituent Elizabeth, whose daughter is guaranteed pediatric care to treat her type 1 diabetes because of these essential benefits. Without coverage, out-of-pocket costs would add up to more than her entire year's salary.

I can't stand here and allow my Republican colleagues to say they are saving people from ObamaCare while they are stripping away essential care for families like Elizabeth's. I urge my colleagues to oppose this bill.

Mr. SESSIONS. Mr. Speaker, I continue to reserve the balance of my time.

Mr. MCGOVERN. Mr. Speaker, I just want to take a second to summarize this rule because people have been asking about it.

It is a closed rule. The only amendments allowed are amendments offered by people who wrote the bill. Those amendments are fixes to fixes to fixes to fixes in their bill and, in the words of Trump, sad.

I would just say, you know, usually when you have a lousy process you have a lousy bill, and that is why only 17 percent of the American people support what my Republican friends are doing.

I yield 1 minute to the gentleman from Texas (Mr. CASTRO).

Mr. CASTRO of Texas. Mr. Speaker, I come from the State, Texas, that has the highest percentage of people who have absolutely no healthcare coverage, who use the emergency room as their health provider, and who also have serious health challenges.

For Texans, if this bill passes, it means that the following things will no longer be in their insurance policy or they will be charged jacked-up fees for them: outpatient care; emergency room trips; in-hospital care; pregnancy, maternity, and newborn care; mental health and substance abuse disorder services; prescription drugs; rehabilitative services and habilitative services; lab tests; preventative services; and pediatric services.

It should also be noted that, with this bill, about 660,000 Texans would lose their healthcare coverage.

Mr. MCGOVERN. Mr. Speaker, I yield 1 minute to the gentleman from Colorado (Mr. PERLMUTTER).

Mr. PERLMUTTER. Mr. Speaker, I thank the gentleman from Massachusetts for yielding me time.

Mr. Speaker, this is a bad joke on America. Here we are, the choice act:

The choice is get sick or go broke.

The choice is more coverage for average Americans or more tax cuts for the rich, higher costs for families.

Twenty-four million people, at least, lose their coverage under the choice act, or TrumpCare.

That is a bad joke. That is a bad choice.

Here is something: discrimination against older Americans. They have five times the cost of younger Americans under TrumpCare, under their choice act.

This hurts Medicare.

There are no savings in this bill—that was what the whole thing was all about—but instead, we get less coverage for average Americans. We get many people cut off their coverage, but we get big tax cuts for the rich.

This is a bad joke. This bill should be defeated. This rule should be defeated.

Mr. MCGOVERN. Mr. Speaker, I would like to inquire of the gentleman from Texas, if I can.

I know he has a few more speakers than he did yesterday, but we have a ton over here, and if there is additional time that he could share with us, we would appreciate it.

Mr. SESSIONS. Mr. Speaker, we are going to keep moving on. We were allocated the same amount of time. I guess the answer would be no.

Mr. MCGOVERN. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. KELLY).

Ms. KELLY of Illinois. Mr. Speaker: ''Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.''

Dr. King spoke these words because the health of our fellow Americans is a moral imperative. What we have before us today is a morally corrupt bill: morally corrupt because it claws away health insurance from 24 million Americans, morally corrupt because it leaves nearly 1 million of my fellow Illinoisans without health insurance, morally corrupt because 240,000 Illinois kids will no longer have the safety and security of their current coverage.

When you cast your vote today, know that you own its aftermath here, forward. Will you cast your vote for party or will you cast your vote to do what is best in the lives of the people you represent?

Think of the last senior whose hand you shook at a townhall. Think of the last child you hugged at a school visit. Does this bill do right by them? Will they be better off?

If you have any doubt, vote ''no.'' Vote ''no,'' and kill this bad bill.

Mr. MCGOVERN. Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. PRICE).

Mr. PRICE of North Carolina. Mr. Speaker, I rise today in strong opposition to this misguided and shortsighted pay-more-for-less bill, also known as TrumpCare.

In all my time in Congress, I have never seen such blatant disregard for the interests of the American people.

Twenty-four million hardworking Americans will lose their coverage.

TrumpCare will raise premiums, while reducing critical premium subsidies that millions depend on. Meanwhile, deductibles and out-of-pocket expenses will go up.

Particularly hurt will be the Americans aged 50 to 64 who will have to pay five times more than others for health coverage, no matter how healthy they may be themselves.

TrumpCare then goes on to ransack the Medicaid funds that older Americans rely on for long-term care, and it shortens the life of the Medicare trust fund by 3 years.

North Carolina consumers in the insurance marketplace, many of them insured for the first time, would face the second highest healthcare cost increases in the entire country, an average of over $7,500. Again: mainly older, poorer North Carolinians. For example, a 64-year-old resident making $22,000 a year would see a premium spike of over $14,000. That is over half of his income.

After years of trying to destroy the ACA, is this the best that Speaker RYAN and President Trump can come up with? Defeat this bill.

Mr. MCGOVERN. Mr. Speaker, I yield 1 minute to the gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I rise in strong opposition to the Republican effort to gut the Affordable Care Act, an effort that will result in millions of people across the country and tens of thousands of my constituents in Rhode Island to lose their health coverage, and it will ultimately result in costs rising.

Before the ACA was passed, the House held 79 hearings over the course of a year. Today's Republican plan was pushed through three committees without a single hearing and with substantial changes being made behind closed doors in the dead of night.

Mr. Speaker, I am a veteran of many healthcare debates, and I can tell you this is not how sound policy is made, especially policy that will have real consequences for hardworking Americans.

Since the passage of the ACA, I have had faith that Republicans and Democrats could come together to strengthen the law and further improve healthcare for all Americans. There is still that opportunity to come together, Mr. Speaker, but the rule, along with the underlying bill, has shaken that faith.

Supporting the rule means putting ideology above the well-being of the American people. This does not have to be a zero-sum game. I know that we can come together.

Let's defeat this rule and the bill. Come together in a bipartisan way to fix the problems of the ACA.

Mr. MCGOVERN. Mr. Speaker, I yield 1 minute to the gentlewoman from Hawaii (Ms. GABBARD).

Ms. GABBARD. Mr. Speaker, people in my home State of Hawaii and all across the country are in desperate need of serious healthcare reform to bring down costs and increase access to quality care.

The legislation before us, though, is not the answer. It perpetuates the problems. It is a handout to insurance and pharmaceutical companies that literally pulls the rug out from those who are most needy and most vulnerable in our communities.

While corporations rake in over $600 billion in tax breaks, many low-income Americans will see their coverage drop completely.

Medicaid, a program that one in five Americans depend on for basic care, would be slashed by hundreds of billions of dollars, shifting costs to already-strained State and local governments.

Our kupuna, our seniors, could see their premiums increase up to five times more than young, healthy people under these new age rating rules in this bill.

Simply put, we need a healthcare system that puts people before profits. I urge my colleagues strongly to vote ''no'' against this legislation.

Mr. MCGOVERN. Mr. Speaker, I include in the RECORD the CBO score for the underlying bill and the first four manager's amendments. We just got it last night, and it is already out-of-date given the fifth manager's amendment that was just submitted late last night.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 23, 2017.

Hon. PAUL RYAN,
Speaker of the House, House of Representatives, Washington, DC.

DEAR MR. SPEAKER: At your request, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have prepared an estimate of the direct spending and revenue effects of H.R. 1628, the American Health Care Act, as posted on the website of the House Committee on Rules on March 22, 2017, incorporating manager's amendments 4, 5, 24, and 25.

As a result of those amendments, this estimate shows smaller savings over the next 10 years than the estimate that CBO issued on March 13 for the reconciliation recommendations of the House Committee on Ways and Means and the House Committee on Energy and Commerce. The estimated effects on health insurance coverage and on premiums for health insurance are similar to those estimated for the committees' recommendations.

EFFECTS ON THE FEDERAL BUDGET

CBO and JCT estimate that enacting H.R. 1628, with the proposed amendments, would reduce federal deficits by $150 billion over the 2017–2026 period; that reduction is the net result of a $1,150 billion reduction in direct spending, partly offset by a reduction of $999 billion in revenues (see Tables 1 and 2). The provisions dealing with health insurance coverage would reduce deficits, on net, by $883 billion (see Table 3); the noncoverage provisions would increase deficits by $733 billion, mostly by reducing revenues.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues. CBO and JCT estimate that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

EFFECTS ON HEALTH INSURANCE COVERAGE

CBO and JCT estimate that, in 2018, 14 million more people would be uninsured under the legislation than under current law. The increase in the number of uninsured people relative to the number under current law would reach 21 million in 2020 and 24 million in 2026 (see Table 4). In 2026, an estimated 52 million people under age 65 would be uninsured, compared with 28 million who would lack insurance that year under current law.

EFFECTS ON PREMIUMS

H.R. 1628, with the proposed amendments, would tend to increase average premiums in the nongroup market before 2020 and lower average premiums thereafter, relative to projections under current law. In 2018 and 2019, according to CBO and JCT's estimates, average premiums for single policyholders in the nongroup market would be 15 percent to 20 percent higher under the legislation than under current law. By 2026, average premiums for single policyholders in the nongroup market would be roughly 10 percent lower than under current law.

UNCERTAINTY SURROUNDING THE ESTIMATES

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to the changes made by the legislation are all difficult to predict, so the estimates in this report are uncertain. But CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes.

COMPARISON WITH THE PREVIOUS ESTIMATE

On March, 13, 2017, CBO and JCT estimated that enacting the reconciliation recommendations of the House Committee on Ways and Means and the House Committee on Energy and Commerce (which were combined into H.R. 1628) would yield a net reduction in federal deficits of $337 billion over the 2017–2026 period. CBO estimates that enacting H.R. 1628, with the proposed amendments, would save $186 billion less over that period. That reduction in savings stems primarily from changes to H.R. 1628 that modify provisions affecting the Internal Revenue Code and the Medicaid program.

Over the 2017–2026 period, modifications to provisions affecting the Internal Revenue Code that are not directly related to the law's insurance coverage provisions would reduce JCT's estimate of revenues by $137 billion. Reducing the threshold for determining the medical care deduction on individuals' income tax returns from 7.5 percent of income to 5.8 percent would reduce revenues by about $90 billion. Other changes include adjusting the effective dates and making other modifications to the provisions that repeal or delay many of the changes in the Affordable Care Act, which would reduce revenues by $48 billion.

A number of changes to the Medicaid program would reduce CBO's estimate of savings by $41 billion over the 2017–2026 period. The reduction would result from revising the formula for calculating the per capita allotments in Medicaid to allow for faster growth of the per capita cost of aged, blind, and disabled enrollees. The effects of changing that formula would be offset somewhat by the effects of three other provisions that would increase savings: reducing the per capita allotment in Medicaid for the state of New York in proportion to any financing the state receives from county governments; providing states the option to make eligibility for Medicaid conditional on satisfying work requirements for enrollees who are not single parents of children under age 6 or who are not pregnant or disabled; and allowing states to receive a block grant for Medicaid coverage of children and some adults instead of funding based on a per capita cap.

Other smaller changes resulting from the manager's amendments would reduce savings by an estimated $8 billion over the period.

Compared with the previous version of the legislation, H.R. 1628, with the proposed amendments, would have similar effects on health insurance coverage: Estimates differ by no more than half a million people in any category in any year over the next decade. (Some differences may appear larger because of rounding.) For example, the decline in Medicaid coverage after 2020 would be smaller than in the previous estimate, mainly because of states' responses to the faster growth in the per capita allotments for aged, blind, and disabled enrollees—but other changes in Medicaid would offset some of those effects.

The legislation's impact on health insurance premiums would be approximately the same as estimated for the previous version.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

KEITH HALL,
Director.

Mr. MCGOVERN. This analysis confirms that the Republicans will give a trillion-dollar tax break to the wealthiest people in this country, and they will kick 24 million Americans off their health insurance.

I will say that is why we are packed with speakers on this side, and there is probably only a couple of people on the gentleman's side, because we are standing with the American people who are outraged by this bill.

Mr. Speaker, I yield 1 minute to the gentleman from Rhode Island (Mr. CICILLINE).

Mr. CICILLINE. Mr. Speaker, last night we watched the President and the House Republicans scramble to achieve political points at the expense of the American people, working through the night. Imagine if they worked this hard on a jobs bills or a bill that raised family incomes or a bill to rebuild our infrastructure. But instead they are trying to pass a tax cut for the rich disguised as a healthcare bill, a bill that will require us to provide big, gigantic tax cuts.

To do that, they impose higher costs on families, higher premiums, higher deductibles. They strip 24 million hard-working Americans from health care, including 60,000 Rhode Islanders. They impose a crushing age tax. They steal from Medicare, and they will destroy nearly 2 million jobs, all so they can give the wealthiest Americans and the most powerful special interests a big, huge tax cut.

Shame on President Trump. Shame on the Republicans.

This is wrong for our country. We can do better than this. We need to protect access to health care, not rob millions of Americans from health care.

Mr. MCGOVERN. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, the healthcare proposal proposed by President Trump and Speaker RYAN raises premiums and deductibles. It imposes an age tax on older Americans, making their health care unaffordable. It throws millions—24 million—Americans off of their insurance. It shifts the cost of health care to the States, and it covers less and less people.

□ 1015

It raises people's fears and insecurities about what this will do if they get sick. It ends maternity care. It is quite outrageous when it tells you that you can't go for emergency services any longer. It would allow insurance companies to, once again, reimpose lifetime limits and annual caps. It allows insurance companies to charge women 48 percent more for the same insurance that any man would pay for.

So why would you be for this? Why? Who benefits? Who benefits?

We are going to provide 400 of the richest families in this Nation with a $7 million tax cut every year. Those are not my words. Take a look at what Families USA says. Take a look at what the Center on Budget and Policy Priorities says about that.

Working people and older Americans are going to pay for a tax cut for the richest people in this Nation. Older Americans are going to be hit the hardest. Not only are they going to get an age tax, but they are going to shift $170 billion out of the Medicare trust fund—a lifeline for older Americans.

Do you know what? It makes me believe that this is the case: What does the GOP stand for? Get Old People.

That is what this bill does. That is what people are going to vote ''yes'' for today. Let me just say this: We have an obligation. We have an obligation to the people of this country to vote ''no'' today on this misrepresented bill.

Mr. SESSIONS. Mr. Speaker, I yield 1 minute to the gentlewoman from Wyoming (Ms. CHENEY), who is the favorite daughter of Wyoming and serves on the Rules Committee.

Ms. CHENEY. Mr. Speaker, there are a lot of charges and allegations being made about what this bill would do, and the reality, Mr. Speaker, is we are living today in the world that they have created on the other side of this aisle. We are living today in a world with skyrocketing costs, plummeting choices, and broken promises across the board.

When you talk about the situation with respect to women in particular, when you talk about what is going to happen with maternity care and with child care, Mr. Speaker, there is a fundamental difference between what they believe on that side of the aisle and what we believe over here.

What we believe over here is that every American—every individual, and in that, we Republicans include women—we think women ought to have the right to make their own choices and their own decisions about care. We know that the kinds of insurance—the so-called insurance—that has been provided under ObamaCare means that women have been denied access to things like maternity care. When you can only get a policy with a $6,000 deductible, that is not care and that is not insurance.

This bill today is fundamental to being able to keep our promises to the American people, to being able to ensure that we have returned authority, we have returned power, and, yes, resources into the hands of individuals so people in Wyoming—in my home State—and all across this country can make their own healthcare decisions and no longer be forced to purchase things they don't want, don't need, and can't use to get coverage.

Mr. MCGOVERN. Mr. Speaker, I yield 30 seconds to the gentlewoman from New Hampshire (Ms. KUSTER).

Ms. KUSTER of New Hampshire. Mr. Speaker, all due respect to my colleague from Wyoming, it is not liberty for a woman to be forced to go to work within weeks of having a child. That is what this bill would do.

Mr. Speaker, it is not liberty for people over 50 years old to be required to pay increased fees and increased expenses simply to go to the hospital, and it is not liberty to have their essential health benefits stripped away. They might not even be able to go to a hospital. It is not liberty for 7 million veterans to have a vets tax, to have their benefits stripped away from an amendment that was introduced in the middle of the night. That is not liberty. Vote ''no'' on this bill.

Mr. MCGOVERN. Mr. Speaker, I yield 1 minute to the gentleman from Virginia (Mr. CONNOLLY).

Mr. CONNOLLY. Mr. Speaker, I thank my friend from Massachusetts for yielding me this time.

The Hippocratic Oath says ''primum non nocere''; ''first, do no harm.''

This bill violates the Hippocratic Oath in all respects. Twenty-four million people losing their health care, our friend from Wyoming thinks that is a choice?

A string of benefits required to be covered by insurance companies to protect consumers, to protect our loved ones when they get ill, vitiated. Maybe that is popular in some parts of this country, but I don't know where they are. This bill will unravel health care for all Americans. It is the wrong path to take, and I urge defeat of this legislation in its entirety.

PARLIAMENTARY INQUIRY

Ms. KAPTUR. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentlewoman will state her parliamentary inquiry.

Ms. KAPTUR. Mr. Speaker, I want to ask why the Democratic microphone is turned off. This happened to me the other day when the Republican microphone was on over there.

The last two speakers we have not been able to hear as well as we heard Ms. CHENEY, and I want to know why that is.

I hope somebody hears my plea and that the Parliamentarian will take care of this problem. This debate is too important to have our microphones at a lower scale.

The SPEAKER pro tempore. The Chair has heard the complaint and will look into it.

The Chair advises that he has had no problem hearing from each of the speakers that have gone to the well or from the leadership tables today.

The gentleman from Texas has 3½ minutes remaining and the gentleman from Massachusetts has 3½ minutes remaining in this debate on the rule.

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

Mr. MCGOVERN. Mr. Speaker, I yield 30 seconds to the gentleman from Florida (Mr. CRIST).

Mr. CRIST. Mr. Speaker, this bill we are talking about takes about $880 billion out of Medicaid. Medicaid is for the poor, and Medicaid is for the disabled. We are in Lent. It is supposed to be the holiest time. I want to read to you from Matthew 25, verse 45: Whatever you do to the least of my brothers, you do unto Me.

Think about that before you vote for this bill. Please vote against it. God bless.

Mr. SESSIONS. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Pasco, Washington (Mr. NEWHOUSE), who is a member of the Rules Committee.

Mr. NEWHOUSE. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, under the ACA, 5 to 6 million Americans were kicked off their healthcare plans, including 300,000 of my fellow Washingtonians who lost coverage despite repeated promises they could keep their plans. A majority of Americans have faced skyrocketing costs, reduced access to quality care, and fewer choices for their families. I believe we can and we must do better.

Under this bill, Americans will have health care that fits individual and family needs instead of federally mandated, one-size-fits-all coverage that is simply unaffordable for far too many people. This bill strengthens and guarantees access for the most vulnerable in our communities.

The ACA has failed. I made a promise to the thousands of my constituents who have told me of the devastation this law has wreaked on their lives that I would not forget them. Americans in every election since 2010 have said loud and clear the same thing, and it is time that we listened.

Mr. Speaker, the American Health Care Act is the first major step in keeping that promise, and I think that we need to take it.

Mr. MCGOVERN. Mr. Speaker, I yield 30 seconds to the gentleman from California (Mr. PANETTA).

Mr. PANETTA. Mr. Speaker, I rise today in opposition of what has become basically the complete repeal of the ACA. Don't get me wrong. I have talked to small-business owners, and I have talked to patients who have talked about the expenses of the ACA. But I have also heard from people in my district on the central coast of California how much it has benefited them, including 65,000 people who now have coverage under Medicaid and 25,000 people who have gained it through the marketplace.

If the AHCA becomes law, we are not making it cheaper, and we are not making it more accessible. Instead, all that is happening is that they are fulfilling a campaign promise.

Mr. Speaker, we must make sure that the ACA is here. We cannot take it away. We must make sure that we provide care, we provide coverage, and we provide the covenant that we promised our constituents.

Mr. SESSIONS. Mr. Speaker, I reserve the balance of my time, and I am prepared to close.

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

Mr. Speaker, I include in the RECORD a letter from 87 patient and provider organizations, including the Cystic Fibrosis Foundation, which is strongly opposed to this bill.

MARCH 20, 2017.

Hon. MITCH MCCONNELL,
Senate Majority Leader,
Washington, DC.
Hon. PAUL RYAN,
Speaker of the House,
Washington, DC.

DEAR LEADER MCCONNELL AND SPEAKER RYAN: The undersigned organizations write to express grave concern about proposals put forth in the American Health Care Act (AHCA) to alter the fundamental structure and purpose of Medicaid, a vital source of health care for patients with ongoing health needs.

We feel compelled to speak out against proposals to phase out Medicaid expansion and implement per capita caps, which threaten the ability of Medicaid to provide critical health care services to many of our most vulnerable citizens. These proposals aim to achieve cost savings of approximately $880 billion, according to the Congressional Budget Office, at the expense of tens of millions of patients who rely on Medicaid for life-sustaining care. While we appreciate the opportunities we have had to work with your staff, we cannot support the Medicaid provisions in this bill and cannot accept policies that prioritize cutting costs by limiting patients' access to care.

MEDICAID IS CRITICAL FOR PATIENTS

Medicaid is a crucial source of coverage for patients with serious and chronic health care needs. Pregnant women depend on Medicaid, which covers roughly 50 percent of all births including many high-risk pregnancies. Medicaid covers cancer patients: nearly one-third of pediatric cancer patients were enrolled in Medicaid in 2013 and approximately 1.52 million adults with a history of cancer were covered by Medicaid in 2015. Over fifty percent of children and one-third of adults living with cystic fibrosis rely on Medicaid to get the treatments and therapies they need to preserve their health. Nearly half of children with asthma are covered by Medicaid or CHIP and adults with diabetes are disproportionally covered by Medicaid as well. The patients we represent are eligible for Medicaid through various pathways, including through income-related and disability criteria.

REJECT PER CAPITA CAPS

The proposal to convert federal financing of Medicaid to a per capita cap system is deeply troubling. This policy is designed to reduce federal funding for Medicaid, forcing states to either make up the difference with their own funds or cut their programs by reducing the number of people they serve and the health benefits they provide.

For patients with ongoing health care needs, this means that Medicaid may no longer cover the care and treatments they need, including breakthrough therapies and technology. In order to save money, the per capita caps are set to grow more slowly than expected Medicaid costs under current law. As the gap between the capped allotment and actual costs increases over time, states will be forced to constrain eligibility, reduce benefits, lower provider payments, or increase cost-sharing. Moreover, by capping the federal government's contribution to Medicaid in this manner, states will be less able to cover the cost of new treatments. This could be devastating for people with serious diseases, for whom groundbreaking treatments represent a new lease on life. For people with cystic fibrosis, cancer, and other diseases, new therapies can be game changers that improve quality of life and increase life expectancy. In fact, we have already seen Medicaid programs respond to current budget constraints by using clinically inappropriate criteria to restrict access to therapies old and new. A per capita cap will only exacerbate the downward pressure on Medicaid budgets and will further reduce access to these therapies for patients.

Pairing financing reforms with increased flexibility, as has often been proposed, would further undermine Medicaid's role as a safety net for patients. Without current guardrails provided by federal requirements—coupled with reduced federal funding—states will have the authority to reduce benefits and eligibility as they see fit and to impose other restrictions, such as waiting periods and enrollment caps. These policies have serious implications for patients—for a person with cancer, enrollment freezes and waiting lists could mean a later-stage diagnosis when treatment costs are higher and survival is less likely. For a person with diabetes, this would risk the ability to adequately manage the disease. Many of our patients rely on costly services that will be quickly targeted for cuts if states are given such flexibility, so it is imperative that current federal safeguards remain in place.

MAINTAIN MEDICAID EXPANSION

While the AHCA has been described as preserving Medicaid expansion for those already enrolled in coverage, we are concerned that estimates show that eliminating the enhanced match for any enrollee with even a small gap in coverage would actually result in millions of people losing coverage. By eliminating the enhanced federal match for any enrollee with a gap in coverage, eventually states will be on the hook for billions of dollars to continue covering this population—an insurmountable financial hurdle. Additionally, seven states have laws that would effectively end Medicaid expansion immediately or soon thereafter when the expansion match rate is eliminated. Nearly half of adults covered by the Medicaid expansion are permanently disabled, have serious physical or mental conditions—such as cancer, stroke, heart disease, arthritis, pregnancy, or diabetes—or are in fair or poor health. Repealing Medicaid expansion will leave these patients without coverage they depend upon to maintain their health.

The proposed financing reforms are a fundamental shift away from Medicaid's role as a safety-net for some of the most vulnerable members of our society. Repealing Medicaid expansion would leave millions without the health care they rely on. Our organizations represent and provide care for millions of Americans living with ongoing health care needs who rely on Medicaid and we cannot support policies that pose such a grave risk to patients.

We hope that we can continue our dialogue as you move forward in this process to arrive at solutions that provide all Americans with high-quality, affordable care regardless of an individual's income, employment status, health status, or geographic location.

Sincerely,

ADAP Advocacy Association; AIDS Action Baltimore; The AIDS Institute; Alpha-1 Foundation; Alport Syndrome Foundation; ALS Association; American Academy of Pediatrics; American Behcet's Disease Association; American Congress of Obstetricians and Gynecologists; American Diabetes Association; American Lung Association; American Parkinson Disease Association; American Society of Hematology; American Thoracic Society; Amyloidosis Support Groups Inc.; ARPKD/CHF Alliance; Arthritis Foundation; Batten Disease Support & Research Association; Bladder Cancer Advocacy Network.

Bridge the Gap—SYNGAP Education and Research Foundation; Bronx Lebanon Hospital Center Department of Family Medicine; CADASIL Together We Have Hope Non-Profit; Cancer Support Community; Child Neurology Foundation; Children's Cause for Cancer Advocacy; Children's Dental Health Project; Chronic Illness and Disability Partnership; Community Access National Network; Congenital Adrenal Hyperplasia Research Education & Support Foundation, Inc.; COPD Foundation; Cure HHT; Cutaneous Lymphoma Foundation; Cystic Fibrosis Foundation; Cystinosis Research Network; debra of America; Endocrine Society; Fibrous Dysplasia Foundation; First Focus Campaign for Children.

FORCE: Facing Our Risk of Cancer Empowered; Foundation for Prader-Willi Research; Friedreich's Ataxia Research Alliance (FARA); Genetic Alliance; Hannah's Hope Fund; Hide & Seek Foundation for Lysosomal Disease Research; Hispanic Health Network; Hope for Hypothalamic Hamartomas; Huntington's Disease Society of America; Immune Deficiency Foundation; The International Pemphigus and Pemphigoid Foundation; Kids v Cancer; Latino Commission on AIDS; LFS Association (Li-Fraumeni Syndrome Association); Liver Health Connection; March of Dimes; Medicare Rights Center; MLD Foundation.

Moebius Syndrome Foundation; Muscular Dystrophy Association (MDA); NASTAD (National Alliance of State & Territorial AIDS Directors); National Alliance on Mental Illness; National Coalition for Cancer Survivorship; National Health Law Program; National Hemophilia Foundation; National Multiple Sclerosis Society; National Organization for Rare Disorders; National Patient Advocate Foundation; National Tay-Sachs & Allied Diseases Association (NTSAD); National Urea Cycle Disorders Foundation; National Viral Hepatitis Roundtable; NBIA Disorders Association; Needle Exchange Emergency Distribution (NEED); Parent Project Muscular Dystrophy (PPMD); Parkinson Alliance; The PCD (Primary Ciliary Dyskinesia) Foundation; Polycystic Kidney Disease Foundation; Pulmonary Fibrosis Foundation.

PXE International; Rett Syndrome Research Trust; Scleroderma Foundation; The

Sudden Arrhythmia Death Syndromes Foundation; T1D Exchange; Trisomy 18 Foundation; Tuberous Sclerosis Alliance; United Way Worldwide; VHL Alliance; Wilson Disease Association; Wishes for Elliott: Advancing SCN8A Research.

Mr. MCGOVERN. Mr. Speaker, I would say to my colleagues that this is a sad day for this institution. This process has been awful. But this is even a sadder day for the American people.

I remind my colleagues that we are supposed to care about one another, especially the most vulnerable in our society. In this era of Trump, Washington has become a mean place. It is a place where it has become unfashionable to worry about the poor, about older Americans, and about those who struggle.

There is absolutely no justification for giving huge tax breaks to billionaires—$1 trillion in tax breaks to millionaires and billionaires, and at the same time throwing 24 million people off of health care and denying millions more essential healthcare protections.

Twenty-four million people—my Republican colleagues have lost their human ability to feel what that means. That is the entire population of Australia.

Mr. Speaker, I have a great deal of respect for my colleagues, but when I look at this bill and I read this bill, I have to wonder: What are you thinking? How could you do this?

I have come to the conclusion there are only two reasons—there are only two ways you can vote for this bill. One is you don't know what is in the bill; or two is you have to have a heart of stone, because this bill is shameful. It is going to hurt people. It is going to hurt your constituents.

Withdraw this bill or vote ''no'' on this bill, but this bill cannot become law. The health care and healthcare protections for the American people are too important.

Mr. Speaker, I urge all my colleagues—both Democrats and Republicans—reject this. Vote ''no.''

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

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

Mr. Speaker, I want to begin by thanking our colleagues, the gentleman from Massachusetts leading the Rules Committee, and his ranking members as they came from each of the committees, some 50 hours' worth of hearings and markups, including some 16 hours in the Rules Committee to not only talk about and vet, but to understand more clearly what we would be voting on.

Mr. Speaker, today is a bill that is a compromise bill, no doubt about it. I had my own plan and I had my own ideas. I took 2 years to get involved in this process. It is difficult to write a healthcare bill. But it didn't have to be my bill; it had to be a bill that we could all work together on.

President Trump has been a part of that. President Trump took time out of his schedule to do this. It is important to the American people. President Trump, more than any single Member of Congress, gave the message to the American people about what was necessary and what he would do. He is going to live up to that, and we should, too.

Mr. Speaker, the bottom line to this whole thing is we are going to present a Republican plan, and we are going to stand behind what we sell. It is better for the American people. But make no mistake about it: we are transferring power, authority, and responsibility not just to States, but also to the American people. It will be up to them to make determinations about their own health care because, for the first time, we will allow some 50 million Americans to have a tax equity, an opportunity to use tax credits that will be available to families anywhere from $2,000 for an individual to $14,000 for a family.

□ 1030

This will empower people who have not found a fair shot at the tax advantages it will give them: small-business owners; the American people; the average worker in this country, including those who work two or three different jobs; as well as those who are uninsured. We believe it is a better shot, an opportunity. We are willing to put our name on it and behind it.

For these reasons, Mr. Speaker, I urge us to move forward. There will be 4 hours of debate that remain in this opportunity. For that reason, I urge my colleagues to support this rule and the underlying bill.

Ms. JACKSON LEE. Mr. Speaker, I rise in opposition to the rule governing House consideration of H.R. 1628, the "American Health Care Act of 2017," better known as "Trumpcare."

I oppose the rule, and the underlying legislation, for the following reasons:

1. The rule under consideration is brought pursuant to "martial law" rule passed yesterday which suspends the normal House procedure and allows for same day consideration, debate, and vote of legislation that will adversely affect the lives of everyone in America except for the top 1 percent;

2. The underlying bill is less than 2 weeks old and has not had a single hearing in any of the Committees of jurisdiction; and

3. The underlying bill does not reflect the input of nearly half the Members of this body because the legislation was drafted in secret, marked up in a single overnight session, and brought to the floor without incorporating a single amendment or idea proposed by the minority.

Mr. Speaker, none of us here has had a meaningful opportunity to review the bill, "Trumpcare 2.0" we are being asked to vote on.

This bill has undergone significant revision from the one marked up just last week by the Budget Committee of which I am a member.

Trumpcare 2.0 no doubt contains many sweeteners and olive branches granted by the Administration and House Republican leaders in backroom deals in a last ditch effort to secure the necessary votes of Republican members to take away health care from 24 million Americans, many of whom are among the most vulnerable persons in society.

None of these changes to the bill before us has been scored by the Congressional Budget Office so we do not know exactly how many more millions of Americans will be hurt.

But what is unlikely to change is that 14 million Americans will lose Medicaid coverage and more than 52 million persons will be uninsured by 2026 under this Republican plan.

In addition to terminating the ACA Medicaid expansion, the "Trumpcare" converts Medicaid to a per-capita cap that is not guaranteed to keep pace with health costs starting in 2020.

The combined effect of these policies is to slash $880 billion in federal Medicaid funding over the next decade.

In short, Trumpcare represents a clear and present danger to the financial and health security of American families, and to the very stability of our nation's health care system overall.

We should follow regular order in the consideration of all legislation, but especially in a matter with great importance to the American people that could impact nearly 300 million people.

For these reasons, I believe the House should reject this rule and the underlying bill.

Instead of trying to enact the largest transfer of wealth from the bottom 99 percent to the top 1 percent in history, House Republicans should work with Democrats to strengthen the Affordable Care Act which has and continues to make life-affirming differences for the better in the lives of more than 300 million Americans.

Mr. SESSIONS. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

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

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

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on ordering the previous question will be followed by 5-minute votes on:

Adopting the resolution, if ordered;

Suspending the rules and passing H.R. 1365; and,

Agreeing to the Speaker's approval of the Journal, if ordered.

The vote was taken by electronic device, and there were—yeas 236, nays 186, not voting 7, as follows:

[Roll No. 191]

YEAS—236

Abraham	Barton	Brat
Aderholt	Bergman	Bridenstine
Allen	Biggs	Brooks (AL)
Amash	Bilirakis	Brooks (IN)
Amodei	Bishop (MI)	Buchanan
Arrington	Bishop (UT)	Buck
Babin	Black	Bucshon
Bacon	Blackburn	Budd
Banks (IN)	Blum	Burgess
Barletta	Bost	Byrne
Barr	Brady (TX)	Calvert

Carter (GA)
Carter (TX)
Chabot
Chaffetz
Cheney
Coffman
Cole
Collins (GA)
Collins (NY)
Comer
Comstock
Conaway
Cook
Costello (PA)
Cramer
Crawford
Culberson
Curbelo (FL)
Davidson
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Farenthold
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gaetz
Gallagher
Garrett
Gibbs
Gohmert
Goodlatte
Gosar
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guthrie
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Johnson, Sam
Jones
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
LaMalfa
Lamborn
Lance
Latta
Lewis (MN)
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marchant
Marino
Marshall
Massie
Mast
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Meehan
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Murphy (PA)
Newhouse
Noem
Nunes
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reed
Reichert
Renacci
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Scalise
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smucker
Stefanik
Stewart
Stivers
Taylor
Tenney
Thompson (PA)
Thornberry
Tiberi
Tipton
Trott
Turner
Upton
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Williams
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NAYS—186

Adams
Aguilar
Barragán
Bass
Beatty
Bera
Beyer
Bishop (GA)
Blumenauer
Blunt Rochester
Bonamici
Boyle, Brendan F.
Brady (PA)
Brown (MD)
Brownley (CA)
Bustos
Butterfield
Capuano
Carbajal
Cárdenas
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Cooper
Correa
Costa
Courtney
Crist
Crowley
Cuellar
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
Delaney
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Ellison
Engel
Eshoo
Espaillat
Esty
Evans
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Gonzalez (TX)
Gottheimer
Green, Al
Green, Gene
Grijalva
Gutiérrez
Hanabusa
Hastings
Heck
Himes
Hoyer
Huffman
Jackson Lee
Jayapal
Jeffries
Johnson, E. B.
Kaptur
Keating
Kelly (IL)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
Krishnamoorthi
Kuster (NH)
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lawson (FL)
Lee
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham, M.
Luján, Ben Ray
Lynch
Maloney, Carolyn B.
Maloney, Sean
Matsui
McCollum
McEachin
McGovern
McNerney
Meeks
Meng
Moore
Moulton
Murphy (FL)
Nadler
Napolitano
Neal
Nolan
Norcross
O'Halleran
O'Rourke
Pallone
Panetta
Pascrell
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Polis
Price (NC)
Quigley
Raskin
Rice (NY)
Richmond
Rosen
Roybal-Allard
Ruiz
Ruppersberger
Ryan (OH)
Sánchez
Sarbanes
Schakowsky
Schiff
Schneider
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sinema
Sires
Slaughter
Smith (WA)
Soto
Speier
Suozzi
Swalwell (CA)
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Vargas
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Wilson (FL)
Yarmuth

NOT VOTING—7

Higgins (NY)
Johnson (GA)
Lieu, Ted
Payne
Rush
Takano
Tsongas

□ 1054

Messrs. O'HALLERAN, SCHNEIDER, and Mrs. TORRES changed their vote from ''yea'' to ''nay.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

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

RECORDED VOTE

Mr. MCGOVERN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 230, noes 194, not voting 5, as follows:

[Roll No. 192]

AYES—230

Abraham
Aderholt
Allen
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barton
Bergman
Biggs
Bilirakis
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Bost
Brady (TX)
Brat
Bridenstine
Brooks (IN)
Buchanan
Buck
Bucshon
Budd
Burgess
Byrne
Calvert
Carter (GA)
Carter (TX)
Chabot
Chaffetz
Cheney
Coffman
Cole
Collins (GA)
Collins (NY)
Comer
Comstock
Conaway
Cook
Costello (PA)
Cramer
Crawford
Culberson
Curbelo (FL)
Davidson
Davis, Rodney
Denham
Dent
DeSantis
DesJarlais
Diaz-Balart
Donovan
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Farenthold
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foxx
Franks (AZ)
Frelinghuysen
Gaetz
Gallagher
Garrett
Gibbs
Goodlatte
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Griffith
Grothman
Guthrie
Harper
Harris
Hartzler
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Hill
Holding
Hollingsworth
Hudson
Huizenga
Hultgren
Hunter
Hurd
Issa
Jenkins (KS)
Jenkins (WV)
Johnson (LA)
Johnson (OH)
Johnson, Sam
Jordan
Joyce (OH)
Katko
Kelly (MS)
Kelly (PA)
King (IA)
King (NY)
Kinzinger
Knight
Kustoff (TN)
Labrador
LaHood
LaMalfa
Lamborn
Lance
Latta
Lewis (MN)
LoBiondo
Long
Loudermilk
Love
Lucas
Luetkemeyer
MacArthur
Marchant
Marino
Marshall
Mast
McCarthy
McCaul
McClintock
McHenry
McKinley
McMorris Rodgers
McSally
Meadows
Meehan
Messer
Mitchell
Moolenaar
Mooney (WV)
Mullin
Murphy (PA)
Newhouse
Noem
Nunes
Olson
Palazzo
Palmer
Paulsen
Pearce
Perry
Pittenger
Poe (TX)
Poliquin
Posey
Ratcliffe
Reed
Reichert
Renacci
Rice (SC)
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Roskam
Ross
Rothfus
Rouzer
Royce (CA)
Russell
Rutherford
Sanford
Scalise
Schweikert
Scott, Austin
Sensenbrenner
Sessions
Shimkus
Shuster
Simpson
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smucker
Stefanik
Stewart
Stivers
Taylor
Tenney
Thompson (PA)
Thornberry
Tiberi
Tipton
Trott
Turner
Upton
Valadao
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Weber (TX)
Webster (FL)
Wenstrup
Westerman
Williams
Wilson (SC)
Wittman
Womack
Woodall
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NOES—194

Adams
Aguilar
Amash
Barragán
Bass
Beatty
Bera
Beyer
Bishop (GA)
Blumenauer
Blunt Rochester
Bonamici
Boyle, Brendan F.
Brady (PA)
Brooks (AL)
Brown (MD)
Brownley (CA)
Bustos
Butterfield
Capuano
Carbajal
Cárdenas
Carson (IN)
Cartwright
Castor (FL)
Castro (TX)
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Cohen
Connolly
Conyers
Cooper
Correa
Costa
Courtney
Crist
Crowley
Cuellar
Cummings
Davis (CA)
Davis, Danny
DeFazio
DeGette
Delaney
DeLauro
DelBene
Demings
DeSaulnier
Deutch
Dingell
Doggett
Doyle, Michael F.
Ellison
Engel
Eshoo
Espaillat
Esty
Evans
Foster
Frankel (FL)
Fudge
Gabbard
Gallego
Garamendi
Gohmert
Gonzalez (TX)
Gosar
Gottheimer
Green, Al
Green, Gene
Grijalva
Gutiérrez
Hanabusa
Hastings
Heck
Higgins (NY)
Himes
Hoyer
Huffman
Jackson Lee
Jayapal
Jeffries
Johnson (GA)
Johnson, E. B.
Jones
Kaptur
Keating
Kelly (IL)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
Krishnamoorthi
Kuster (NH)
Langevin
Larsen (WA)
Larson (CT)
Lawrence
Lawson (FL)
Lee
Levin
Lewis (GA)
Lipinski
Loebsack
Lofgren
Lowenthal
Lowey
Lujan Grisham, M.
Luján, Ben Ray
Lynch
Maloney, Carolyn B.
Maloney, Sean
Massie
Matsui
McCollum
McEachin
McGovern
McNerney
Meeks
Meng
Moore
Moulton
Murphy (FL)
Nadler

Napolitano
Neal
Nolan
Norcross
O'Halleran
O'Rourke
Pallone
Panetta
Pascrell
Pelosi
Perlmutter
Peters
Peterson
Pingree
Pocan
Polis
Price (NC)
Quigley
Raskin
Rice (NY)
Richmond
Rosen
Roybal-Allard
Ruiz
Ruppersberger
Ryan (OH)
Sánchez
Sarbanes
Schakowsky
Schiff
Schneider
Schrader
Scott (VA)
Scott, David
Serrano
Sewell (AL)
Shea-Porter
Sherman
Sinema
Sires
Slaughter
Smith (WA)
Soto
Speier
Suozzi
Swalwell (CA)
Thompson (CA)
Thompson (MS)
Titus
Tonko
Torres
Vargas
Veasey
Vela
Velázquez
Visclosky
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Welch
Wilson (FL)
Yarmuth

NOT VOTING—5

Lieu, Ted
Payne
Rush
Takano
Tsongas

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining.

□ 1102

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

DEPARTMENT OF HOMELAND SECURITY ACQUISITION INNOVATION ACT

The SPEAKER pro tempore (Ms. FOXX). The unfinished business is the question on suspending the rules and passing the bill (H.R. 1365) to amend the Homeland Security Act of 2002 to require certain acquisition innovation, and for other purposes, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. DONOVAN) that the House suspend the rules and pass the bill, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

RECORDED VOTE

Mrs. BLACK. Madam Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 424, noes 0, not voting 5, as follows:

[Roll No. 193]

AYES—424

Abraham
Adams
Aderholt
Aguilar
Allen
Amash
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barr
Barragán
Barton
Bass
Beatty
Bera
Bergman
Beyer
Biggs
Bilirakis
Bishop (GA)
Bishop (MI)
Bishop (UT)
Black
Blackburn
Blum
Blumenauer
Blunt Rochester
Bonamici
Bost
Boyle, Brendan F.
Brady (PA)
Brady (TX)
Brat
Bridenstine
Brooks (AL)
Brooks (IN)
Brown (MD)
Brownley (CA)
Buchanan
Buck
Bucshon
Budd
Burgess
Bustos
Butterfield
Byrne
Calvert
Capuano
Carbajal
Cárdenas
Carson (IN)
Carter (GA)
Carter (TX)
Cartwright
Castor (FL)
Castro (TX)
Chabot
Chaffetz
Cheney
Chu, Judy
Cicilline
Clark (MA)
Clarke (NY)
Clay
Cleaver
Clyburn
Coffman
Cohen
Cole
Collins (GA)
Collins (NY)
Comer
Comstock
Conaway
Connolly
Conyers
Cook
Cooper
Correa
Costa
Costello (PA)
Courtney
Cramer
Crawford
Crist
Crowley
Cuellar
Culberson
Cummings
Curbelo (FL)
Davidson
Davis (CA)
Davis, Danny
Davis, Rodney
DeFazio
DeGette
Delaney
DeLauro
DelBene
Demings
Denham
Dent
DeSantis
DeSaulnier
DesJarlais
Deutch
Diaz-Balart
Dingell
Doggett
Donovan
Doyle, Michael F.
Duffy
Duncan (SC)
Duncan (TN)
Dunn
Ellison
Emmer
Engel
Eshoo
Espaillat
Esty
Evans
Farenthold
Faso
Ferguson
Fitzpatrick
Fleischmann
Flores
Fortenberry
Foster
Foxx
Frankel (FL)
Franks (AZ)
Frelinghuysen
Fudge
Gabbard
Gaetz
Gallagher
Gallego
Garamendi
Garrett
Gibbs
Gohmert
Gonzalez (TX)
Goodlatte
Gosar
Gottheimer
Gowdy
Granger
Graves (GA)
Graves (LA)
Graves (MO)
Green, Al
Green, Gene
Griffith
Grijalva
Grothman
Guthrie
Gutiérrez
Hanabusa
Harper
Harris
Hartzler
Hastings
Heck
Hensarling
Herrera Beutler
Hice, Jody B.
Higgins (LA)
Higgins (NY)
Hill
Himes
Holding
Hollingsworth
Hoyer
Hudson
Huffman
Huizenga
Hultgren
Hunter
Hurd
Issa
Jackson Lee
Jayapal
Jeffries
Jenkins (KS)
Jenkins (WV)
Johnson (GA)
Johnson (LA)
Johnson (OH)
Johnson, E. B.
Johnson, Sam
Jones
Jordan
Joyce (OH)
Kaptur
Katko
Keating
Kelly (IL)
Kelly (MS)
Kelly (PA)
Kennedy
Khanna
Kihuen
Kildee
Kilmer
Kind
King (IA)
King (NY)
Kinzinger
Knight
Krishnamoorthi
Kuster (NH)
Kustoff (TN)
Labrador
LaHood
LaMalfa
Lamborn
Lance
Langevin
Larsen (WA)
Larson (CT)
Latta
Lawrence
Lawson (FL)
Lee
Levin
Lewis (GA)
Lewis (MN)
Lipinski
LoBiondo
Loebsack
Lofgren
Long
Loudermilk
Love
Lowenthal
Lowey
Lucas
Luetkemeyer
Lujan Grisham, M.
Luján, Ben Ray
Lynch
MacArthur
Maloney, Carolyn B.
Maloney, Sean
Marchant
Marino
Marshall
Massie
Mast
Matsui
McCarthy
McCaul
McClintock
McCollum
McEachin
McGovern
McHenry
McKinley
McMorris Rodgers
McNerney
McSally
Meadows
Meehan
Meeks
Meng
Messer
Mitchell
Moolenaar
Mooney (WV)
Moore
Moulton
Mullin
Murphy (FL)
Murphy (PA)
Nadler
Napolitano
Neal
Newhouse
Noem
Nolan
Norcross
Nunes
O'Halleran
O'Rourke
Olson
Palazzo
Pallone
Palmer
Panetta
Pascrell
Paulsen
Pearce
Pelosi
Perlmutter
Perry
Peters
Peterson
Pingree
Pittenger
Pocan
Poe (TX)
Poliquin
Polis
Posey
Price (NC)
Quigley
Raskin
Ratcliffe
Reed
Reichert
Renacci
Rice (NY)
Rice (SC)
Richmond
Roby
Roe (TN)
Rogers (AL)
Rogers (KY)
Rohrabacher
Rokita
Rooney, Francis
Rooney, Thomas J.
Ros-Lehtinen
Rosen
Roskam
Ross
Rothfus
Rouzer
Roybal-Allard
Royce (CA)
Ruiz
Ruppersberger
Russell
Rutherford
Ryan (OH)
Sánchez
Sanford
Sarbanes
Scalise
Schakowsky
Schiff
Schneider
Schrader
Schweikert
Scott (VA)
Scott, Austin
Scott, David
Sensenbrenner
Serrano
Sessions
Sewell (AL)
Shea-Porter
Sherman
Shimkus
Shuster
Simpson
Sinema
Sires
Slaughter
Smith (MO)
Smith (NE)
Smith (NJ)
Smith (TX)
Smith (WA)
Smucker
Soto
Speier
Stefanik
Stewart
Stivers
Suozzi
Swalwell (CA)
Taylor
Tenney
Thompson (CA)
Thompson (MS)
Thompson (PA)
Thornberry
Tiberi
Tipton
Titus
Tonko
Torres
Trott
Turner
Upton
Valadao
Vargas
Veasey
Vela
Velázquez
Visclosky
Wagner
Walberg
Walden
Walker
Walorski
Walters, Mimi
Walz
Wasserman Schultz
Waters, Maxine
Watson Coleman
Weber (TX)
Webster (FL)
Welch
Wenstrup
Westerman
Williams
Wilson (FL)
Wilson (SC)
Wittman
Womack
Woodall
Yarmuth
Yoder
Yoho
Young (AK)
Young (IA)
Zeldin

NOT VOTING—5

Lieu, Ted
Payne
Rush
Takano
Tsongas

□ 1111

So (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

THE JOURNAL

The SPEAKER pro tempore. The unfinished business is the question on agreeing to the Speaker's approval of the Journal, which the Chair will put de novo.

The question is on the Speaker's approval of the Journal.

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

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

The yeas and nays were ordered.

The SPEAKER pro tempore. This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 218, nays 201, answered ''present'' 1, not voting 9, as follows:

[Roll No. 194]

YEAS—218

Abraham
Aderholt
Allen
Amodei
Arrington
Babin
Bacon
Banks (IN)
Barletta
Barton
Bilirakis
Bishop (UT)
Black
Blackburn
Blumenauer
Bonamici
Brady (TX)
Brat
Bridenstine
Brooks (AL)
Brooks (IN)
Buchanan
Bucshon
Bustos
Byrne
Calvert
Carter (TX)
Castro (TX)
Chabot
Chaffetz
Cheney
Chu, Judy
Cicilline
Clay
Collins (NY)
Comer
Comstock
Conyers
Cook
Cooper
Correa
Cramer
Crawford
Cuellar
Culberson
Curbelo (FL)
Davidson
Davis (CA)
Davis, Danny
Davis, Rodney
DeLauro
DelBene
Demings
Dent
DesJarlais
Deutch
Doggett
Donovan
Duncan (SC)
Duncan (TN)
Dunn
Emmer
Engel
Esty
Farenthold
Faso

Ferguson	Lowey	Russell
Fleischmann	Lucas	Rutherford
Fortenberry	Luetkemeyer	Scalise
Foster	Lujan Grisham, M.	Schneider
Frankel (FL)	Marchant	Schweikert
Frelinghuysen	Marino	Scott, Austin
Gabbard	Marshall	Scott, David
Gallego	Massie	Sensenbrenner
Garamendi	McCarthy	Sessions
Garrett	McCaul	Shea-Porter
Gibbs	McClintock	Sherman
Goodlatte	McHenry	Shimkus
Gottheimer	McMorris Rodgers	Shuster
Gowdy	McNerney	Simpson
Granger	Meadows	Sinema
Graves (MO)	Meeks	Slaughter
Grothman	Meng	Smith (MO)
Guthrie	Messer	Smith (NE)
Harper	Mitchell	Smith (NJ)
Harris	Moolenaar	Smith (TX)
Heck	Mooney (WV)	Smith (WA)
Hensarling	Mullin	Smucker
Higgins (LA)	Murphy (FL)	Speier
Himes	Murphy (PA)	Stefanik
Hollingsworth	Nadler	Stewart
Huffman	Newhouse	Suozzi
Huizenga	Nunes	Taylor
Hultgren	O'Rourke	Tenney
Hunter	Olson	Thornberry
Issa	Palazzo	Titus
Johnson (LA)	Pascrell	Torres
Johnson, Sam	Perry	Trott
Kelly (MS)	Pocan	Vela
Kelly (PA)	Polis	Wagner
Kildee	Posey	Walden
King (IA)	Quigley	Walker
King (NY)	Ratcliffe	Walorski
Knight	Reed	Walters, Mimi
Krishnamoorthi	Rice (SC)	Walz
Kuster (NH)	Roby	Wasserman Schultz
Kustoff (TN)	Rogers (KY)	Webster (FL)
Labrador	Rohrabacher	Welch
LaHood	Rooney, Francis	Wenstrup
LaMalfa	Rooney, Thomas J.	Westerman
Lamborn	Ross	Williams
Latta	Rothfus	Wilson (SC)
Lawson (FL)	Royce (CA)	Wittman
Lewis (MN)	Ruiz	Womack
Lipinski	Ruppersberger	Yarmuth
Long	Ryan (OH)	Young (IA)
Loudermilk	Sánchez	Zeldin
Lowenthal	Sarbanes	

NAYS—201

Adams	DeFazio	Jenkins (KS)
Aguilar	DeGette	Jenkins (WV)
Amash	Delaney	Johnson (GA)
Barr	Denham	Johnson (OH)
Barragán	DeSantis	Johnson, E. B.
Bass	DeSaulnier	Jones
Beatty	Diaz-Balart	Jordan
Bera	Dingell	Joyce (OH)
Bergman	Doyle, Michael F.	Kaptur
Beyer	Duffy	Katko
Biggs	Ellison	Keating
Bishop (GA)	Eshoo	Kelly (IL)
Bishop (MI)	Espaillat	Kennedy
Blum	Evans	Khanna
Blunt Rochester	Fitzpatrick	Kihuen
Bost	Flores	Kilmer
Boyle, Brendan F.	Foxx	Kind
Brady (PA)	Franks (AZ)	Kinzinger
Brown (MD)	Fudge	Lance
Brownley (CA)	Gaetz	Langevin
Buck	Gallagher	Larsen (WA)
Burgess	Gonzalez (TX)	Larson (CT)
Butterfield	Gosar	Lawrence
Capuano	Graves (GA)	Lee
Carbajal	Graves (LA)	Levin
Carson (IN)	Green, Al	Lewis (GA)
Carter (GA)	Green, Gene	LoBiondo
Cartwright	Griffith	Loebsack
Castor (FL)	Grijalva	Lofgren
Clark (MA)	Gutiérrez	Love
Clarke (NY)	Hanabusa	Luján, Ben Ray
Cleaver	Hartzler	Lynch
Clyburn	Hastings	MacArthur
Coffman	Herrera Beutler	Maloney, Carolyn B.
Cohen	Hice, Jody B.	Maloney, Sean
Collins (GA)	Higgins (NY)	Mast
Conaway	Hill	Matsui
Connolly	Holding	McEachin
Costa	Hoyer	McGovern
Costello (PA)	Hudson	McKinley
Courtney	Hurd	McSally
Crist	Jackson Lee	Meehan
Crowley	Jayapal	Moore
Cummings	Jeffries	Moulton
Napolitano	Renacci	Stivers
Neal	Rice (NY)	Swalwell (CA)
Noem	Richmond	Thompson (CA)
Nolan	Roe (TN)	Thompson (MS)
Norcross	Rogers (AL)	Thompson (PA)
O'Halleran	Rokita	Tiberi
Pallone	Ros-Lehtinen	Tipton
Palmer	Rosen	Turner
Panetta	Roskam	Upton
Paulsen	Rouzer	Valadao
Payne	Roybal-Allard	Vargas
Pearce	Ryan (OH)	Veasey
Pelosi	Sánchez	Velázquez
Perlmutter	Sanford	Visclosky
Peters	Sarbanes	Walberg
Peterson	Schakowsky	Waters, Maxine
Pingree	Schiff	Watson Coleman
Pittenger	Schrader	Weber (TX)
Poe (TX)	Scott (VA)	Wilson (FL)
Poliquin	Serrano	Woodall
Price (NC)	Sewell (AL)	Yoder
Raskin	Sires	Yoho
Reichert	Soto	Young (AK)

ANSWERED ''PRESENT''—1

Tonko

NOT VOTING—9

Budd	Gohmert	Rush
Cárdenas	Lieu, Ted	Takano
Cole	McCollum	Tsongas

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining.

□ 1117

So the Journal was approved.

The result of the vote was announced as above recorded.

AMERICAN HEALTH CARE ACT OF 2017

Mrs. BLACK. Mr. Speaker, pursuant to House Resolution 228, I call up the bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. SIMPSON). Pursuant to House Resolution 228, the amendments specified in section 2 of House Resolution 228 shall be considered as adopted, and the bill, as amended, is considered read.

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

H.R. 1628

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''American Health Care Act of 2017''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—ENERGY AND COMMERCE

Subtitle A—Patient Access to Public Health Programs

SEC. 101. THE PREVENTION AND PUBLIC HEALTH FUND.

(a) IN GENERAL.—Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11), as amended by

section 5009 of the 21st Century Cures Act, is amended—

(1) in paragraph (2), by adding ''and'' at the end;

(2) in paragraph (3)—

(A) by striking ''each of fiscal years 2018 and 2019'' and inserting ''fiscal year 2018''; and

(B) by striking the semicolon at the end and inserting a period; and

(3) by striking paragraphs (4) through (8).

(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the funds made available by such section 4002, the unobligated balance at the end of fiscal year 2018 is rescinded.

SEC. 102. COMMUNITY HEALTH CENTER PROGRAM.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting '', and an additional $422,000,000 for fiscal year 2017'' after ''2017''.

SEC. 103. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397bb(a)(7), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the 1-year period beginning on the date of the enactment of this Act, no Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the State.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term ''prohibited entity'' means an entity, including its affiliates, subsidiaries, successors, and clinics—

(A) that, as of the date of enactment of this Act—

(i) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;

(ii) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and

(iii) provides for abortions, other than an abortion—

(I) if the pregnancy is the result of an act of rape or incest; or

(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself; and

(B) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $350,000,000.

(2) DIRECT SPENDING.—The term ''direct spending'' has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

Subtitle B—Medicaid Program Enhancement

SEC. 111. REPEAL OF MEDICAID PROVISIONS.

The Social Security Act is amended—

(1) in section 1902 (42 U.S.C. 1396a)—

(A) in subsection (a)(47)(B), by inserting ''and provided that any such election shall cease to be effective on January 1, 2020, and no such election shall be made after that date'' before the semicolon at the end; and

(B) in subsection (l)(2)(C), by inserting ''and ending December 31, 2019,'' after ''January 1, 2014,'';

(2) in section 1915(k)(2) (42 U.S.C. 1396n(k)(2)), by striking ''during the period described in paragraph (1)'' and inserting ''on or after the date referred to in paragraph (1) and before January 1, 2020''; and

(3) in section 1920(e) (42 U.S.C. 1396r–1(e)), by striking ''under clause (i)(VIII), clause (i)(IX), or clause (ii)(XX) of subsection (a)(10)(A)'' and inserting ''under clause (i)(VIII) or clause (ii)(XX) of section 1902(a)(10)(A) before January 1, 2020, section 1902(a)(10)(A)(i)(IX),''.

SEC. 112. REPEAL OF MEDICAID EXPANSION.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) in section 1902 (42 U.S.C. 1396a)—

(A) in subsection (a)(10)(A)—

(i) in clause (i)(VIII), by inserting ''and ending December 31, 2019,'' after ''2014,'';

(ii) in clause (ii)(XX), by inserting ''and ending December 31, 2017,'' after ''2014,''; and

(iii) in clause (ii), by adding at the end the following new subclause:

''(XXIII) beginning January 1, 2020—

''(aa) who are expansion enrollees (as defined in subsection (nn)(1)); or

''(bb) who are grandfathered expansion enrollees (as defined in subsection (nn)(2));''; and

(B) by adding at the end the following new subsection:

''(nn) EXPANSION ENROLLEES.—In this title:

''(1) IN GENERAL.—The term 'expansion enrollee' means an individual—

''(A) who is under 65 years of age;

''(B) who is not pregnant;

''(C) who is not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII;

''(D) who is not described in any of subclauses (I) through (VII) of subsection (a)(10)(A)(i); and

''(E) whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

''(2) GRANDFATHERED EXPANSION ENROLLEES.—The term 'grandfathered expansion enrollee' means an expansion enrollee who—

''(A) was enrolled under the State plan under this title (or under a waiver of such plan) as of December 31, 2019; and

''(B) does not have a break in eligibility for medical assistance under such State plan (or waiver) for more than one month after such date.

''(3) APPLICATION OF RELATED PROVISIONS.—Any reference in subsection (a)(10)(G), (k), or (gg) of this section or in section 1903, 1905(a), 1920(e), or 1937(a)(1)(B) to individuals described in subclause (VIII) of subsection (a)(10)(A)(i) shall be deemed to include a reference to expansion enrollees (including grandfathered expansion enrollees).''; and

(2) in section 1905 (42 U.S.C. 1396d)—

(A) in subsection (y)(1), in the matter preceding subparagraph (A)—

(i) by inserting ''and that has elected to cover newly eligible individuals before March 1, 2017'' after ''that is one of the 50 States or the District of Columbia''; and

(ii) by inserting after ''subclause (VIII) of section 1902(a)(10)(A)(i)'' the following: ''who, for periods after December 31, 2019, are grandfathered expansion enrollees (as defined in section 1902(nn)(2))''; and

(B) in subsection (z)(2)—

(i) in subparagraph (A), by inserting after ''section 1937'' the following: ''and, for periods after December 31, 2019, who are grandfathered expansion enrollees (as defined in section 1902(nn)(2))''; and

(ii) in subparagraph (B)(ii)—

(I) in subclause (III), by adding ''and'' at the end; and

(II) by striking subclauses (IV), (V), and (VI) and inserting the following new subclause:

''(IV) 2017 and each subsequent year is 80 percent.''.

(b) SUNSET OF ESSENTIAL HEALTH BENEFITS REQUIREMENT.—Section 1937(b)(5) of the Social Security Act (42 U.S.C. 1396u–7(b)(5)) is amended by adding at the end the following: ''This paragraph shall not apply after December 31, 2019.''.

SEC. 113. ELIMINATION OF DSH CUTS.

Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (7)—

(A) in subparagraph (A)—

(i) in clause (i)—

(I) in the matter preceding subclause (I), by striking ''2025'' and inserting ''2019''; and

(ii) in clause (ii)—

(I) in subclause (I), by adding ''and'' at the end;

(II) in subclause (II), by striking the semicolon at the end and inserting a period; and

(III) by striking subclauses (III) through (VIII); and

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

''(C) EXEMPTION FROM REDUCTION FOR NON-EXPANSION STATES.—

''(i) IN GENERAL.—In the case of a State that is a non-expansion State for a fiscal year, subparagraph (A)(i) shall not apply to the DSH allotment for such State and fiscal year.

''(ii) NO CHANGE IN REDUCTION FOR EXPANSION STATES.—In the case of a State that is an expansion State for a fiscal year, the DSH allotment for such State and fiscal year shall be determined as if clause (i) did not apply.

''(iii) NON-EXPANSION AND EXPANSION STATE DEFINED.—

''(I) The term 'expansion State' means with respect to a fiscal year, a State that, as of July 1 of the preceding fiscal year, provides for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115).

''(II) The term 'non-expansion State' means, with respect to a fiscal year, a State that is not an expansion State.''; and

(2) in paragraph (8), by striking ''fiscal year 2025'' and inserting ''fiscal year 2019''.

SEC. 114. REDUCING STATE MEDICAID COSTS.

(a) LETTING STATES DISENROLL HIGH DOLLAR LOTTERY WINNERS.—

(1) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(17), by striking ''(e)(14), (e)(14)'' and inserting ''(e)(14), (e)(15)''; and

(B) in subsection (e)—

(i) in paragraph (14) (relating to modified adjusted gross income), by adding at the end the following new subparagraph:

''(J) TREATMENT OF CERTAIN LOTTERY WINNINGS AND INCOME RECEIVED AS A LUMP SUM.—

''(i) IN GENERAL.—In the case of an individual who is the recipient of qualified lottery winnings (pursuant to lotteries occurring on or after January 1, 2020) or qualified lump sum income (received on or after such

date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received—

''(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than $80,000;

''(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or equal to $80,000 but less than $90,000;

''(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to $90,000 but less than $100,000; and

''(IV) over a period of 3 months plus 1 additional month for each increment of $10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of $1,260,000 or more), if the amount of such winnings or income is greater than or equal to $100,000.

''(ii) COUNTING IN EQUAL INSTALLMENTS.—For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

''(iii) HARDSHIP EXEMPTION.—An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, may continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State under the State plan (or in the case of a waiver of the plan under section 1115, incorporated in such waiver), or as otherwise established by such State in accordance with such standards as may be specified by the Secretary, that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

''(iv) NOTIFICATIONS AND ASSISTANCE REQUIRED IN CASE OF LOSS OF ELIGIBILITY.—A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i), before the date on which the individual loses such eligibility, inform the individual of the date on which the individual would no longer be considered ineligible by reason of such clause to receive medical assistance under the State plan or under any waiver of such plan and the date on which the individual would be eligible to reapply to receive such medical assistance.

''(v) QUALIFIED LOTTERY WINNINGS DEFINED.—In this subparagraph, the term 'qualified lottery winnings' means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

''(vi) QUALIFIED LUMP SUM INCOME DEFINED.—In this subparagraph, the term 'qualified lump sum income' means income that is received as a lump sum from one of the following sources:

''(I) Monetary winnings from gambling (as defined by the Secretary and including monetary winnings from gambling activities described in section 1955(b)(4) of title 18, United States Code).

''(II) Income received as liquid assets from the estate (as defined in section 1917(b)(4)) of a deceased individual.''; and

(ii) by striking ''(14) EXCLUSION'' and inserting ''(15) EXCLUSION''.

(2) RULES OF CONSTRUCTION.—

(A) INTERCEPTION OF LOTTERY WINNINGS ALLOWED.—Nothing in the amendment made by paragraph (1)(B)(i) shall be construed as preventing a State from intercepting the State lottery winnings awarded to an individual in the State to recover amounts paid by the State under the State Medicaid plan under title XIX of the Social Security Act for medical assistance furnished to the individual.

(B) APPLICABILITY LIMITED TO ELIGIBILITY OF RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by paragraph (1)(B)(i) shall be construed, with respect to a determination of household income for purposes of a determination of eligibility for medical assistance under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) made by applying modified adjusted gross income under subparagraph (A) of section 1902(e)(14) of such Act (42 U.S.C. 1396a(e)(14)), as limiting the eligibility for such medical assistance of any individual that is a member of the household other than the individual (or the individual's spouse) who received qualified lottery winnings or qualified lump-sum income (as defined in subparagraph (J) of such section 1902(e)(14), as added by paragraph (1)(B)(i) of this subsection).

(b) REPEAL OF RETROACTIVE ELIGIBILITY.—

(1) IN GENERAL.—

(A) STATE PLAN REQUIREMENTS.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by striking ''in or after the third month before the month in which he made application'' and inserting ''in or after the month in which the individual made application''.

(B) DEFINITION OF MEDICAL ASSISTANCE.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by striking ''in or after the third month before the month in which the recipient makes application for assistance'' and inserting ''in or after the month in which the recipient makes application for assistance''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to medical assistance with respect to individuals whose eligibility for such assistance is based on an application for such assistance made (or deemed to be made) on or after October 1, 2017.

(c) UPDATING ALLOWABLE HOME EQUITY LIMITS IN MEDICAID.—

(1) IN GENERAL.—Section 1917(f)(1) of the Social Security Act (42 U.S.C. 1396p(f)(1)) is amended—

(A) in subparagraph (A), by striking ''subparagraphs (B) and (C)'' and inserting ''subparagraph (B)'';

(B) by striking subparagraph (B);

(C) by redesignating subparagraph (C) as subparagraph (B); and

(D) in subparagraph (B), as so redesignated, by striking ''dollar amounts specified in this paragraph'' and inserting ''dollar amount specified in subparagraph (A)''.

(2) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by paragraph (1) shall apply with respect to eligibility determinations made after the date that is 180 days after the date of the enactment of this section.

(B) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX of the Social Security Act that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by amendments made by this subsection, the respective plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 115. SAFETY NET FUNDING FOR NON-EXPANSION STATES.

Title XIX of the Social Security Act is amended by inserting after section 1923 (42 U.S.C. 1396r–4) the following new section:

''ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY NET PROVIDERS IN NON-EXPANSION STATES

''SEC. 1923A. (a) IN GENERAL.—Subject to the limitations of this section, for each year during the period beginning with fiscal year 2018 and ending with fiscal year 2022, each State that is one of the 50 States or the District of Columbia and that, as of July 1 of the preceding fiscal year, did not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the State plan approved under section 1115) (each such State or District referred to in this section for the fiscal year as a 'non-expansion State') may adjust the payment amounts otherwise provided under the State plan under this title (or a waiver of such plan) to health care providers that provide health care services to individuals enrolled under this title (in this section referred to as 'eligible providers') so long as the payment adjustment to such an eligible provider does not exceed the provider's costs in furnishing health care services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) to individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

''(b) INCREASE IN APPLICABLE FMAP.—Notwithstanding section 1905(b), the Federal medical assistance percentage applicable with respect to expenditures attributable to a payment adjustment under subsection (a) for which payment is permitted under subsection (c) shall be equal to—

''(1) 100 percent for calendar quarters in fiscal years 2018, 2019, 2020, and 2021; and

''(2) 95 percent for calendar quarters in fiscal year 2022.

''(c) ANNUAL ALLOTMENT LIMITATION.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for all calendar quarters in a fiscal year in excess of the $2,000,000,000 multiplied by the ratio of—

''(1) the population of the State with income below 138 percent of the poverty line in 2015 (as determined based the table entitled 'Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age' for the universe of the civilian noninstitutionalized population for whom poverty status is determined based on the 2015 American Community Survey 1–Year Estimates, as published by the Bureau of the Census), to

''(2) the sum of the populations under paragraph (1) for all non-expansion States.

''(d) DISQUALIFICATION IN CASE OF STATE COVERAGE EXPANSION.—If a State is a non-expansion for a fiscal year and provides eligibility for medical assistance described in subsection (a) during the fiscal year, the State shall no longer be treated as a non-expansion State under this section for any subsequent fiscal years.''.

SEC. 116. PROVIDING INCENTIVES FOR INCREASED FREQUENCY OF ELIGIBILITY REDETERMINATIONS.

(a) IN GENERAL.—Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14))

(relating to modified adjusted gross income), as amended by section 114(a)(1), is further amended by adding at the end the following:

''(K) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII) or clause (ii)(XX) of subsection (a)(10)(A), a State shall redetermine such individual's eligibility for such medical assistance no less frequently than once every 6 months.''.

(b) INCREASED ADMINISTRATIVE MATCHING PERCENTAGE.—For each calendar quarter during the period beginning on October 1, 2017, and ending on December 31, 2019, the Federal matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) with respect to State expenditures during such quarter that are attributable to meeting the requirement of section 1902(e)(14) (relating to determinations of eligibility using modified adjusted gross income) of such Act shall be increased by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to increase the frequency of eligibility redeterminations required by subparagraph (K) of such section (relating to eligibility redeterminations made on a 6-month basis) (as added by subsection (a)).

SEC. 117. PERMITTING STATES TO APPLY A WORK REQUIREMENT FOR NONDISABLED, NONELDERLY, NONPREGNANT ADULTS UNDER MEDICAID.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as previously amended, is further amended by adding at the end the following new subsection:

''(oo) WORK REQUIREMENT OPTION FOR NONDISABLED, NONELDERLY, NONPREGNANT ADULTS.—

''(1) IN GENERAL.—Beginning October 1, 2017, subject to paragraph (3), a State may elect to condition medical assistance to a nondisabled, nonelderly, nonpregnant individual under this title upon such an individual's satisfaction of a work requirement (as defined in paragraph (2)).

''(2) WORK REQUIREMENT DEFINED.—In this section, the term 'work requirement' means, with respect to an individual, the individual's participation in work activities (as defined in section 407(d)) for such period of time as determined by the State, and as directed and administered by the State.

''(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may not apply such requirement to—

''(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) an individual who is under 19 years of age;

''(C) an individual who is the only parent or caretaker relative in the family of a child who has not attained 6 years of age or who is the only parent or caretaker of a child with disabilities; or

''(D) an individual who is married or a head of household and has not attained 20 years of age and who—

''(i) maintains satisfactory attendance at secondary school or the equivalent; or

''(ii) participates in education directly related to employment.''.

(b) INCREASE IN MATCHING RATE FOR IMPLEMENTATION.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

''(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures during a calendar quarter for which the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased for such calendar quarter by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of section 1902.''.

Subtitle C—Per Capita Allotment for Medical Assistance

SEC. 121. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.

Title XIX of the Social Security Act is amended—

(1) in section 1903 (42 U.S.C. 1396b)—

(A) in subsection (a), in the matter before paragraph (1), by inserting ''and section 1903A(a)'' after ''except as otherwise provided in this section''; and

(B) in subsection (d)(1), by striking ''to which'' and inserting ''to which, subject to section 1903A(a),''; and

(2) by inserting after such section 1903 the following new section:

''SEC. 1903A. PER CAPITA-BASED CAP ON PAYMENTS FOR MEDICAL ASSISTANCE.

''(a) APPLICATION OF PER CAPITA CAP ON PAYMENTS FOR MEDICAL ASSISTANCE EXPENDITURES.—

''(1) IN GENERAL.—If a State has excess aggregate medical assistance expenditures (as defined in paragraph (2)) for a fiscal year (beginning with fiscal year 2020), the amount of payment to the State under section 1903(a)(1) for each quarter in the following fiscal year shall be reduced by ¼ of the excess aggregate medical assistance payments (as defined in paragraph (3)) for that previous fiscal year. In this section, the term 'State' means only the 50 States and the District of Columbia.

''(2) EXCESS AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'excess aggregate medical assistance expenditures' means, for a State for a fiscal year, the amount (if any) by which—

''(A) the amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State and fiscal year; exceeds

''(B) the amount of the target total medical assistance expenditures (as defined in subsection (c)) for the State and fiscal year.

''(3) EXCESS AGGREGATE MEDICAL ASSISTANCE PAYMENTS.—In this subsection, the term 'excess aggregate medical assistance payments' means, for a State for a fiscal year, the product of—

''(A) the excess aggregate medical assistance expenditures (as defined in paragraph (2)) for the State for the fiscal year; and

''(B) the Federal average medical assistance matching percentage (as defined in paragraph (4)) for the State for the fiscal year.

''(4) FEDERAL AVERAGE MEDICAL ASSISTANCE MATCHING PERCENTAGE.—In this subsection, the term 'Federal average medical assistance matching percentage' means, for a State for a fiscal year, the ratio (expressed as a percentage) of—

''(A) the amount of the Federal payments that would be made to the State under section 1903(a)(1) for medical assistance expenditures for calendar quarters in the fiscal year if paragraph (1) did not apply; to

''(B) the amount of the medical assistance expenditures for the State and fiscal year.

''(b) ADJUSTED TOTAL MEDICAL ASSISTANCE EXPENDITURES.—Subject to subsection (g), the following shall apply:

''(1) IN GENERAL.—In this section, the term 'adjusted total medical assistance expenditures' means, for a State—

''(A) for fiscal year 2016, the product of—

''(i) the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures; and

''(ii) the 1903A FY16 population percentage (as defined in paragraph (4)) for the State; or

''(B) for fiscal year 2019 or a subsequent fiscal year, the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year that is attributable to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) but shall not be construed as including any expenditures attributable to the program under section 1928. In applying subparagraph (B), non-DSH supplemental payments (as defined in subsection (d)(4)(A)(ii)) and payments described in subsection (d)(4)(A)(iii) shall be treated as fully attributable to 1903A enrollees.

''(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year, the medical assistance payments as reported by medical service category on the Form CMS-64 quarterly expense report (or successor to such a report form, and including enrollment data and subsequent adjustments to any such report, in this section referred to collectively as a 'CMS-64 report') for which payment is (or may otherwise be) made pursuant to section 1903(a)(1).

''(3) EXCLUDED EXPENDITURES.—In this section, the term 'excluded expenditures' means, for a State and fiscal year, expenditures under the State plan (or under a waiver of such plan) that are attributable to any of the following:

''(A) DSH.—Payment adjustments made for disproportionate share hospitals under section 1923.

''(B) MEDICARE COST-SHARING.—Payments made for medicare cost-sharing (as defined in section 1905(p)(3)).

''(C) SAFETY NET PROVIDER PAYMENT ADJUSTMENTS IN NON-EXPANSION STATES.—Payment adjustments under subsection (a) of section 1923A for which payment is permitted under subsection (c) of such section.

''(4) 1903A FY 16 POPULATION PERCENTAGE.—In this subsection, the term '1903A FY16 population percentage' means, for a State, the Secretary's calculation of the percentage of the actual medical assistance expenditures, as reported by the State on the CMS–64 reports for calendar quarters in fiscal year 2016, that are attributable to 1903A enrollees (as defined in subsection (e)(1)).

''(c) TARGET TOTAL MEDICAL ASSISTANCE EXPENDITURES.—

''(1) CALCULATION.—In this section, the term 'target total medical assistance expenditures' means, for a State for a fiscal year and subject to paragraph (4), the sum of the products, for each of the 1903A enrollee categories (as defined in subsection (e)(2)), of—

''(A) the target per capita medical assistance expenditures (as defined in paragraph (2)) for the enrollee category, State, and fiscal year; and

''(B) the number of 1903A enrollees for such enrollee category, State, and fiscal year, as determined under subsection (e)(4).

''(2) TARGET PER CAPITA MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term 'target per capita medical assistance expenditures' means, for a 1903A enrollee category and State—

''(A) for fiscal year 2020, an amount equal to—

''(i) the provisional FY19 target per capita amount for such enrollee category (as calculated under subsection (d)(5)) for the State; increased by

''(ii) the applicable annual inflation factor (as defined in paragraph (3)) for fiscal year 2020; and

''(B) for each succeeding fiscal year, an amount equal to—

''(i) the target per capita medical assistance expenditures (under subparagraph (A) or this subparagraph) for the 1903A enrollee category and State for the preceding fiscal year, increased by

''(ii) the applicable annual inflation factor for that succeeding fiscal year.

''(3) APPLICABLE ANNUAL INFLATION FACTOR.—In paragraph (2), the term 'applicable annual inflation factor' means, for a fiscal year—

''(A) for each of the 1903A enrollee categories described in subparagraphs (C), (D), and (E) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved; and

''(B) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase described in subparagraph (A) plus 1 percentage point.

''(4) DECREASE IN TARGET EXPENDITURES FOR REQUIRED EXPENDITURES BY CERTAIN POLITICAL SUBDIVISIONS.—

''(A) IN GENERAL.—In the case of a State that had a DSH allotment under section 1923(f) for fiscal year 2016 that was more than 6 times the national average of such allotments for all the States for such fiscal year and that requires political subdivisions within the State to contribute funds towards medical assistance or other expenditures under the State plan under this title (or under a waiver of such plan) for a fiscal year (beginning with fiscal year 2020), the target total medical assistance expenditures for such State and fiscal year shall be decreased by the amount that political subdivisions in the State are required to contribute under the plan (or waiver) without reimbursement from the State for such fiscal year, other than contributions described in subparagraph (B).

''(B) EXCEPTIONS.—The contributions described in this subparagraph are the following:

''(i) Contributions required by a State from a political subdivision that, as of the first day of the calendar year in which the fiscal year involved begins—

''(I) has a population of more than 5,000,000, as estimated by the Bureau of the Census; and

''(II) imposes a local income tax upon its residents.

''(ii) Contributions required by a State from a political subdivision for administrative expenses if the State required such contributions from such subdivision without reimbursement from the State as of January 1, 2017.

''(d) CALCULATION OF FY19 PROVISIONAL TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (g), the following shall apply:

''(1) CALCULATION OF BASE AMOUNTS FOR FISCAL YEAR 2016.—For each State the Secretary shall calculate (and provide notice to the State not later than April 1, 2018, of) the following:

''(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2016.

''(B) The number of 1903A enrollees for the State in fiscal year 2016 (as determined under subsection (e)(4)).

''(C) The average per capita medical assistance expenditures for the State for fiscal year 2016 equal to—

''(i) the amount calculated under subparagraph (A); divided by

''(ii) the number calculated under subparagraph (B).

''(2) FISCAL YEAR 2019 AVERAGE PER CAPITA AMOUNT BASED ON INFLATING THE FISCAL YEAR 2016 AMOUNT TO FISCAL YEAR 2019 BY CPI-MEDICAL.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each State equal to—

''(A) the average per capita medical assistance expenditures for the State for fiscal year 2016 (calculated under paragraph (1)(C)); increased by

''(B) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September, 2016 to September, 2019.

''(3) AGGREGATE AND AVERAGE EXPENDITURES PER CAPITA FOR FISCAL YEAR 2019.—The Secretary shall calculate for each State the following:

''(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019.

''(B) The number of 1903A enrollees for the State in fiscal year 2019 (as determined under subsection (e)(4)).

''(4) PER CAPITA EXPENDITURES FOR FISCAL YEAR 2019 FOR EACH 1903A ENROLLEE CATEGORY.—The Secretary shall calculate (and provide notice to each State not later than January 1, 2020, of) the following:

''(A)(i) For each 1903A enrollee category, the amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019 for individuals in the enrollee category, calculated by excluding from medical assistance expenditures those expenditures attributable to expenditures described in clause (iii) or non-DSH supplemental expenditures (as defined in clause (ii)).

''(ii) In this paragraph, the term 'non-DSH supplemental expenditure' means a payment to a provider under the State plan (or under a waiver of the plan) that—

''(I) is not made under section 1923;

''(II) is not made with respect to a specific item or service for an individual;

''(III) is in addition to any payments made to the provider under the plan (or waiver) for any such item or service; and

''(IV) complies with the limits for additional payments to providers under the plan (or waiver) imposed pursuant to section 1902(a)(30)(A), including the regulations specifying upper payment limits under the State plan in part 447 of title 42, Code of Federal Regulations (or any successor regulations).

''(iii) An expenditure described in this clause is an expenditure that meets the criteria specified in subclauses (I), (II), and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated state health program, or any other similar expenditure (as defined by the Secretary).

''(B) For each 1903A enrollee category, the number of 1903A enrollees for the State in fiscal year 2019 in the enrollee category (as determined under subsection (e)(4)).

''(C) For fiscal year 2016, the State's non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

''(i) the total amount of non-DSH supplemental expenditures (as defined in subparagraph (A)(ii)) and payments described in subparagraph (A)(iii) for the State for fiscal year 2016; to

''(ii) the amount described in subsection (b)(1)(A) for the State for fiscal year 2016.

''(D) For each 1903A enrollee category an average medical assistance expenditures per capita for the State for fiscal year 2019 for the enrollee category equal to—

''(i) the amount calculated under subparagraph (A) for the State, increased by the non-DSH supplemental and pool payment percentage for the State (as calculated under subparagraph (C)); divided by

''(ii) the number calculated under subparagraph (B) for the State for the enrollee category.

''(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (f)(2), the Secretary shall calculate for each State a provisional FY19 per capita target amount for each 1903A enrollee category equal to the average medical assistance expenditures per capita for the State for fiscal year 2019 (as calculated under paragraph (4)(D)) for such enrollee category multiplied by the ratio of—

''(A) the product of—

''(i) the fiscal year 2019 average per capita amount for the State, as calculated under paragraph (2); and

''(ii) the number of 1903A enrollees for the State in fiscal year 2019, as calculated under paragraph (3)(B); to

''(B) the amount of the adjusted total medical assistance expenditures for the State for fiscal year 2019, as calculated under paragraph (3)(A).

''(e) 1903A ENROLLEE; 1903A ENROLLEE CATEGORY.—Subject to subsection (g), for purposes of this section, the following shall apply:

''(1) 1903A ENROLLEE.—The term '1903A enrollee' means, with respect to a State and a month and subject to subsection (i)(1)(B), any Medicaid enrollee (as defined in paragraph (3)) for the month, other than such an enrollee who for such month is in any of the following categories of excluded individuals:

''(A) CHIP.—An individual who is provided, under this title in the manner described in section 2101(a)(2), child health assistance under title XXI.

''(B) IHS.—An individual who receives any medical assistance under this title for services for which payment is made under the third sentence of section 1905(b).

''(C) BREAST AND CERVICAL CANCER SERVICES ELIGIBLE INDIVIDUAL.—An individual who is entitled to medical assistance under this title only pursuant to section 1902(a)(10)(A)(ii)(XVIII).

''(D) PARTIAL-BENEFIT ENROLLEES.—An individual who—

''(i) is an alien who is entitled to medical assistance under this title only pursuant to section 1903(v)(2);

''(ii) is entitled to medical assistance under this title only pursuant to subclause (XII) or (XXI) of section 1902(a)(10)(A)(ii) (or pursuant to a waiver that provides only comparable benefits);

''(iii) is a dual eligible individual (as defined in section 1915(h)(2)(B)) and is entitled to medical assistance under this title (or under a waiver) only for some or all of medicare cost-sharing (as defined in section 1905(p)(3)); or

''(iv) is entitled to medical assistance under this title and for whom the State is providing a payment or subsidy to an employer for coverage of the individual under a group health plan pursuant to section 1906 or section 1906A (or pursuant to a waiver that provides only comparable benefits).

''(2) 1903A ENROLLEE CATEGORY.—The term '1903A enrollee category' means each of the following:

''(A) ELDERLY.—A category of 1903A enrollees who are 65 years of age or older.

''(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who are eligible for medical assistance under this title on the basis of being blind or disabled.

''(C) CHILDREN.—A category of 1903A enrollees (not described in a previous subparagraph) who are children under 19 years of age.

''(D) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a previous subparagraph) for whom the amounts expended for medical assistance are subject to an increase or change in the Federal medical assistance percentage under subsection (y) or (z)(2), respectively, of section 1905.

''(E) OTHER NONELDERLY, NONDISABLED, NON-EXPANSION ADULTS.—A category of 1903A enrollees who are not described in any previous subparagraph.

''(3) MEDICAID ENROLLEE.—The term 'Medicaid enrollee' means, with respect to a State for a month, an individual who is eligible for medical assistance for items or services under this title and enrolled under the State plan (or a waiver of such plan) under this title for the month.

''(4) DETERMINATION OF NUMBER OF 1903A ENROLLEES.—The number of 1903A enrollees for a State and fiscal year, and, if applicable, for a 1903A enrollee category, is the average monthly number of Medicaid enrollees for such State and fiscal year (and, if applicable, in such category) that are reported through the CMS–64 report under (and subject to audit under) subsection (h).

''(f) SPECIAL PAYMENT RULES.—

''(1) APPLICATION IN CASE OF RESEARCH AND DEMONSTRATION PROJECTS AND OTHER WAIVERS.—In the case of a State with a waiver of the State plan approved under section 1115, section 1915, or another provision of this title, this section shall apply to medical assistance expenditures and medical assistance payments under the waiver, in the same manner as if such expenditures and payments had been made under a State plan under this title and the limitations on expenditures under this section shall supersede any other payment limitations or provisions (including limitations based on a per capita limitation) otherwise applicable under such a waiver.

''(2) TREATMENT OF STATES EXPANDING COVERAGE AFTER FISCAL YEAR 2016.—In the case of a State that did not provide for medical assistance for the 1903A enrollee category described in subsection (e)(2)(D) during fiscal year 2016 but which provides for such assistance for such category in a subsequent year, the provisional FY19 per capita target amount for such enrollee category under subsection (d)(5) shall be equal to the provisional FY19 per capita target amount for the 1903A enrollee category described in subsection (e)(2)(E).

''(3) IN CASE OF STATE FAILURE TO REPORT NECESSARY DATA.—If a State for any quarter in a fiscal year (beginning with fiscal year 2019) fails to satisfactorily submit data on expenditures and enrollees in accordance with subsection (h)(1), for such fiscal year and any succeeding fiscal year for which such data are not satisfactorily submitted—

''(A) the Secretary shall calculate and apply subsections (a) through (e) with respect to the State as if all 1903A enrollee categories for which such expenditure and enrollee data were not satisfactorily submitted were a single 1903A enrollee category; and

''(B) the growth factor otherwise applied under subsection (c)(2)(B) shall be decreased by 1 percentage point.

''(g) RECALCULATION OF CERTAIN AMOUNTS FOR DATA ERRORS.—The amounts and percentage calculated under paragraphs (1) and (4)(C) of subsection (d) for a State for fiscal year 2016, and the amounts of the adjusted total medical assistance expenditures calculated under subsection (b) and the number of Medicaid enrollees and 1903A enrollees determined under subsection (e)(4) for a State for fiscal year 2016, fiscal year 2019, and any subsequent fiscal year, may be adjusted by the Secretary based upon an appeal (filed by the State in such a form, manner, and time, and containing such information relating to data errors that support such appeal, as the Secretary specifies) that the Secretary determines to be valid, except that any adjustment by the Secretary under this subsection for a State may not result in an increase of the target total medical assistance expenditures exceeding 2 percent.

''(h) REQUIRED REPORTING AND AUDITING OF CMS–64 DATA; TRANSITIONAL INCREASE IN FEDERAL MATCHING PERCENTAGE FOR CERTAIN ADMINISTRATIVE EXPENSES.—

''(1) REPORTING.—In addition to the data required on form Group VIII on the CMS–64 report form as of January 1, 2017, in each CMS-64 report required to be submitted (for each quarter beginning on or after October 1, 2018), the State shall include data on medical assistance expenditures within such categories of services and categories of enrollees (including each 1903A enrollee category and each category of excluded individuals under subsection (e)(1)) and the numbers of enrollees within each of such enrollee categories, as the Secretary determines are necessary (including timely guidance published as soon as possible after the date of the enactment of this section) in order to implement this section and to enable States to comply with the requirement of this paragraph on a timely basis.

''(2) AUDITING.—The Secretary shall conduct for each State an audit of the number of individuals and expenditures reported through the CMS–64 report for fiscal year 2016, fiscal year 2019, and each subsequent fiscal year, which audit may be conducted on a representative sample (as determined by the Secretary).

''(3) TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—For amounts expended during calendar quarters beginning on or after October 1, 2017, and before October 1, 2019—

''(A) the Federal matching percentage applied under section 1903(a)(3)(A)(i) shall be increased by 10 percentage points to 100 percent;

''(B) the Federal matching percentage applied under section 1903(a)(3)(B) shall be increased by 25 percentage points to 100 percent; and

''(C) the Federal matching percentage applied under section 1903(a)(7) shall be increased by 10 percentage points to 60 percent but only with respect to amounts expended that are attributable to a State's additional administrative expenditures to implement the data requirements of paragraph (1).

''(i) FLEXIBLE BLOCK GRANT OPTION FOR STATES.—

''(1) IN GENERAL.—In the case of a State that elects the option of applying this subsection for a 10-fiscal-year period (beginning no earlier than fiscal year 2020 and, at the State option, for any succeeding 10-fiscal-year period) and that has a plan approved by the Secretary under paragraph (2) to carry out the option for such period—

''(A) the State shall receive, instead of amounts otherwise payable to the State under this title for medical assistance for block grant individuals within the applicable block grant category (as defined in paragraph (6)) for the State during the period in which the election is in effect, the amount specified in paragraph (4);

''(B) the previous provisions of this section shall be applied as if—

''(i) block grant individuals within the applicable block grant category for the State and period were not section 1903A enrollees for each 10-fiscal year period for which the State elects to apply this subsection; and

''(ii) if such option is not extended at the end of a 10-fiscal-year-period, the per capita limitations under such previous provisions shall again apply after such period and such limitations shall be applied as if the election under this subsection had never taken place;

''(C) the payment under this subsection may only be used consistent with the State plan under paragraph (2) for block grant health care assistance (as defined in paragraph (7)); and

''(D) with respect to block grant individuals within the applicable block grant category for the State for which block grant health care assistance is made available under this subsection, such assistance shall be instead of medical assistance otherwise provided to the individual under this title.

''(2) STATE PLAN FOR ADMINISTERING BLOCK GRANT OPTION.—

''(A) IN GENERAL.—No payment shall be made under this subsection to a State pursuant to an election for a 10-fiscal-year period under paragraph (1) unless the State has a plan, approved under subparagraph (B), for such period that specifies—

''(i) the applicable block grant category with respect to which the State will apply the option under this subsection for such period;

''(ii) the conditions for eligibility of block grant individuals within such applicable block grant category for block grant health care assistance under the option, which shall be instead of other conditions for eligibility under this title, except that in the case of a State that has elected the applicable block grant category described in—

''(I) subparagraph (A) of paragraph (6), the plan must provide for eligibility for pregnant women and children required to be provided medical assistance under subsections (a)(10)(A)(i) and (e)(4) of section 1902; or

''(II) subparagraph (B) of paragraph (6), the plan must provide for eligibility for pregnant women required to be provided medical assistance under subsection (a)(10)(A)(i); and

''(iii) the types of items and services, the amount, duration, and scope of such services, the cost-sharing with respect to such services, and the method for delivery of block grant health care assistance under this subsection, which shall be instead of the such types, amount, duration, and scope, cost-sharing, and methods of delivery for medical assistance otherwise required under this title, except that the plan must provide for assistance for—

''(I) hospital care;

''(II) surgical care and treatment;

''(III) medical care and treatment;

''(IV) obstetrical and prenatal care and treatment;

''(V) prescribed drugs, medicines, and prosthetic devices;

''(VI) other medical supplies and services; and

''(VII) health care for children under 18 years of age.

''(B) REVIEW AND APPROVAL.—A plan described in subparagraph (A) shall be deemed approved by the Secretary unless the Secretary determines, within 30 days after the date of the Secretary's receipt of the plan, that the plan is incomplete or actuarially unsound and, with respect to such plan and its implementation under this subsection, the requirements of paragraphs (1), (10)(B), (17), and (23) of section 1902(a) shall not apply.

''(3) AMOUNT OF BLOCK GRANT FUNDS.—

''(A) FOR INITIAL FISCAL YEAR.—The block grant amount under this paragraph for a State for the initial fiscal year in the first 10-fiscal-year period is equal to the sum of the products (for each applicable block grant category for such State and period) of—

''(i) the target per capita medical assistance expenditures for such State for such fiscal year (under subsection (c)(2));

''(ii) the number of 1903A enrollees for such category and State for fiscal year 2019, as determined under subsection (e)(4); and

''(iii) the Federal average medical assistance matching percentage (as defined in subsection (a)(4)) for the State for fiscal year 2019.

''(B) FOR ANY SUBSEQUENT FISCAL YEAR.—The block grant amount under this paragraph for a State for each succeeding fiscal year (in any 10-fiscal-year period) is equal to the block grant amount under subparagraph (A) (or this subparagraph) for the State for the previous fiscal year increased by the annual increase in the consumer price index for all urban consumers (all items; U.S. city average) for the fiscal year involved.

''(C) AVAILABILITY OF ROLLOVER FUNDS.—The block grant amount under this paragraph for a State for a fiscal year shall remain available to the State for expenditures under this subsection for the succeeding fiscal year but only if an election is in effect under this subsection for the State in such succeeding fiscal year.

''(4) FEDERAL PAYMENT AND STATE RESPONSIBILITY.—The Secretary shall pay to each State with an election in effect under this subsection for a fiscal year, from its block grant amount under paragraph (3) available for such fiscal year, an amount for each quarter of such fiscal year equal to the enhanced FMAP described in the first sentence of section 2105(b) of the total amount expended under the State plan under this subsection during such quarter, and the State is responsible for the balance of funds to carry out such plan.

''(5) BLOCK GRANT INDIVIDUAL DEFINED.—In this subsection, the term 'block grant individual' means, with respect to a State for a 10-fiscal-year period, an individual who is not disabled (as defined for purposes of the State plan) and who is within an applicable block grant category for the State and such period.

''(6) APPLICABLE BLOCK GRANT CATEGORY DEFINED.—In this subsection, the term 'applicable block grant category' means with respect to a State for a 10-fiscal-year period, either of the following as specified by the State for such period in its plan under paragraph (2)(A)(i):

''(A) 2 ENROLLEE CATEGORIES.—Both of the following 1903A enrollee categories:

''(i) CHILDREN.—The 1903A enrollee category specified in subparagraph (C) of subsection (e)(2).

''(ii) OTHER NONELDERLY, NONDISABLED, NON-EXPANSION ADULTS.—The 1903A enrollee category specified in subparagraph (E) of such subsection.

''(B) OTHER NONELDERLY, NONDISABLED, NON-EXPANSION ADULTS.—Only the 1903A enrollee category specified in subparagraph (E) of subsection (e)(2).

''(7) BLOCK GRANT HEALTH CARE ASSISTANCE.—In this subsection, the term 'block grant health care assistance' means assistance for health-care-related items and medical services for block grant individuals within the applicable block grant category for the State and 10-fiscal-year period involved who are low-income individuals (as defined by the State).

''(8) AUDITING.—As a condition of receiving funds under this subsection, a State shall contract with an independent entity to conduct audits of its expenditures made with respect to activities funded under this subsection for each fiscal year for which the State elects to apply this subsection to ensure that such funds are used consistent with this subsection and shall make such audits available to the Secretary upon the request of the Secretary.''.

Subtitle D—Patient Relief and Health Insurance Market Stability

SEC. 131. REPEAL OF COST-SHARING SUBSIDY.

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2019.

SEC. 132. PATIENT AND STATE STABILITY FUND.

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following new title:

''TITLE XXII—PATIENT AND STATE STABILITY FUND

''SEC. 2201. ESTABLISHMENT OF PROGRAM.

''There is hereby established the 'Patient and State Stability Fund' to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator'), to provide funding, in accordance with this title, to the 50 States and the District of Columbia (each referred to in this section as a 'State') during the period, subject to section 2204(c), beginning on January 1, 2018, and ending on December 31, 2026, for the purposes described in section 2202.

''SEC. 2202. USE OF FUNDS.

''(a) IN GENERAL.—Subject to subsection (b), a State may use the funds allocated to the State under this title for any of the following purposes:

''(1) Helping, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer enroll in health insurance coverage in the individual market in the State, as such market is defined by the State (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose).

''(2) Providing incentives to appropriate entities to enter into arrangements with the State to help stabilize premiums for health insurance coverage in the individual market, as such markets are defined by the State.

''(3) Reducing the cost for providing health insurance coverage in the individual market and small group market, as such markets are defined by the State, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost) and to individuals who have high costs of health insurance coverage due to the low density population of the State in which they reside.

''(4) Promoting participation in the individual market and small group market in the State and increasing health insurance options available through such market.

''(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); or any combination of such services.

''(6) Maternity coverage and newborn care.

''(7) Prevention, treatment, or recovery support services for individuals with mental or substance use disorders, focused on either or both of the following:

''(A) Direct inpatient or outpatient clinical care for treatment of addiction and mental illness.

''(B) Early identification and intervention for children and young adults with serious mental illness.

''(8) Providing payments, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.

''(9) Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the State.

''(b) REQUIRED USE OF INCREASE IN ALLOTMENT.—A State shall use the additional allocation provided to the State from the funds appropriated under the second sentence of section 2204(b) for each year only for the purposes described in paragraphs (6) and (7) of subsection (a).

''SEC. 2203. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

''(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

''(1) IN GENERAL.—To be eligible for an allocation of funds under this title for a year during the period described in section 2201 for use for one or more purposes described in section 2202, a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2018, not later than 45 days after the date of the enactment of this title and, in the case of allocations for a subsequent year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

''(A) a description of how the funds will be used for such purposes;

''(B) a certification that the State will make, from non-Federal funds, expenditures for such purposes in an amount that is not less than the State percentage required for the year under section 2204(e)(1); and

''(C) such other information as the Administrator may require.

''(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of this title and of the reason for such denial.

''(3) ONE-TIME APPLICATION.—If an application of a State is approved for a year, with respect to a purpose described in section 2202, such application shall be treated as approved, with respect to such purpose, for each subsequent year through 2026.

''(4) TREATMENT AS A STATE HEALTH CARE PROGRAM.—Any program receiving funds from an allocation for a State under this title, including pursuant to subsection (b), shall be considered to be a 'State health care program' for purposes of sections 1128, 1128A, and 1128B.

''(b) DEFAULT FEDERAL SAFEGUARD.—

''(1) IN GENERAL.—

''(A) 2018.—For allocations made under this title for 2018, in the case of a State that does not submit an application under subsection (a) by the 45-day submission date applicable to such year under subsection (a)(1) and in the case of a State that does submit such an application by such date that is not approved, subject to section 2204(e), the Administrator, in consultation with the State insurance commissioner, shall use the allocation that would otherwise be provided to the State under this title for such year, in accordance with paragraph (2), for such State.

''(B) 2019 THROUGH 2026.—In the case of a State that does not have in effect an approved application under this section for 2019 or a subsequent year beginning during the period described in section 2201, subject to

section 2204(e), the Administrator, in consultation with the State insurance commissioner, shall use the allocation that would otherwise be provided to the State under this title for such year, in accordance with paragraph (2), for such State.

''(2) REQUIRED USE FOR MARKET STABILIZATION PAYMENTS TO ISSUERS.—Subject to section 2204(a), an allocation for a State made pursuant to paragraph (1) for a year shall be used to carry out the purpose described in section 2202(2) in such State by providing payments to appropriate entities described in such section with respect to claims that exceed $50,000 (or, with respect to allocations made under this title for 2020 or a subsequent year during the period specified in section 2201, such dollar amount specified by the Administrator), but do not exceed $350,000 (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such dollar amount specified by the Administrator), in an amount equal to 75 percent (or, with respect to allocations made under this title for 2020 or a subsequent year during such period, such percentage specified by the Administrator) of the amount of such claims.

''SEC. 2204. ALLOCATIONS.

''(a) APPROPRIATION.—For the purpose of providing allocations for States (including pursuant to section 2203(b)) under this title there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(1) for 2018, $15,000,000,000;
''(2) for 2019, $15,000,000,000;
''(3) for 2020, $10,000,000,000;
''(4) for 2021, $10,000,000,000;
''(5) for 2022, $10,000,000,000;
''(6) for 2023, $10,000,000,000;
''(7) for 2024, $10,000,000,000;
''(8) for 2025, $10,000,000,000; and
''(9) for 2026, $10,000,000,000.

The amount otherwise appropriated under the previous sentence for 2020 shall be increased by $15,000,000,000, to be used and available under subsection (d) only for the purposes described in paragraphs (6) and (7) of section 2202(a).

''(b) ALLOCATIONS.—

''(1) PAYMENT.—

''(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the Administrator shall, with respect to a State and not later than the date specified under subparagraph (B) for such year, allocate, subject to subsection (e), for such State (including pursuant to section 2203(b)) the amount determined for such State and year under paragraph (2).

''(B) SPECIFIED DATE.—For purposes of subparagraph (A), the date specified in this subparagraph is—

''(i) for 2018, the date that is 45 days after the date of the enactment of this title; and

''(ii) for 2019 and subsequent years, January 1 of the respective year.

''(2) ALLOCATION AMOUNT DETERMINATIONS.—

''(A) FOR 2018 AND 2019.—

''(i) IN GENERAL.—For purposes of paragraph (1), the amount determined under this paragraph for 2018 and 2019 for a State is an amount equal to the sum of—

''(I) the relative incurred claims amount described in clause (ii) for such State and year; and

''(II) the relative uninsured and issuer participation amount described in clause (iv) for such State and year.

''(ii) RELATIVE INCURRED CLAIMS AMOUNT.—For purposes of clause (i), the relative incurred claims amount described in this clause for a State for 2018 and 2019 is the product of—

''(I) 85 percent of the amount appropriated under subsection (a) for the year; and

''(II) the relative State incurred claims proportion described in clause (iii) for such State and year.

''(iii) RELATIVE STATE INCURRED CLAIMS PROPORTION.—The relative State incurred claims proportion described in this clause for a State and year is the amount equal to the ratio of—

''(I) the adjusted incurred claims by the State, as reported through the medical loss ratio annual reporting under section 2718 of the Public Health Service Act for the third previous year; to

''(II) the sum of such adjusted incurred claims for all States, as so reported, for such third previous year.

''(iv) RELATIVE UNINSURED AND ISSUER PARTICIPATION AMOUNT.—For purposes of clause (i), the relative uninsured and issuer participation amount described in this clause for a State for 2018 and 2019 is the product of—

''(I) 15 percent of the amount appropriated under subsection (a) for the year; and

''(II) the relative State uninsured and issuer participation proportion described in clause (v) for such State and year.

''(v) RELATIVE STATE UNINSURED AND ISSUER PARTICIPATION PROPORTION.—The relative State uninsured and issuer participation proportion described in this clause for a State and year is—

''(I) in the case of a State not described in clause (vi) for such year, 0; and

''(II) in the case of a State described in clause (vi) for such year, the amount equal to the ratio of—

''(aa) the number of individuals residing in such State who for the third preceding year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved; to

''(bb) the sum of the number of such individuals for all States described in clause (vi) for the third preceding year.

''(vi) STATES DESCRIBED.—For purposes of clause (v), a State is described in this clause, with respect to 2018 and 2019, if the State satisfies either of the following criterion:

''(I) The ratio described in subclause (II) of clause (v) that would be determined for such State by substituting '2015' for each reference in such subclause to 'the third preceding year' and by substituting 'all such States' for the reference in item (bb) of such subclause to 'all States described in clause (vi)' is greater than the ratio described in such subclause that would be determined for such State by substituting '2013' for each reference in such subclause to 'the third preceding year' and by substituting 'all such States' for the reference in item (bb) of such subclause to 'all States described in clause (vi)'.

''(II) The State has fewer than three health insurance issuers offering qualified health plans through the Exchange for 2017.

''(B) FOR 2020 THROUGH 2026.—For purposes of paragraph (1), the amount determined under this paragraph for a year (beginning with 2020) during the period described in section 2201 for a State is an amount determined in accordance with an allocation methodology specified by the Administrator which—

''(i) takes into consideration the adjusted incurred claims of such State, the number of residents of such State who for the previous year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved, and the number of health insurance issuers participating in the insurance market in such State for such year;

''(ii) is established after consultation with health care consumers, health insurance issuers, State insurance commissioners, and other stakeholders and after taking into consideration additional cost and risk factors that may inhibit health care consumer and health insurance issuer participation; and

''(iii) reflects the goals of improving the health insurance risk pool, promoting a more competitive health insurance market, and increasing choice for health care consumers.

''(c) ANNUAL DISTRIBUTION OF PREVIOUS YEAR'S REMAINING FUNDS.— In carrying out subsection (b), the Administrator shall, with respect to a year (beginning with 2020 and ending with 2027), not later than March 31 of such year—

''(1) determine the amount of funds, if any, from the amounts appropriated under subsection (a) for the previous year but not allocated for such previous year; and

''(2) if the Administrator determines that any funds were not so allocated for such previous year, allocate such remaining funds, in accordance with the allocation methodology specified pursuant to subsection (b)(2)(B)—

''(A) to States that have submitted an application approved under section 2203(a) for such previous year for any purpose for which such an application was approved; and

''(B) for States for which allocations were made pursuant to section 2203(b) for such previous year, to be used by the Administrator for such States, to carry out the purpose described in section 2202(2) in such States by providing payments to appropriate entities described in such section with respect to claims that exceed $1,000,000;

with, respect to a year before 2027, any remaining funds being made available for allocations to States for the subsequent year.

''(d) AVAILABILITY.—Amounts appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2027.

''(e) CONDITIONS FOR AND LIMITATIONS ON RECEIPT OF FUNDS.—The Secretary may not make an allocation under this title for a State, with respect to a purpose described in section 2202—

''(1) in the case of an allocation that would be made to a State pursuant to section 2203(a), if the State does not agree that the State will make available non-Federal contributions towards such purpose in an amount equal to—

''(A) for 2020, 7 percent of the amount allocated under this subsection to such State for such year and purpose;

''(B) for 2021, 14 percent of the amount allocated under this subsection to such State for such year and purpose;

''(C) for 2022, 21 percent of the amount allocated under this subsection to such State for such year and purpose;

''(D) for 2023, 28 percent of the amount allocated under this subsection to such State for such year and purpose;

''(E) for 2024, 35 percent of the amount allocated under this subsection to such State for such year and purpose;

''(F) for 2025, 42 percent of the amount allocated under this subsection to such State for such year and purpose; and

''(G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose;

''(2) in the case of an allocation that would be made for a State pursuant to section 2203(b), if the State does not agree that the State will make available non-Federal contributions towards such purpose in an amount equal to—

''(A) for 2020, 10 percent of the amount allocated under this subsection to such State for such year and purpose;

''(B) for 2021, 20 percent of the amount allocated under this subsection to such State for such year and purpose; and

''(C) for 2022, 30 percent of the amount allocated under this subsection to such State for such year and purpose;

''(D) for 2023, 40 percent of the amount allocated under this subsection to such State for such year and purpose;

''(E) for 2024, 50 percent of the amount allocated under this subsection to such State for such year and purpose;

''(F) for 2025, 50 percent of the amount allocated under this subsection to such State for such year and purpose; and

''(G) for 2026, 50 percent of the amount allocated under this subsection to such State for such year and purpose; or

''(3) if such an allocation for such purpose would not be permitted under subsection (c)(7) of section 2105 if such allocation were payment made under such section.''.

SEC. 133. CONTINUOUS HEALTH INSURANCE COVERAGE INCENTIVE.

Subpart I of part A of title XXVII of the Public Health Service Act is amended—

(1) in section 2701(a)(1)(B), by striking ''such rate'' and inserting ''subject to section 2710A, such rate'';

(2) by redesignating the second section 2709 as section 2710; and

(3) by adding at the end the following new section:

''SEC. 2710A. ENCOURAGING CONTINUOUS HEALTH INSURANCE COVERAGE.

''(a) PENALTY APPLIED.—

''(1) IN GENERAL.—Notwithstanding section 2701, subject to the succeeding provisions of this section, a health insurance issuer offering health insurance coverage in the individual market shall, in the case of an individual who is an applicable policyholder of such coverage with respect to an enforcement period applicable to enrollments for a plan year beginning with plan year 2019 (or, in the case of enrollments during a special enrollment period, beginning with plan year 2018), increase the monthly premium rate otherwise applicable to such individual for such coverage during each month of such period, by an amount determined under paragraph (2).

''(2) AMOUNT OF PENALTY.—The amount determined under this paragraph for an applicable policyholder enrolling in health insurance coverage described in paragraph (1) for a plan year, with respect to each month during the enforcement period applicable to enrollments for such plan year, is the amount that is equal to 30 percent of the monthly premium rate otherwise applicable to such applicable policyholder for such coverage during such month.

''(b) DEFINITIONS.—For purposes of this section:

''(1) APPLICABLE POLICYHOLDER.—The term 'applicable policyholder' means, with respect to months of an enforcement period and health insurance coverage, an individual who—

''(A) is a policyholder of such coverage for such months;

''(B) cannot demonstrate that (through presentation of certifications described in section 2704(e) or in such other manner as may be specified in regulations, such as a return or statement made under section 6055(d) or 36B of the Internal Revenue Code of 1986), during the look-back period that is with respect to such enforcement period, there was not a period of at least 63 continuous days during which the individual did not have creditable coverage (as defined in paragraph (1) of section 2704(c) and credited in accordance with paragraphs (2) and (3) of such section); and

''(C) in the case of an individual who had been enrolled under dependent coverage under a group health plan or health insurance coverage by reason of section 2714 and such dependent coverage of such individual ceased because of the age of such individual, is not enrolling during the first open enrollment period following the date on which such coverage so ceased.

''(2) LOOK-BACK PERIOD.—The term 'look-back period' means, with respect to an enforcement period applicable to an enrollment of an individual for a plan year beginning with plan year 2019 (or, in the case of an enrollment of an individual during a special enrollment period, beginning with plan year 2018) in health insurance coverage described in subsection (a)(1), the 12-month period ending on the date the individual enrolls in such coverage for such plan year.

''(3) ENFORCEMENT PERIOD.—The term 'enforcement period' means—

''(A) with respect to enrollments during a special enrollment period for plan year 2018, the period beginning with the first month that is during such plan year and that begins subsequent to such date of enrollment, and ending with the last month of such plan year; and

''(B) with respect to enrollments for plan year 2019 or a subsequent plan year, the 12-month period beginning on the first day of the respective plan year.''.

SEC. 134. INCREASING COVERAGE OPTIONS.

Section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022) is amended—

(1) in subsection (a)(3), by inserting ''and with respect to a plan year before plan year 2020'' after ''subsection (e)''; and

(2) in subsection (d), by adding at the end the following:

''(5) SUNSET.—The provisions of this subsection shall not apply after December 31, 2019, and after such date any reference to this subsection or level of coverage or plan described in this subsection and any requirement under law applying such a level of coverage or plan shall have no force or effect (and such a requirement shall be applied as if this section had been repealed).''.

SEC. 135. CHANGE IN PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES.

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)), as inserted by section 1201(4) of the Patient Protection and Affordable Care Act, is amended by inserting after ''(consistent with section 2707(c))'' the following: ''or, for plan years beginning on or after January 1, 2018, as the Secretary may implement through interim final regulation, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio for adults (consistent with section 2707(c)) as the State involved may provide''.

SEC. 136. ESSENTIAL HEALTH BENEFITS DEFINED BY THE STATES.

Section 1302 of the Patient Protection and Affordable Care Act (42 U.S.C. 18022) is amended—

(1) in subsection (a)(1), by striking ''by the Secretary''; and

(2) in subsection (b)—

(A) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (6)''; and

(B) by adding at the end the following new paragraph:

''(6) ESSENTIAL HEALTH BENEFITS FOR PLAN AND TAXABLE YEARS BEGINNING ON OR AFTER JANUARY 1, 2018.—For plan years and taxable years beginning on or after January 1, 2018, each State shall define the essential health benefits with respect to health plans offered in such State, for the purposes of section 36B of the Internal Revenue Code of 1986.''.

Subtitle E—Implementation Funding

SEC. 141. AMERICAN HEALTH CARE IMPLEMENTATION FUND.

(a) IN GENERAL.—There is hereby established an American Health Care Implementation Fund (referred to in this section as the ''Fund'') within the Department of Health and Human Services to carry out sections 121, 132, 202, and 214 (including the amendments made by such sections).

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $1,000,000,000 for Federal administrative expenses to carry out the sections described in subsection (a) (including the amendments made by such sections).

TITLE II—COMMITTEE ON WAYS AND MEANS

Subtitle A—Repeal and Replace of Health-Related Tax Policy

SEC. 201. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

Subparagraph (B) of section 36B(f)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years beginning after December 31, 2017, and before January 1, 2020.''.

SEC. 202. ADDITIONAL MODIFICATIONS TO PREMIUM TAX CREDIT.

(a) MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN.—

(1) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended—

(A) by inserting ''(determined without regard to subparagraphs (A), (C)(ii), and (C)(iv) of paragraph (1) thereof and without regard to whether the plan is offered on an Exchange)'' after ''1301(a) of the Patient Protection and Affordable Care Act'', and

(B) by striking ''shall not include'' and all that follows and inserting ''shall not include any health plan that—

''(i) is a grandfathered health plan or a grandmothered health plan, or

''(ii) includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).''.

(2) DEFINITION OF GRANDMOTHERED HEALTH PLAN.—Section 36B(c)(3) of such Code is amended by adding at the end the following new subparagraph:

''(C) GRANDMOTHERED HEALTH PLAN.—

''(i) IN GENERAL.—The term 'grandmothered health plan' means health insurance coverage which is offered in the individual health insurance market as of October 1, 2013, and is permitted to be offered in such market after January 1, 2014, as a result of CCIIO guidance.

''(ii) CCIIO GUIDANCE DEFINED.—The term 'CCIIO guidance' means the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified (including by a communication entitled 'Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through Calendar Year 2017' issued on February 29, 2016, by the Director of the Center for Consumer Information & Insurance Oversight of such Centers).

''(iii) INDIVIDUAL HEALTH INSURANCE MARKET.—The term 'individual health insurance market' means the market for health insurance coverage (as defined in section 9832(b)) offered to individuals other than in connection with a group health plan (within the meaning of section 5000(b)(1)).''.

(3) CONFORMING AMENDMENT RELATED TO ABORTION COVERAGE.—Section 36B(c)(3) of

such Code, as amended by paragraph (2), is amended by adding at the end the following new subparagraph:

''(D) CERTAIN RULES RELATED TO ABORTION.—

''(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

''(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

''(iii) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).''.

(4) CONFORMING AMENDMENTS RELATED TO OFF-EXCHANGE COVERAGE.—

(A) ADVANCE PAYMENT NOT APPLICABLE.—Section 1412 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

''(f) EXCLUSION OF OFF-EXCHANGE COVERAGE.—Advance payments under this section, and advance determinations under section 1411, with respect to any credit allowed under section 36B shall not be made with respect to any health plan which is not enrolled in through an Exchange.''.

(B) REPORTING.—Section 6055(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(3) INFORMATION RELATING TO OFF-EXCHANGE PREMIUM CREDIT ELIGIBLE COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of a qualified health plan (as defined in section 36B(c)(3)) which is not enrolled in through an Exchange established under title I of the Patient Protection and Affordable Care Act, a return described in this subsection shall include—

''(A) a statement that such plan is a qualified health plan (as defined in section 36B(c)(3)),

''(B) the premiums paid with respect to such coverage,

''(C) the months during which such coverage is provided to the individual,

''(D) the adjusted monthly premium for the applicable second lowest cost silver plan (as defined in section 36B(b)(3)) for each such month with respect to such individual, and

''(E) such other information as the Secretary may prescribe.''.

(C) OTHER CONFORMING AMENDMENTS.—

(i) Section 36B(b)(2)(A) of such Code is amended by striking ''and which were enrolled'' and all that follows and inserting '', or''.

(ii) Section 36B(b)(3)(B)(i) of such Code is amended by striking ''the same Exchange'' and all that follows and inserting ''the Exchange through which such taxpayer is permitted to obtain coverage, and''.

(iii) Section 36B(c)(2)(A)(i) of such Code is amended by striking ''that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act''.

(b) MODIFICATION OF APPLICABLE PERCENTAGE.—Section 36B(b)(3)(A) of such Code is amended to read as follows:

''(A) APPLICABLE PERCENTAGE.—

''(i) IN GENERAL.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial percentage to the final percentage specified in such table for such income tier with respect to a taxpayer of the age involved:

''In the case of household income (expressed as a percent of the poverty line) within the following income tier:	Up to Age 29		Age 30-39		Age 40-49		Age 50-59		Over Age 59	
	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %	Initial %	Final %
Up to 133%	2	2	2	2	2	2	2	2	2	2
133%-150%	3	4	3	4	3	4	3	4	3	4
150%-200%	4	4.3	4	5.3	4	6.3	4	7.3	4	8.3
200%-250%	4.3	4.3	5.3	5.9	6.3	8.05	7.3	9	8.3	10
250%-300%	4.3	4.3	5.9	5.9	8.05	8.35	9	10.5	10	11.5
300%-400%	4.3	4.3	5.9	5.9	8.35	8.35	10.5	10.5	11.5	11.5

''(ii) AGE DETERMINATIONS.—

''(I) IN GENERAL.—For purposes of clause (i), the age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

''(II) JOINT RETURNS.—In the case of a joint return, the age of the older spouse shall be taken into account under clause (i).

''(iii) INDEXING.—In the case of any taxable year beginning in calendar year 2019, the initial and final percentages contained in clause (i) shall be adjusted to reflect—

''(I) the excess (if any) of the rate of premium growth for the period beginning with calendar year 2013 and ending with calendar year 2018, over the rate of income growth for such period, and

''(II) in addition to any adjustment under subclause (I), the excess (if any) of the rate of premium growth for calendar year 2018, over the rate of growth in the consumer price index for calendar year 2018.

''(iv) FAILSAFE.—Clause (iii)(II) shall apply only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for calendar year 2018 exceeds an amount equal to 0.504 percent of the gross domestic product for such calendar year.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 2017.

(2) ADVANCE PAYMENT NOT APPLICABLE TO OFF-EXCHANGE COVERAGE.—The amendment made by subsection (a)(4)(A) shall take effect on January 1, 2018.

(3) REPORTING.—The amendment made by subsection (a)(4)(B) shall apply to coverage provided for months beginning after December 31, 2017.

(4) MODIFICATION OF APPLICABLE PERCENTAGE.—The amendment made by subsection (b) shall apply to taxable years beginning after December 31, 2018.

SEC. 203. SMALL BUSINESS TAX CREDIT.

(a) IN GENERAL.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(j) SHALL NOT APPLY.—This section shall not apply with respect to amounts paid or incurred in taxable years beginning after December 31, 2019.''.

(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

(1) by striking ''Any term'' and inserting the following:

''(1) IN GENERAL.—Any term''; and

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

''(2) EXCLUSION OF HEALTH PLANS INCLUDING COVERAGE FOR ABORTION.—

''(A) IN GENERAL.—The term 'qualified health plan' does not include any health plan that includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest) .

''(B) CERTAIN RULES RELATED TO ABORTION.—

''(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any employer from purchasing for its employees separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the employer contributions for such coverage or plan.

''(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as such separate coverage or plan is not paid for with any employer contribution eligible for the credit allowed under this section.

''(iii) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2019.

(2) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—The amendments made by subsection (b)

shall apply to taxable years beginning after December 31, 2017.

SEC. 204. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 5000A(c) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (2)(B)(iii), by striking ''2.5 percent'' and inserting ''Zero percent'', and

(2) in paragraph (3)—

(A) by striking ''$695'' in subparagraph (A) and inserting ''$0'', and

(B) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 205. EMPLOYER MANDATE.

(a) IN GENERAL.—

(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting ''($0 in the case of months beginning after December 31, 2015)'' after ''$2,000''.

(2) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting ''($0 in the case of months beginning after December 31, 2015)'' after ''$3,000''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 206. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

Section 4980I of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(h) SHALL NOT APPLY.—No tax shall be imposed under this section with respect to any taxable period beginning after December 31, 2019, and before January 1, 2026.''.

SEC. 207. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

(b) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking ''Such term'' and all that follows through the period.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by striking subsection (f) and by redesignating subsection (g) as subsection (f).

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2016.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2016.

SEC. 208. REPEAL OF INCREASE OF TAX ON HEALTH SAVINGS ACCOUNTS.

(a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''20 percent'' and inserting ''10 percent''.

(b) ARCHER MSAS.—Section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''20 percent'' and inserting ''15 percent''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2016.

SEC. 209. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended by striking subsection (i).

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 210. REPEAL OF MEDICAL DEVICE EXCISE TAX.

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(d) APPLICABILITY.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2016.''.

SEC. 211. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: ''This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 212. REDUCTION OF INCOME THRESHOLD FOR DETERMINING MEDICAL CARE DEDUCTION.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''5.8 percent''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

SEC. 213. REPEAL OF MEDICARE TAX INCREASE.

(a) IN GENERAL.—Subsection (b) of section 3101 of the Internal Revenue Code of 1986 is amended to read as follows:

''(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to 1.45 percent of the wages (as defined in section 3121(a)) received by such individual with respect to employment (as defined in section 3121(b)).''.

(b) SECA.—Subsection (b) of section 1401 of the Internal Revenue Code of 1986 is amended to read as follows:

''(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 2.9 percent of the amount of the self-employment income for such taxable year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2022.

SEC. 214. REFUNDABLE TAX CREDIT FOR HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Section 36B of the Internal Revenue Code of 1986 is amended to read as follows:

''SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

''(a) ALLOWANCE OF PREMIUM TAX CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year the sum of the monthly credit amounts with respect to such taxpayer for calendar months during such taxable year which are eligible coverage months appropriately taken into account under subsection (b)(2) with respect to the taxpayer or any qualifying family member of the taxpayer.

''(b) MONTHLY CREDIT AMOUNTS.—

''(1) IN GENERAL.—The monthly credit amount with respect to any taxpayer for any calendar month is the lesser of—

''(A) the sum of the monthly limitation amounts determined under subsection (c) with respect to the taxpayer and the taxpayer's qualifying family members for such month, or

''(B) the amount paid for a qualified health plan for the taxpayer and the taxpayer's qualifying family members for such month.

''(2) ELIGIBLE COVERAGE MONTH REQUIREMENT.—No amount shall be taken into account under subparagraph (A) or (B) of paragraph (1) with respect to any individual for any month unless such month is an eligible coverage month with respect to such individual.

''(c) MONTHLY LIMITATION AMOUNTS.—

''(1) IN GENERAL.—The monthly limitation amount with respect to any individual for any eligible coverage month during any taxable year is 1/12 of—

''(A) $2,000 in the case of an individual who has not attained age 30 as of the beginning of such taxable year,

''(B) $2,500 in the case of an individual who has attained age 30 but who has not attained age 40 as of such time,

''(C) $3,000 in the case of an individual who has attained age 40 but who has not attained age 50 as of such time,

''(D) $3,500 in the case of an individual who has attained age 50 but who has not attained age 60 as of such time, and

''(E) $4,000 in the case of an individual who has attained age 60 as of such time.

''(2) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—The credit allowed under subsection (a) with respect to any taxpayer for any taxable year shall be reduced (but not below zero) by 10 percent of the excess (if any) of—

''(A) the taxpayer's modified adjusted gross income (as defined in section 36B(d)(2)(B), as in effect for taxable years beginning before January 1, 2020) for such taxable year, over

''(B) $75,000 (twice such amount in the case of a joint return).

''(3) OTHER LIMITATIONS.—

''(A) AGGREGATE DOLLAR LIMITATION.—The sum of the monthly limitation amounts taken into account under this section with respect to any taxpayer for any taxable year shall not exceed $14,000.

''(B) MAXIMUM NUMBER OF INDIVIDUALS TAKEN INTO ACCOUNT.—With respect to any taxpayer for any month, monthly limitation amounts shall be taken into account under this section only with respect to the 5 oldest individuals with respect to whom monthly limitation amounts could (without regard to this subparagraph) otherwise be so taken into account.

''(d) ELIGIBLE COVERAGE MONTH.—For purposes of this section, the term 'eligible coverage month' means, with respect to any individual, any month if, as of the first day of such month, the individual meets the following requirements:

''(1) The individual is covered by a health insurance coverage which is certified by the State in which such insurance is offered as coverage that meets the requirements for qualified health plans under subsection (f).

''(2) The individual is not eligible for—

''(A) coverage under a group health plan (within the meaning of section 5000(b)(1)) other than coverage under a plan substantially all of the coverage of which is of excepted benefits described in section 9832(c), or

''(B) coverage described in section 5000A(f)(1)(A).

''(3) The individual is either—

''(A) a citizen or national of the United States, or

''(B) a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641)).

''(4) The individual is not incarcerated, other than incarceration pending the disposition of charges.

''(e) QUALIFYING FAMILY MEMBER.—For purposes of this section, the term 'qualifying family member' means—

''(1) in the case of a joint return, the taxpayer's spouse,

''(2) any dependent of the taxpayer, and

''(3) with respect to any eligible coverage month, any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27 if such child is covered for such month under a qualified health plan which also covers the taxpayer (in the case of a joint return, either spouse).

''(f) QUALIFIED HEALTH PLAN.—For purposes of this section, the term 'qualified health plan' means any health insurance coverage (as defined in section 9832(b)) if—

''(1) such coverage is offered in the individual health insurance market within a State (within the meaning of section 5000A(f)(1)(C)),

''(2) substantially all of such coverage is not of excepted benefits described in section 9832(c),

''(3) such coverage does not consist of short-term limited duration insurance (within the meaning of section 2791(b)(5) of the Public Health Service Act),

''(4) such coverage is not a grandfathered health plan (as defined in section 1251 of the Patient Protection and Affordable Care Act) or a grandmothered health plan (as defined in section 36B(c)(3)(C) as in effect for taxable years beginning before January 1, 2020), and

''(5) such coverage does not include coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).

''(g) SPECIAL RULES.—

''(1) MARRIED COUPLES MUST FILE JOINT RETURN.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), if the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, no credit shall be allowed under this section to such taxpayer unless such taxpayer and the taxpayer's spouse file a joint return for such taxable year.

''(B) EXCEPTION FOR CERTAIN TAXPAYERS.—Subparagraph (A) shall not apply to any married taxpayer who—

''(i) is living apart from the taxpayer's spouse at the time the taxpayer files the tax return,

''(ii) is unable to file a joint return because such taxpayer is a victim of domestic abuse or spousal abandonment,

''(iii) certifies on the tax return that such taxpayer meets the requirements of clauses (i) and (ii), and

''(iv) has not met the requirements of clauses (i), (ii), and (iii) for each of the 3 preceding taxable years.

''(2) DENIAL OF CREDIT TO DEPENDENTS.—

''(A) IN GENERAL.—No credit shall be allowed under this section to any individual who is a dependent with respect to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

''(B) COORDINATION WITH RULE FOR OLDER CHILDREN.—In the case of any individual who is a qualifying family member described in subsection (e)(3) with respect to another taxpayer for any month, in determining the amount of any credit allowable to such individual under this section for any taxable year of such individual which includes such month, the monthly limitation amount with respect to such individual for such month shall be zero and no amount paid for any qualified health plan with respect to such individual for such month shall be taken into account.

''(3) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Amounts described in subsection (b)(1)(B) with respect to any month shall not be taken into account in determining the deduction allowed under section 213 except to the extent that such amounts exceed the amount described in subsection (b)(1)(A) with respect to such month.

''(4) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year—

''(A) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 1412 of the Patient Protection and Affordable Care Act for months beginning in such taxable year, and

''(B) the tax imposed by section 1 for such taxable year shall be increased by the excess (if any) of—

''(i) the aggregate amount paid on behalf of such taxpayer under such section 1412 for months beginning in such taxable year, over

''(ii) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a).

''(5) SPECIAL RULES FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

''(A) IN GENERAL.—If the taxpayer or any qualifying family member of the taxpayer is provided a qualified small employer health reimbursement arrangement for an eligible coverage month, the sum determined under subsection (b)(1)(A) with respect to the taxpayer shall be reduced (but not below zero) by 1/12 of the permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement for each such month such arrangement is provided to such taxpayer.

''(B) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this paragraph, the term 'qualified small employer health reimbursement arrangement' has the meaning given such term by section 9831(d)(2).

''(C) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (A) shall be applied by substituting 'the number of months during the year for which such arrangement was provided' for '12'.

''(6) CERTAIN RULES RELATED TO NON-QUALIFIED HEALTH PLANS.—The rules of section 36B(c)(3)(D), as in effect for taxable years beginning before January 1, 2020, shall apply with respect to subsection (f)(5).

''(7) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2020, each dollar amount in subsection (c)(1), the $75,000 amount in subsection (c)(2)(B), and the dollar amount in subsection (c)(3)(A), shall 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 the taxable year begins, determined—

''(I) by substituting 'calendar year 2019' for 'calendar year 1992' in subparagraph (B) thereof, and

''(II) by substituting for the CPI referred to section 1(f)(3)(A) the amount that such CPI would have been if the annual percentage increase in CPI with respect to each year after 2019 had been one percentage point greater.

''(B) TERMS RELATED TO CPI.—

''(i) ANNUAL PERCENTAGE INCREASE.—For purposes of subparagraph (A)(ii)(II), the term 'annual percentage increase' means the percentage (if any) by which CPI for any year exceeds CPI for the prior year.

''(ii) OTHER TERMS.—Terms used in this paragraph which are also used in section 1(f)(3) shall have the same meanings as when used in such section.

''(C) ROUNDING.—Any increase determined under subparagraph (A) shall be rounded to the nearest multiple of $50.

''(8) RULES RELATED TO STATE CERTIFICATION OF QUALIFIED HEALTH PLANS.—A certification shall not be taken into account under subsection (d)(1) unless such certification is made available to the public and meets such other requirements as the Secretary may provide.

''(9) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section and section 1412 of the Patient Protection and Affordable Care Act.''.

(b) ADVANCE PAYMENT OF CREDIT.—Section 1412 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

''(f) APPLICATION TO CERTAIN PLANS.—The Secretary and the Secretary of the Treasury shall prescribe such regulations as each respective Secretary may deem necessary in order to establish and operate the advance payment program established under this section for individuals covered under qualified health plans (whether enrolled in through an Exchange or otherwise) in such a manner that protects taxpayer information (including names, taxpayer identification numbers, and other confidential information), provides robust verification of all information necessary to establish eligibility of taxpayer for advance payments under this section, ensures proper and timely payments to appropriate health providers, and protects program integrity to the maximum extent feasible.''.

(c) INCREASED PENALTY ON ERRONEOUS CLAIMS OF CREDIT.—Section 6676(a) of the Internal Revenue Code of 1986 is amended by inserting ''(25 percent in the case of a claim for refund or credit relating to the health insurance coverage credit under section 36B)''.

(d) REPORTING BY EMPLOYERS.—Section 6051(a) of such Code is amended by striking ''and'' at the end of paragraph (14), by striking the period at the end of paragraph (15) and inserting '', and'', and by inserting after paragraph (15) the following new paragraph:

''(16) each month with respect to which the employee is eligible for coverage described in section 36B(d)(2) in connection with employment with the employer.''.

(e) COORDINATION WITH OTHER TAX BENEFITS.—

(1) CREDIT FOR HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.—Section 35(g) of such Code is amended by adding at the end the following new paragraph:

''(14) COORDINATION WITH HEALTH INSURANCE COVERAGE CREDIT.—

''(A) IN GENERAL.—An eligible coverage month to which the election under paragraph (11) applies shall not be treated as an eligible coverage month (as defined in section 36B(d)) for purposes of section 36B with respect to the taxpayer or any of the taxpayer's qualifying family members (as defined in section 36B(e)).

''(B) COORDINATION WITH ADVANCE PAYMENTS OF HEALTH INSURANCE COVERAGE CREDIT.—In the case of a taxpayer who makes the election under paragraph (11) with respect to any eligible coverage month in a taxable year or on behalf of whom any advance payment is made under section 7527 with respect to any month in such taxable year—

''(i) the tax imposed by this chapter for the taxable year shall be increased by the excess, if any, of—

''(I) the sum of any advance payments made on behalf of the taxpayer under section 7527 and section 1412 of the Patient Protection and Affordable Care Act, over

''(II) the sum of the credits allowed under this section (determined without regard to

paragraph (1)) and section 36B (determined without regard to subsection (g)(4)(A) thereof) for such taxable year, and

''(ii) section 36B(g)(4)(B) shall not apply with respect to such taxpayer for such taxable year.''.

(2) TRADE OR BUSINESS DEDUCTION.—Section 162(l) of such Code is amended by adding at the end the following new paragraph:

''(6) COORDINATION WITH HEALTH INSURANCE COVERAGE CREDIT.—The deduction otherwise allowable to a taxpayer under paragraph (1) for any taxable year shall be reduced (but not below zero) by the amount of the credit allowable to such taxpayer under section 36B (determined without regard to subsection (g)(4)(A) thereof) for such taxable year.''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2019, in taxable years ending after such date.

SEC. 215. 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 1992' in subparagraph (B) thereof .''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 216. 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 not be taken into account under subparagraph (A)(iii) and shall not be subject to division between the spouses.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 217. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

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

''(D) TREATMENT OF CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to coverage beginning after December 31, 2017.

Subtitle B—Repeal of Certain Consumer Taxes

SEC. 221. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.

Subsection (j) of section 9008 of the Patient Protection and Affordable Care Act is amended to read as follows:

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2010, and ending before January 1, 2017.''.

SEC. 222. REPEAL OF HEALTH INSURANCE TAX.

Subsection (j) of section 9010 of the Patient Protection and Affordable Care Act is amended to read as follows:

''(j) REPEAL.—This section shall apply to calendar years beginning after December 31, 2013, and ending before January 1, 2017.''.

Subtitle C—Repeal of Tanning Tax

SEC. 231. REPEAL OF TANNING TAX.

(a) IN GENERAL.—The Internal Revenue Code of 1986 is amended by striking chapter 49.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services performed after June 30, 2017.

Subtitle D—Remuneration From Certain Insurers

SEC. 241. REMUNERATION FROM CERTAIN INSURERS.

Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(I) TERMINATION.—This paragraph shall not apply to taxable years beginning after December 31, 2016.''.

Subtitle E—Repeal of Net Investment Income Tax

SEC. 251. REPEAL OF NET INVESTMENT INCOME TAX.

(a) IN GENERAL.—Subtitle A of the Internal Revenue Code of 1986 is amended by striking chapter 2A.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2016.

The SPEAKER pro tempore. The bill shall be debatable for 4 hours equally divided and controlled by the chair and ranking minority member of the Committee on the Budget or their respective designees.

The gentlewoman from Tennessee (Mrs. BLACK) and the gentleman from Kentucky (Mr. YARMUTH) each will control 2 hours.

The Chair recognizes the gentlewoman from Tennessee.

GENERAL LEAVE

Mrs. BLACK. Mr. Speaker, I ask unanimous consent that all Members have 7 legislative days in which to revise and extend their remarks on H.R. 1628, the American Health Care Act of 2017.

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

There was no objection.

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

I rise today to speak in favor of the American Health Care Act, a bill that repeals many of the worst aspects of ObamaCare, and begins to repair the damage caused by the law by bringing choice, competition, and patient-centered solutions back into our healthcare system.

Standing here today in the House debating this bill is a proud moment for me. I was working as a nurse in Nashville in the 1990s when, fresh off of the failure of HillaryCare, the Clinton administration pushed out a single-payer pilot program in Tennessee called TennCare.

As the story goes, Vice President Gore and the Democratic Governor sketched out a program on a napkin while sitting in a local bar. I saw firsthand the negative impact of government-run health care on patient care. I saw the costs rise, and the quality of care fall. I saw the burdens being placed on doctors, patients, hospitals, and care providers. I saw patients faced with fewer choices and more regulation. And I saw the devastating impact that TennCare was having on our State's budget, gobbling up so much State spending that other priorities like education and infrastructure were getting squeezed.

I couldn't sit idly by while this was happening in my State, so I decided to get involved in public service, and it is what inspired me to run for office at the very beginning. And when, in 2009 and 2010, I saw the same principles being debated and eventually implemented on the national level, I thought my experience in Tennessee would be valuable to the national debate. I told the people in my district that, if elected to Congress, I would fight to repeal and replace ObamaCare.

In 2011, I sponsored the first piece of legislation that repealed a part of ObamaCare. And today, we take the largest step yet in rescuing the American people from the damage that has been done by ObamaCare.

We are united in our goal to repeal ObamaCare and replace it with patient-centered health care. Right now, ObamaCare is imploding. We were promised premiums that would decrease by $2,500; instead, average family premiums in the employer market have soared by $4,300.

We were promised healthcare costs would go down; instead, deductibles have skyrocketed.

We were promised we could keep our doctor, and keep our health insurance plans; instead, millions of Americans have lost their insurance and the doctors that they liked.

In short, the Affordable Care Act was neither affordable, nor did it provide the quality of care that the American people deserve.

The American Health Care Act is a first step in our efforts to deliver patient-centered healthcare reform. This bill returns to the American people freedom and choice in their healthcare decisions. It gets government out of the relationship between patients and their doctors—where it has never belonged—and puts people back in charge of their own health care. It brings the free market principle of competition to an industry that has long been dominated by government intervention.

Today we are faced with a stark choice: Do we vote to continue the damage ObamaCare is doing to our country and our constituents, or do we vote to go down another path, a better way of doing health care in this country?

While no legislation is perfect, this bill does accomplish some important reforms. It zeros out the mandates. It repeals taxes. It repeals the subsidies. It allows people to choose health insurance plans that are unique to their families, instead of purchasing a one-size-fits-all plan that is mandated by some Washington bureaucrat, and it modernizes Medicaid, a once-in-a-lifetime entitlement reform.

Ending Medicaid's open-ended funding structure will play an important role in addressing the future budget deficits and our growing national debt. I applaud my colleagues who have stayed in this fight and continue to make this bill better.

The members of the Budget Committee, which I chair, outlined four principles they believed would improve the bill. Those principles led to significant changes to allow more State flexibility in Medicaid and ensure that tax credits truly served the people they are meant to serve.

Others fought to eliminate Federal ObamaCare regulations that drive up the cost of health care for all Americans and give those powers back to the States. At the same time, we also ensure that States have the resources to provide maternity and newborn care and treatment for mental health and substance abuse.

I agree with these changes, and I applaud my colleagues for the work to make sure that we truly reverse the damage ObamaCare is doing to our healthcare system and our economy.

ObamaCare's legacy is clear: more government, less choice, and higher costs. Our vision for health care in America is the opposite: more freedom, more choice, and lower costs. Put simply, the American Health Care Act is a good first step, but it is only a first step.

My good friend and our former colleague, Dr. Tom Price, will use his position as Secretary of Health and Human Services to address some of the regulatory burden of ObamaCare through administrative action. We have voted already and will continue to vote on individual pieces of legislation to implement even more patient-centered, free market reforms that we cannot address through reconciliation.

In fact, we just passed two bills already this week. One would allow small businesses to join together to purchase insurance, and the other would increase competition by tearing down antitrust regulations. That bill received 416 votes. This shows that these bills are commonsense measures that include bipartisan support.

The day is finally here where we have an opportunity to fulfill that promise that we have made to the American people. I, for one, cannot sit idly by and let this opportunity go to waste. Campaigning is easy compared to governing, but our constituents did not elect us to do what is easy. They elected us to do what is right.

I urge my colleagues to join me in voting ''yes'' on the American Health Care Act, to rescue the American people from ObamaCare.

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

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

Mr. Speaker, after 7 years of campaigning against the Affordable Care Act, congressional Republicans have finally produced what they cynically describe as a replacement plan.

Sadly, however, this bill will unravel all of the progress we made under the ACA, including expanding access to health insurance to 22 million Americans and improving the quality of coverage and care for tens of millions more.

It nearly doubles the amount of uninsured people in this country, guts Medicaid by almost $900 billion, and weakens the Medicare trust fund.

□ 1130

That was bad enough. But the last-minute changes to this bill are astonishing and appalling. This legislation now allows insurers to end coverage for prescription drugs, mental health, maternity and newborn care, preventive care, emergency room visits, hospitalizations, outpatient care, rehab visits, lab services, and pediatric care. That is not progress. That is not a fix. That is a potential health crisis for every American.

My Republican colleagues are well aware of this. Why else would they have drafted this bill and these last-minute changes in secret? Why else would complicated legislation affecting the lives of millions be sent to the floor just 2 weeks after it was introduced with no congressional hearings, not a single one, on a bill that impacts the health care of nearly every American family? Why else would they rush the bill to the floor without an updated Congressional Budget Office estimate of how much coverage and care will be lost by their backroom deal that ends consumer protections?

I get it. I wouldn't want to, nor would I know how to justify giving nearly $1 trillion in tax cuts to corporations and the wealthy paid for by threatening the health and well-being of millions of American families.

Who is getting these huge windfalls?

Companies like Amgen, with annual profits of more than $3 million; Medtronic, with annual profits of more than $6 billion; and Gilead Sciences, with $13 billion in profits in 2016 alone.

When the CBO released its report last week showing that 24 million hard-working Americans will be left without healthcare coverage by 2026 if we pass this bill, that premiums will rise 15 to 20 percent next year, that people will pay thousands of dollars more in deductibles and out-of-pocket costs, and that older Americans will be priced out of the market by an age tax, I thought for sure it was dead on arrival, that there was no way my Republican colleagues would walk this plank. But here they are, and they are trying to take millions of American families with them.

Fourteen million Americans will lose health coverage next year if this bill is approved. Twenty-one million Americans will lose coverage in the next 3 years alone, wiping out all of the coverage gains from the ACA in just 3 years. For pretty much everyone else in the individual market, deductibles and other costs will be higher. And for lower-income individuals, out-of-pocket costs will be much higher.

Insurance companies will again be able to sell plans that offer much less financial protection, and we will return to the days when millions of people in this country will live in fear that they are always one serious illness or accident away from bankruptcy.

This bill will result in the largest transfer of wealth from struggling families to the well-off in our Nation's history, giving $1 trillion in tax breaks to millionaires, billionaires, and corporations. It is Robin Hood in reverse, but this is far worse because access to life-saving care is being stolen.

I don't say that casually. I have met people, constituents of mine, whose lives have been saved because of the Affordable Care Act.

This is from one of my constituents:

''My name is Kevin Schweitzer. I am 62 years old and I'm a lifelong resident of Louisville, Kentucky.

''I worked hard, took risks and built a successful small business that I sold at age 59. My wife and I were excited about our prospects as we headed into early retirement. As a retiree too young for Medicare, I purchased health insurance on the open market. Less than a year later, I was diagnosed with lymphoma. I have undergone multiple scans and 2 cycles of chemo. I am winning the battle so far, but since this disease is in my blood I will be fighting it for the rest of my life.

''A cancer diagnosis is a life-changing event that not only attacks the body, but the mental stress is just as tough to deal with. Thanks to ObamaCare, I've been able to rest easier knowing that my illness wouldn't bankrupt my family and that I'll be able to provide for my wife even after I'm gone.''

I also heard from a young woman named Sarah Adkins. She suffers from chronic kidney disease. Sarah was able to get health insurance because of the ACA. On January 9, 2011, it saved her life. One of her kidneys shut down and almost went septic. If she didn't have coverage, she would have waited or not gone to the hospital at all. The doctor told her that if she had arrived at the ER an hour later, she would have died.

Mr. Speaker, the health of my constituents Kevin Schweitzer and Sarah Adkins is at stake in this debate. They, and the hundreds of other constituents I have heard from who have serious and chronic health conditions, will need high-quality, affordable health coverage for the rest of their lives. Under this bill, they will get less coverage, it will cost more, and eventually they will be priced out of the market, leaving them nowhere to turn for the care they need.

And that is not all. Because of the last-minute changes to this bill, insurers will be able to sell stripped-down coverage to weed out people with preexisting conditions. They will be able to refuse, for example, to offer coverage for chemotherapy drugs and cancer treatments, insulin pumps, hospital stays, and prescription drugs that treat chronic conditions across the board. Basically, if you have a serious health problem, the care you need may not be available to you at all.

When the American people were promised by President Trump and Republican congressional leadership that their existing coverage would be preserved and that everybody would have insurance and it would be less expensive and much better, they, understandably, believed they would be treated much better than this. None of those promises are in this bill. In fact, the opposite of every one of those promises is what is in this bill. Those were promises made to every family in our congressional districts, and this bill fails them at every turn.

Mr. Speaker, I urge my colleagues to oppose this legislation, and I reserve the balance of my time.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. MCCLINTOCK).

Mr. MCCLINTOCK. Mr. Speaker, I remind the gentleman from Kentucky that every promise made to the American people in support of ObamaCare was rapidly broken. We are now, at this moment in time, watching the death throes of ObamaCare.

More people are paying the State tax penalty or claiming hardship exemptions than are buying ObamaCare policies. In a third of our counties, there is no choice left at all. You get one provider. Soon, we are warned, some regions will have no providers at all. Premiums soared an average of 25 percent last year, and this year we are warned it could be 40 percent or more.

Critics cite the CBO estimate that 24 million Americans will lose their coverage. It is important to understand their reasoning there. The CBO believes that people won't buy health insurance unless we force them to buy health insurance. In fact, people won't buy health insurance that is not a good value for them, and, clearly, ObamaCare isn't.

We replace it with a vigorous buyer's market where plans across the country will compete to offer consumers better services at lower prices tailored to their own needs and wants. And we assure these plans are within their financial reach with $90 billion of additional support that the CBO simply ignores.

The AHCA's biggest achievement is to replace coercion with choice for every American. It ends the individual mandate that forces Americans to buy products they don't want. It ends the employer mandate that has trapped many low-income workers in part-time jobs. It begins to restore consumers' freedom of choice, the best guarantee of quality and value in any market. It allows Americans to meet more of their healthcare needs with pretax dollars. It relieves the premium base of the enormous cost of preexisting conditions by moving them to a block-granted assigned risk pool.

Mr. Speaker, ObamaCare is collapsing, premiums are skyrocketing, and providers are fleeing. This may well be our last off-ramp on this road to ruin.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 38,200 people from his congressional district in California losing health care and coverage.

Mr. Speaker, I yield 1½ minutes to the gentlewoman from California (Ms. LEE), a distinguished member of the Budget Committee.

Ms. LEE. Mr. Speaker, I rise in strong opposition to H.R. 1628, which is a bill to take away health care from 24 million Americans.

Whether you believe it or not, health care is a basic right. This shameful bill steals from those who can least afford it, including seniors, veterans, people living with HIV, children, and the disabled. It would, yes, rip away health care from 24 million people. It would reduce benefits, make families pay more for less, and transfer $600 billion in tax cuts to the very wealthy. This is outrageous.

Access to women's health is denied by defunding Planned Parenthood. Medicaid, as we know it, will end. Healthcare costs for working families and seniors will skyrocket. And now it eliminates essential health benefits like maternity, mental health, and emergency care.

This is not a health bill. It is a tax giveaway to the wealthy.

Let me tell you, as a woman of faith, I am appalled and I am saddened by the hypocrisy displayed in this bill by people who say they are religious. I want to remind you—in the Scriptures, the Book of Mark, chapter 12:31, we are reminded to love your neighbor as yourself.

This bill shows disdain for the most vulnerable and would lead to death and destruction and disease for millions of Americans.

I hope Republicans remember to love their neighbor as themselves today and vote ''no'' on this mean-spirited bill. Let's defeat this harmful and morally bankrupt bill. This is a matter of life and death, and the American people deserve better.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. JOHNSON), a member of the Budget Committee.

Mr. JOHNSON of Ohio. Mr. Speaker, the American people spoke loudly and clearly last November. In fact, they have been speaking loudly and clearly ever since this fatally flawed bill called ObamaCare was signed into law. And now we are hours away from the vote that the American people have been waiting years for.

This vote can be distilled down to simply this, and each Member of this body must ask themselves this simple question: Are they willing to allow ObamaCare to remain the law of the land? Or are we going to begin to restore healthcare decisions to the American people and their doctors?

Those who choose to vote against the American Health Care Act, regardless of how they attempt to justify it, will be voting to keep ObamaCare in place. This is an inescapable fact that will remain long after the smoke and spin and handwringing from political pundits following this vote has gone and disappeared, regardless of how the votes go.

There is no such thing as perfect legislation in a body of 435 men and women representing 435 different parts of the Nation.

There is consensus among the American people that this law should be repealed and replaced, and today the people's House will either acknowledge the will of the people or we will defy it.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 40,500 people from his congressional district in Ohio losing health coverage and care.

Mr. Speaker, I yield 1½ minutes to the gentleman from Massachusetts (Mr. MOULTON), a distinguished member of the Budget Committee.

Mr. MOULTON. Mr. Speaker, I would also like to remind the gentleman from Ohio that the latest poll put the will of the American people at 17 percent in favor of this bill.

I would like to read a message from my Republican constituent:

''The American Health Care Act would strain the fiscal resources necessary to support the Commonwealth's

continued commitment to universal health coverage.''

This constituent is the Republican Governor of Massachusetts, who knows that TrumpCare destroys our ability to ensure access to quality, affordable healthcare coverage.

Another Republican in my State, Governor Mitt Romney, worked with the Democratic legislature to create the Nation's first system to provide affordable, comprehensive health care. RomneyCare wasn't perfect, but Republicans and Democrats worked together to improve it, and they created a system with higher approval ratings than TrumpCare or even ObamaCare.

We can do this. Health care should not be partisan. It should be about investing in our people, in our families, and in our future so that Americans can live healthy, productive lives. But that is not what this Republican TrumpCare bill does.

Michael is a constituent from Gloucester, the old fishing city. He was prescribed OxyContin by his doctors, and then became addicted. But he was able to enter a treatment program through Medicaid, the kind of program that will be cut by TrumpCare. He is now back at work as an electrician, and he says that the Affordable Care Act saved his life.

I am a veteran, and I get my health care at the VA. Sometimes it takes me weeks to get an appointment. If this Republican bill passes, it will throw 8 million veterans off private health care, forcing them into the VA, and creating even longer wait times. That is no way to treat those who have put their lives on the line for our country.

Perhaps it's no surprise that this bill is being jammed down the throats of Congress and the American people like a dead fish.

Nobody wants it and it will make a lot of people sick.

What we should be doing here in Washington is coming together as Republicans and Democrats to have an open, honest debate, and improve the health care system.

Everyone says Congress doesn't work—don't prove them right.

I urge my colleagues to vote no on this terrible bill and to instead come to the table like we did in Massachusetts.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Minnesota (Mr. LEWIS), who is a distinguished member of the Budget Committee.

□ 1145

Mr. LEWIS of Minnesota. Mr. Speaker, I rise today in support of the American Health Care Act, and I ask the other side: Just what is it you are trying to preserve by voting ''no?''

Premiums rising double digits for years for the last 7 years? In my home State of Minnesota, back-to-back premium increases of 50 to 67 percent?

Young, healthy people being priced out of the insurance market, 8 million in 2014, choosing to pay the penalty instead of buying insurance?

That is the genesis of the death spiral in the insurance markets. That is what this bill is trying to correct.

Deductibles, copays—I had a deductible on my own individual policy, a skyrocketing deductible. There are deductibles of $13,000. That is not health care. That is not even access.

Drug formularies being tightened to save money, so people are denied prescription drugs, a prescription drug tax; thousands of Minnesotans losing their plans, 100,000 when a big insurer dropped out; 1,000 counties with one insurer—that is what you are trying to preserve on the other side, people voting ''no'' on this bill?

Emergency State legislation trying to prop up MNsure in my home State because it is failing, and $1 trillion in taxes and spending that is bankrupting the country—that is what the other side is trying to preserve.

Those voting ''no'' on this bill, we have a choice today. You can embrace the status quo and see the markets spiral out of control completely, or you can vote for change and do the right thing.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 50,200 people from his congressional district in Minnesota losing health coverage and care.

I yield 1½ minutes to the gentleman from New York (Mr. JEFFRIES), a distinguished member of the Budget Committee.

Mr. JEFFRIES. Mr. Speaker, the Trump Presidency has been characterized by chaos, crisis, and confusion, and this Republican healthcare debacle has been no different.

The American people clearly understand that TrumpCare will be an unmitigated disaster. Under TrumpCare, working families will pay more and get less. Under TrumpCare, premiums will increase. Under TrumpCare, copays will increase. Under TrumpCare, deductibles will increase. Under TrumpCare, out-of-pocket expenses will increase.

Under TrumpCare, 24 million hardworking Americans will lose their health coverage. Under TrumpCare, individuals between the age of 50 and 64 will pay a regressive age tax.

Health care is a matter of life and death; that is why we take it so seriously. TrumpCare will lead to increased death, disease, and destitution, and that is why we oppose this horrible piece of legislation.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. ARRINGTON) who is a member of the Budget Committee.

Mr. ARRINGTON. Mr. Speaker, ObamaCare's disastrous effects over the last several years have wreaked havoc on our small businesses, broken the backs of middle and working class families, and have had a disproportionately negative impact on rural America. Those are the folks who I represent in west Texas.

While the current bill before us is far from perfect—and let's be honest, there is no such thing as perfect legislation—it reverses course and takes us in the right direction. It repeals the mandates and restores freedom to individuals and markets.

It repeals about $1 trillion of taxes. It reduces deficit spending by over $100 billion, making it the largest entitlement reform since the 1960s. It rolls back regulations, gives maximum flexibility to States, and begins to defederalize health care.

For 7 years now, Republicans have promised the American people that if we were given control of the Presidency and the House and the Senate, then we would repeal and replace ObamaCare. And now that we are given the opportunity to govern and to keep our promises and to deliver results for the American people, we can't let perfect be the enemy of good.

The debate is now closing. We have two choices. We either pass a good but imperfect bill, or we leave ObamaCare in place. That is an unacceptable alternative.

As leaders, we have a moral obligation to do something, to not stand idly by while the people suffer under a system that is failing them.

If we are going to restore the greatness of America and transfer power back to the people, we need more than policy solutions, even perfect policy solutions. We need the political will and the courage to lead.

This is a rescue mission, Mr. Speaker, and it isn't without risk; but I have faith in the President and his team. I have faith in our States and the free markets, and, above all, Mr. Speaker, I have faith in the American people.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 60,400 people from his congressional district in Texas losing health coverage and care.

I yield 2 minutes to the gentleman from New York (Mr. HIGGINS), a distinguished member of the Budget Committee and the Ways and Means Committee.

Mr. HIGGINS of New York. Mr. Speaker, this never needed to be an ideological fist fight. Democrats were always willing to take into account serious and constructive alternatives to the law that we have today that make it better, to make it affordable, more affordable for the American people.

But this bill is a blatant takeaway from the American people of money and protection. If you are 50 to 64 years old, you get clobbered. If you are 64 years old, you make $26,000 a year, according to the Republican-led Congressional Budget Office, your premiums go from $1,700 a year to $14,000 a year.

Fact: UnitedHealthcare is one of the largest private health insurers in America.

Fact: UnitedHealthcare will have $200 billion in revenues this year, and they paid their chief executive officer $66 million in compensation in 2014.

Fact: UnitedHealthcare is under investigation today by the Department of Justice for stealing billions of dollars from the Medicare program.

Fact: The Republican health bill, on page 67, in 7 words, gives UnitedHealthcare, their high-paid executives, and all of their cronies, a massive tax cut to continue to screw the American people.

Mr. Speaker, we can do much better. We are prepared to do much better. But this is a financial assault on good, hardworking Americans who want to do one thing at the end of the day, after paying too much money for health care throughout the year, and that is, when they need their health care, it is available to them and their family.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. FASO), a distinguished member of the Budget Committee.

Mr. FASO. Mr. Speaker, I wanted to point out to my colleagues that a fundamental change is being made with the new health law we have before us, and that is, we are, for the first time, equalizing the treatment of people who do not have employer-provided health care.

Those of us who have employer-provided health care, 170 million Americans, that is not a taxable event for them. It is not a taxable event where they have to pay tax at the end of the year on the value of that employer-provided health care.

And yet, if you are the person who does not have employer-provided health care, if you are the husband and wife with two kids making 45 or $50,000, and your employer does not provide health care, you receive absolutely no tax subsidy through the Tax Code.

This bill, through the advance refundable tax credits, will, for the first time, give someone the choice to buy health care and give them the opportunity and the means to buy health care that they previously have not had. It is not a markedly important distinction, frankly, from the Affordable Care Act, where you only could buy the health care through an exchange-approved policy.

This policy, under this legislation today, will allow someone the flexibility and the freedom to buy a policy of their choosing, not one dictated by Washington. So that is a fundamental important distinction between the status quo and what this legislation would offer.

Mr. Speaker, and my colleagues, I urge support for the bill. It is not perfect, as we all know, but it is something that is long overdue.

I would also point out that the numbers that my colleague from Kentucky uses are really based upon fantasy. Those numbers are simply incorrect, and the people of our State and our country will have health care under the provisions of this bill, and we will work hard to ensure that they do.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 65,800 people from his congressional district in New York losing health coverage and care.

I yield 2 minutes to the gentlewoman from Washington (Ms. DELBENE), a distinguished member of the Budget Committee and the Ways and Means Committee.

Ms. DELBENE. Mr. Speaker, if Republicans crafted legislation that lived up to the promise of insurance for everybody, they would have broad bipartisan support. But that is not what they did.

This bill threatens massive disruption and chaos, not only to our healthcare system, but to middle class families, families who sit at their kitchen table trying to figure out how to pay their mortgage, buy groceries, and also get health coverage for their kids. This Republican bill does nothing to help them.

In their rush to check a political box, Republicans have crafted legislation that does nothing but hurt working Americans, and, in the last 24 hours, it has gone from bad to worse.

Make no mistake, the changes made in the 11th hour to appease the most extreme Members of Congress have put lifesaving care even further out of reach.

Some may use alternative facts, but this is reality, and the reality is that their bill robs $75 billion from Medicare, forces older Americans to pay five times more than others, and shifts $312 billion in out-of-pocket costs onto middle class families.

But this is about more than numbers. It is about people like Rachel, from Kirkland, Washington, who suffered a heart attack and blood clot at the age of 35. She now depends on frequent tests, medications and doctors' visits to stay healthy. Thankfully, it is all covered by her insurance.

Rachel told me: ''I'm horrified by the talking point that equates repealing the Affordable Care Act with getting freedom back. For me, the loss of the ACA gives me nothing but the freedom to die sooner and worry more.''

I am not voting against this bill because it is a Republican bill. I am voting ''no'' for families like Rachel's.

Health care doesn't need to be a partisan issue, and I stand ready and willing to work on commonsense solutions that expand coverage and reduce costs. But I was sent here to make my constituents' lives better. This bill does not do that. I encourage my colleagues to vote ''no.''

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. GAETZ) who is a distinguished member of our Budget Committee.

Mr. GAETZ. Mr. Speaker, I rise to repeal the disaster that is ObamaCare. ObamaCare functions as a wet blanket over the American economy, stopping businesses from growing, and impairing the rights of individuals to make their own decisions about health care.

Mr. Speaker, I specifically implore my conservative colleagues to vote for this bill and give us a chance to get out from under this disastrous law. This legislation represents $1 trillion in tax cuts, $1.15 trillion in spending cuts, $150 billion in deficit reduction; defunding Planned Parenthood.

How long have we been fighting to defund Planned Parenthood?

Close the illegal alien loophole that allows people to enroll in ObamaCare, only to check their status in this country subsequently.

We install work requirements. I don't think people that are able to work but choose not to should expect us to go borrow money from China to pay for their health care. Installing those work requirements is fundamental to bold conservative reform.

Block grants for States so that finally they can be liberated from the oppressive hand of the Federal Government, and also blocking States from additional Medicaid expansion.

We have been engaging in these conservative fights for years, and finally, today, we have got the chance to put a win on the board; and so I am joining our President, our Speaker, and many conservatives in this Congress in voting for the American Health Care Act.

When we win, when we do this, not only do we enhance our economy, not only do we free up opportunities for broader prosperity in America, but we allow people to be in charge of health care, and we move from a government-centered system to a patient-centered system. That was the promise we made in the elections, and that is the promise I intend to keep by voting for this bill.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 56,000 people from his congressional district in Florida losing health coverage and care.

I yield 1¾ minutes to the gentlewoman from Florida (Ms. WASSERMAN SCHULTZ), a distinguished member of the Budget Committee.

□ 1200

Ms. WASSERMAN SCHULTZ. Mr. Speaker, I stand in opposition to the Republican pay more for less care act, under which Americans will suffer from higher healthcare costs, less coverage, a crushing age tax, and a ransacking of the Medicare trust fund, which our seniors depend on for long-term care.

Under the age tax, Americans aged 50 to 64 will be forced to pay five times higher premiums than others, no matter how healthy they are. Under TrumpCare, a 64-year-old with an income of $26,500 in the individual market will pay $12,900 more in their premiums every year under this bill.

In addition, TrumpCare will take away health care from 24 million hardworking Americans and will force families to pay higher premiums and deductibles. In fact, for families enrolled in the ACA marketplace, premiums are expected to increase by 15 to 20 percent.

It will also punish millions of people who experience a lapse in coverage by forcing them to pay a 30 percent higher premium each month in order to receive care.

Tell that to Suzanne Boyd from Sunrise, Florida, who, with two daughters heading to college, lost her husband to lung cancer and then lost the insurance coverage she had through her employer. Thankfully, she was able to obtain coverage under the ACA for $192 a month with subsidies rather than a 30 percent Republican sick tax for getting a life-threatening illness.

Yet this bill apparently isn't harmful enough for the far-right extremists in the Republican Party, whom Republican leadership has tried to appease by cutting the ACA essential health benefits like mental health, maternity, and emergency services.

Mr. Speaker, this bill is like taking a sledgehammer to a clock that is moving a little slow rather than working on precision fine tuning instead. It is an immoral piece of legislation. As a breast cancer survivor, I urge every Member to stand with my sister survivors all across the country, who number in the millions, to make sure that you don't devastate our health and make sure that we don't have our lives threatened.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Indiana (Mr. ROKITA), who is the vice chair of the Budget Committee.

Mr. ROKITA. Mr. Speaker, I thank the chairwoman.

I am really proud, Mr. Speaker, of the Budget Committee. We did great work last week, and everyone was heard: six motions on the Republican side, six motions on the Democratic side, and the debate was civil. Tones weren't raised; theatrics, by and large, weren't employed; and we made the bill better. That was the process the week before that when the committees of jurisdiction had this legislation.

It is my hope that, as we pass this bill off the floor of the House—and it is a bill being passed off the floor of the House and not into law right now—and as it goes to the Senate, that the bill will continue to be improved. That is the legislative process.

I am very proud of the members of the staff of the Budget Committee for being a major part of that process and starting that process. We did good work. You don't have to pass this bill to find out what is in it as we had to with ObamaCare. This process will continue.

I am very pleased, also, that we have Medicaid block grants, or lump sum payments to the States, that are available now to cover at least our able-bodied children and adults. It is a huge step forward in letting States have the flexibility they need to decide who really needs this assistance, how they should get it, and what they should get in terms of health care.

This is good legislation. This is what we were sent to do, and we are keeping our promises to the American people by passing this legislation.

Mr. Speaker, I urge all my colleagues to vote ''yes.''

Mr. YARMUTH. Mr. Speaker, I remind my friend from Indiana that his vote for this bill will result in 37,900 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 1½ minutes to the gentleman from Pennsylvania (Mr. BRENDAN F. BOYLE), who is a distinguished member of the Budget Committee.

Mr. BRENDAN F. BOYLE of Pennsylvania. Mr. Speaker, I rise today in opposition to TrumpCare, the Republican plan to cut Medicare and Medicaid, increase healthcare costs, and take health care away from tens of millions of Americans, all while providing the largest transfer of wealth from working families to our Nation's richest, and all of this in the name of choice and freedom. But we all know that, under this bill, that is just code for survival of the fittest, economic Darwinism.

Mr. Speaker, let me bring this a little closer to home for me. Thanks to TrumpCare, 36,700 of my constituents covered by the ACA's Medicaid expansion now stand to lose this lifesaving coverage. Here is one of them, constituent Maura McGrath, a 17-year-old with Down syndrome.

Maura's parents, Joe and Rita, know firsthand why Medicaid is so important. Medicaid has been critical to keeping their daughter alive and saving their family from bankruptcy. Even though Joe and Rita both work, the cost of Maura's care is too expensive to afford on their own, not to mention that Rita is a breast cancer survivor and Joe suffers from Parkinson's disease. Medicaid provides the McGraths peace of mind knowing Maura will receive the care that she needs and they aren't alone to fend for themselves, given the tough hand they have been dealt.

Mr. Speaker, for Maura and everyone in my district, say ''no'' to TrumpCare.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Louisiana (Mr. HIGGINS).

Mr. HIGGINS of Louisiana. Mr. Speaker, I rise unscripted and in passionate support of freedom. I have heard many statements with words like ''fact'' and details of the minutia of these plans. I will share with you a fact.

Two hundred years ago, my ancestral forefather was born. He was a young, poor Irishman born into indentured servitude. He heard a whisper of a land born across the sea, a land where a man could own his own property, a land where a man could keep the toil of his labor. So he garnered his courage, he saved his money, and he booked passage on a cargo vessel converted to carry human beings. According to the letter unearthed by my sainted mother, his sleeping berth measured 2 by 2 by 5.

What could have driven my ancestral forefather—and yours, Mr. Speaker—indeed, all of America? What drove our ancestral forefathers to come to this land? Freedom. Freedom drove us, and it is freedom for which I stand.

The Affordable Care Act, known as ObamaCare, is 8,000 pages—8,000 pages—of regulation and taxation. There is not a man or a woman amongst us, from sea to shining sea, who believes this body can produce 8,000 pages of freedom. The American Health Care Act is 124 pages of reasonable legislation based upon the best input of free market principles.

A vote against the American Health Care Act is a vote against freedom. It is a vote against 124 pages of reasonable legislation, and it is a vote for 8,000 pages of ObamaCare.

Mr. Speaker, I urge my colleagues to vote ''yes'' for the American Health Care Act.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that the gentleman's vote for this bill will result in 50,100 people from his congressional district in Louisiana losing health coverage and care.

Mr. Speaker, I yield 1½ minutes to the gentlewoman from Washington (Ms. JAYAPAL), who is the distinguished vice ranking member of the Budget Committee.

Ms. JAYAPAL. Mr. Speaker, I thank the distinguished gentleman for yielding and for his tremendous leadership.

Mr. Speaker, this reckless Republican plan is a betrayal of the American people. How is it a betrayal?

Callously stripping 24 million people of health care is a betrayal.

Putting an age tax on people aged 50 to 64 who will pay up to $14,000 more in annual premiums is a betrayal.

Gutting essential benefits like maternity care, prescription drug coverage, emergency services, and fundamentally destroying protections for Americans with preexisting conditions is a betrayal.

Slashing Medicaid by $880 billion and stripping the safety net for our seniors, our kids, and people with disabilities is a betrayal.

The burden of all of this, Mr. Speaker, will fall on the States, who will have to come up with billions of dollars.

Mr. Speaker, this bill is not about freedom or choice. This bill is a travesty, and the American people will pay the price.

This is not a healthcare bill. The only people who benefit are millionaires, billionaires, and insurance companies, who will get $1 trillion in tax benefits while working Americans pay more and get nothing.

Mr. Speaker, this bill is pure greed, and real people will suffer and die from it. Vote ''no,'' and protect our care.

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

Mr. Speaker, I want to recognize that our Members on the other side of the aisle are sharing some data on the coverage of per congressional district based on a study that was conducted by the Center for American Progress, which is a left-leaning organization to begin with. The Center for American Progress employs a flawed methodology for estimating this coverage. In

fact, their foundational numbers are actually based on CBO's coverage estimates, estimates that the CBO itself has established are not infallible.

These coverage numbers only take into account plans that they consider comprehensive major medical policies. This is a term that is used in the very law that we are trying to dismantle today. These coverage estimates do not account for things that we have in our bill, such as HSA plans that allow purchase with tax credits, and many medical plans.

So the AHCA increases freedom for Americans to purchase the kind of coverage that works for them, not the narrowly defined coverage that we see that the Federal Government likes.

Mr. Speaker, I yield 1½ minutes to the gentleman from California (Mr. MCCLINTOCK), who is a member of our committee.

Mr. MCCLINTOCK. Mr. Speaker, I simply want to underscore what the chairwoman has already laid out.

When my friend from Kentucky says that his constituents will lose coverage, he is basing it on two premises. He is ignoring the $90 billion of additional funds that we freed up in the Budget Committee to assure that nobody will face sticker shock as we make this transition.

Second, he assumes that the only reason that people buy insurance is if we force them to buy it. The reality is many are refusing to buy ObamaCare policies even when they are faced with these crushing tax policies. The AHCA replaces this heavyhanded and failing bureaucratic nightmare.

Ultimately, we are going to be judged not on polls or fairy tales, but on whether the vast majority of Americans have a better experience with this new consumer-driven market than they had with the bureaucratized, one-size-fits-all ObamaCare system. That system has already been weighed in the balance and found wanting by the American people, and I am here to stake my reputation on the prediction that they will find better policies with better services at lower costs when they are restored the freedom to be consumers in a marketplace with a supportive tax structure that assures that these policies are within the financial reach of every American family.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 38,200 people from his congressional district in California losing health coverage and care.

Mr. Speaker, I yield 1½ minutes to the gentleman from California (Mr. CARBAJAL), who is a distinguished member of the Budget Committee.

Mr. CARBAJAL. Mr. Speaker, before I came to Congress, I worked in local government as a county supervisor. One of my proudest achievements during that time was working in a bipartisan way to create a program that reduced the rate of uninsured children in our county by over 90 percent—all before the Affordable Care Act was signed into law. Since the Affordable Care Act, I saw firsthand the direct and positive impact of this legislation over the past 7 years to communities and families across the central coast.

The Affordable Care Act meant Sarah, from Lompoc, could open her small business and afford insurance coverage for her two children.

It meant that Kathleen, in San Luis Obispo, who was diagnosed with ovarian and breast cancer, that her $500,000 medical bill was covered by her healthcare plan.

It meant that Adrienne, from Buellton, now could afford to pay for her husband's nursing facility, as his debilitating disease prevents her from being able to physically care for him.

Repealing legislation that has improved the quality of life not only for Sarah, Kathleen, and Adrienne, but for the over 20 million Americans who have gained health insurance under the Affordable Care Act, would be callous, cruel, and irresponsible.

Instead of taking away health care from 24 million Americans, let's work together to create a more equitable, affordable, and accessible healthcare system for all.

□ 1215

Mrs. BLACK. Mr. Speaker, I yield 1 minute to the gentleman from South Carolina (Mr. SANFORD).

Mr. SANFORD. Mr. Speaker, I want to make clear that I agree with what every Republican speaker has said thus far on the need to repeal and replace the Affordable Care Act. I want to say how much I admire the Speaker and the leadership team, President Trump and his team, Chairwoman BLACK, and others on the Budget Committee for what they have brought to bear.

My simple question is one of timing. What I tell my boys consistently is: If you don't know, you don't go.

One of the things that I think we have to really look at in this bill is one of process. It does do a lot of good things, as has been pointed out by the Republican speakers, but it still leaves in place community rating. It leaves in place the architecture, I think, of a flawed bill that came with the Affordable Care Act.

The question is: Can we build on top of that to do the very good things that are talked about in this bill, or do we take just a little bit more time to make certain that we have it right?

I think that when you look at this notion of lowering premiums, look at it like rent control in New York. Rent control in New York has done a lot of good for some folks, but it has hurt a lot of others in the process.

The question we fundamentally have to ask ourselves is: At this juncture, can we make the changes necessary?

Mr. YARMUTH. Mr. Speaker, I mention to my colleague that his vote against this bill will result in 56,600 people from his congressional district in South Carolina losing health coverage and care.

Mr. Speaker, I yield 1¾ minutes to the gentlewoman from Texas (Ms. JACKSON LEE).

Ms. JACKSON LEE. Mr. Speaker, I thank the distinguished gentleman of the Budget Committee for his leadership.

Our mothers and our doctors have warned us about poison pills. Well, let me say that, this morning, the Republicans are giving to the American people a poison meal that would affect my friend, the senior citizen, with $175 billion being taken away from Medicare; a poison meal that will affect a young child who is being seen by a doctor.

The Children's Hospital Association, including the Texas Children's Hospital, has said to vote ''no'' on this bill because 30 million children will have no health insurance.

This will impact working families making $31,000 a year. They will have to pay $4,000 more out of pocket. In 2026, under pay more for less, $52 million Americans will be uninsured.

This poison meal is getting worse and worse.

Then, in the dark of night, what did they do?

They took away hospitalization. They took away pregnancy, maternity, and newborn care. They took away mental health and substance abuse care.

Those States that are experiencing the opioid abuse and epidemic, what are they going to do?

They have threatened community health centers. They are closing rural hospitals.

What is this disaster of TrumpCare?

It is injuring my good friend who is sitting there in the hospital room. It is injuring Anna Nunez. It is injuring small businesses who say that they can live better under the Affordable Care Act, and the youngster that is a junior in college who said she would not be alive had it not been for the Affordable Care Act.

More than half of the American people—and it is growing—are against this bill done in the dark of night. It is the poison meal that is keeping those who need health insurance away from health insurance.

I ask my colleagues to vote ''no.'' Don't feed the American people a poison meal.

Mr. Speaker, as a member of the Budget Committee and the representative of a congressional district that has benefited enormously from the Affordable Care Act, I rise in strong and unyielding opposition to H.R. 1628, the so-called ''American Health Care Act,'' which more accurately should be called ''Trumpcare, the Pay More For Less Act.''

Seven years ago yesterday, March 23, 2010, President Barack Obama signed into law the landmark Affordable Care Act passed by the Democratic controlled 111th Congress.

Seven years later, the verdict is in on the Affordable Care Act; the American people have judged it a success and are adamantly opposed to any effort to repeal a law that has brought to more than 20 million Americans the peace of mind and security that comes with

knowing they have access to affordable, high quality health care.

Before the passage of the Affordable Care Act, 17.1 of Americans lacked health insurance; today nearly nine of ten (89.1%) are insured, which is the highest rate since Gallup began tracking insurance coverage in 2008.

Because of the Affordable Healthcare Act:

1. insurance companies are banned from discriminating against anyone, including 17 million children, with a preexisting condition, or charging higher rates based on gender or health status;

2. 6.6 million young-adults up to age 26 can stay on their parents' health insurance plans;

3. 100 million Americans no longer have annual or life-time limits on healthcare coverage;

4. 6.3 million seniors in the ''donut hole'' have saved $6.1 billion on their prescription drugs;

5. 3.2 million seniors now get free annual wellness visits under Medicare, and

6. 360,000 Small Businesses are using the Health Care Tax Credit to help them provide health insurance to their workers;

7. Pregnancy is no longer a pre-existing condition and women can no longer be charged a higher rate just because they are women.

We are becoming a nation of equals when it comes to access to affordable healthcare insurance.

The President and congressional Republicans call this enviable record of success a ''disaster.''

The American people do not agree and that is why they reject overwhelmingly (56%–17%) this Republican attempt to repeal the Affordable Care Act according to the latest Quinnipiac poll.

Americans know a disaster when they see one and they see one in the making: it is called ''Trumpcare,'' masquerading as the ''American Health Care Act,'' which will force Americans to ''pay more for less.''

And they are right to be alarmed at what they see.

This ''Pay-More-For-Less'' bill is a massive $900 billion tax cut for the wealthy, paid for on the backs of America's seniors, the vulnerable, the poor, and working class households.

This ''Robin Hood in reverse'' bill is unprecedented and breathtaking in its audacity—no bill ever tried to give so much to the rich while taking so much from the poor and working class.

Trumpcare represents the largest transfer of wealth from the bottom 99% to the top 1% in American history.

This callous Republican scheme gives gigantic tax cuts to the rich, and pays for it by taking insurance away from 24 million people, leaving 52 million uninsured, and raising costs for the poor and middle class.

In addition, Republicans are giving the pharmaceutical industry a big tax repeal, worth nearly $25 billion over a decade without demanding in return any reduction in the cost of prescription and brand-name drugs.

To paraphrase Winston Churchill, of this bill, it can truly be said that ''never has so much been taken from so many to benefit so few.''

The Pay-More-For-Less plan destroys the Medicaid program under the cover of repealing the Affordable Care Act Medicaid expansion.

CBO estimates 14 million Americans will lose Medicaid coverage by 2026 under the Republican plan.

In addition to terminating the ACA Medicaid expansion, the bill converts Medicaid to a per-capita cap that is not guaranteed to keep pace with health costs starting in 2020.

The combined effect of these policies is to slash $880 billion in federal Medicaid funding over the next decade.

The cuts get deeper with each passing year, reaching 25% of Medicaid spending in 2026.

These steep cuts will force states to drop people from Medicaid entirely or ration care for those who most need access to comprehensive coverage.

The Pay-More-For-Less plan undermines the health care safety net for vulnerable populations.

Currently, Medicaid provides coverage to more than 70 million Americans, including children, pregnant women, seniors in Medicare, people who are too disabled to work, and parents struggling to get by on poverty-level wages.

In addition to doctor and hospital visits, Medicaid covers long-term services like nursing homes and home and community-based services that allow people with chronic health conditions and disabilities to live independently.

To date, 31 states and D.C. have expanded Medicaid eligibility to low-income adults, which, when combined with the ACA's other coverage provisions, has helped to reduce the nation's uninsured rate to the lowest in history.

Trumpcare throws 24 million Americans off their health insurance by 2026 according to the Congressional Budget Office.

Low-income people will be hit especially hard because 14 million people will lose access to Medicaid by 2026 according to CBO.

Trumpcare massively shifts who gets insured in the nongroup market.

According to CBO, ''fewer lower-income people would obtain coverage through the nongroup market under the legislation than current law,'' and, ''a larger share of enrollees in the nongroup market would be younger people and a smaller share would be older people.''

The projected 10% reduction in premiums is not the result of better care or efficiency—it is in large part the result of higher-cost and older people being pushed out of a market that is also selling plans that provide less financial protection.

People with low incomes suffer the greatest losses in coverage.

CBO projects the uninsured rate for people in their 30s and 40s with incomes below 200% of poverty will reach 38% in 2026 under this bill, nearly twice the rate projected under current law.

Among people aged 50–64, CBO projects 30% of those with incomes below 200% of poverty will be uninsured in 2026.

Under current law, CBO projects the uninsured rate would only be 12 percent.

Being uninsured is not about ''freedom.''

Speaker Ryan has argued that people will happily forgo insurance coverage because this bill gives them that ''freedom.''

The argument makes as much sense as the foolish claim that slaves came to America as ''immigrants'' seeking a better life.

The freedom to be uninsured is no freedom at all to people in their 50s and 60s with modest incomes who simply cannot afford to pay thousands of dollars toward premiums.

They do not really have a choice.

The claim of our Republican friends that Trumpcare provides more freedom to all Americans calls to mind the words of Anatole France:

''The law, in its majestic equality, forbids the rich as well as the poor to sleep under bridges, to beg in the streets, and to steal bread from the market.''

Trumpcare raises costs for Americans nearing retirement, essentially imposing an ''Age Tax.''

The bill allows insurance companies to charge older enrollees higher premiums than allowed under current law, while reducing the size of premium tax credits provided.

Again, these changes hit low-income older persons the hardest.

A 64-year-old with an income of $26,500 buying coverage in the individual market will pay $12,900 more toward their premiums in 2026, on average.

Trumpcare raises costs for individuals and families with modest incomes, particularly older Americans.

A recent analysis found that in 2020, individuals with incomes of about $31,000 would pay on average $4,000 more out of pocket for health care—which is like getting a 13% pay cut.

And the older you are, the worse it gets.

An analysis by the Urban Institute estimates that for Americans in their 50s and 60s, the tax credits alone would only be sufficient to buy plans with major holes in them, such as a $30,000 deductible for family coverage and no coverage at all of brand-name drugs or many therapy services.

Another reason I oppose the Trumpcare bill before us is because its draconian cuts in Medicaid funding and phase-out of Medicaid expansion put community health centers at risk.

Community health centers are consumer-driven and patient-centered organizations that serve as a comprehensive and cost effective primary health care option for America's most underserved communities.

Community health centers serve as the health care home for more than 25 million patients in nearly 10,000 communities across the country.

Across the country, 550 new clinics have opened to receive 5 million new patients since 2009.

Community health centers serve everyone regardless of ability to pay or insurance status:

1. 71% of health center patients have incomes at or below 100% of poverty and 92% have incomes less than 200% of poverty;

2. 49% of health center patients are on Medicaid; and

3. 24% are uninsured;

4. Community health centers annually serve on average 1.2 million homeless patients and more than 300,000 veterans.

Community health centers reduce health care costs and produce savings—on average, health centers save 24% per Medicaid patient when compared to other providers.

Community health centers integrate critical medical and social services such as oral health, mental health, substance abuse, case management, and translation, under one roof.

Community health centers employ nearly 190,000 people and generate over $45 billion in total economic activity in some of the nation's most distressed communities.

Community health centers serve on the front lines of public health crises such as the Zika virus and the opioid epidemic.

Mr. Speaker, community health centers are on the front lines of every major health crisis our country faces, from providing access to care (and employment) to veterans to addressing the opioid epidemic to responding to public health threats like the Zika virus.

We should be providing more support and funding to community health centers, not making it more difficult for them to serve the communities that desperately need them by slashing Medicaid funding.

Trumpcare Republican plan leaves rural Americans worse off.

Mr. Speaker, health insurance has historically been more expensive in rural areas because services cost more and it is hard to have a stable individual market with a small population.

Under the Affordable Care Act, premium subsidies are tied to local costs, which helps keeps premium costs down.

But they are not under the Republican plan.

So, under the Republican plan residents in rural areas, who tend to be older and poorer, will pay much more and get much less health insurance.

At the end of the day, Mr. Speaker, the powerful and compelling reasons to reject Trumpcare lies in the real world experiences of the American people.

Let me briefly share with you the positive, life affirming difference made by the Affordable Care Act in the lives of just three of the millions of Americans it has helped.

Joan Fanwick: ''If Obamacare is repealed, I don't know if I'll live to see the next President''

''After nearly a decade of mysterious health scares, I was diagnosed with an autoimmune disorder called Sjogren's Syndrome last year, when I was a junior at Temple University.

''It's a chronic illness with no known cause or cure, and without close medical surveillance and care, it can lead to life-threatening complications (like the blood infections I frequently experience).

''For me, having this disorder means waking up every morning and taking 10 different medications.

''It also means a nurse visiting my apartment every Saturday to insert a needle into the port in my chest, so I can give myself IV fluids throughout the week.

''Without insurance, my medical expenses would cost me about $1,000 per week—more than $50,000 per year. And that doesn't even include hospitalizations.

''My medical bills aren't cheap under Obamacare, but I can afford them.

''Under Obamacare, insurance companies aren't allowed to cut you off when your costs climb so right now, the most I personally have to pay out of pocket is $1,000 per year.''

Brian Norgaard: ''I am a small business owner and leadership trainer who Obamacare has helped tremendously.''

Brian Norgaard, a Dallas, Texas resident, called my office to express his opposition to Trumpcare and to offer share how the Affordable Care Act has helped small business owners like himself:

''I am a small business owner and leadership trainer who Obamacare has helped tremendously.

''My wife and I both own small businesses in the Dallas, Texas area and as a result of the huge savings we received after paying lower [healthcare] premiums under Obamacare, we were able to reinvest those saving into both of our businesses and the community.

''And the healthcare we received was quality, at that.''

Ashley Walton: ''For cancer survivors, we literally live and die by insurance''

Ashley Walton was 25 when a mole on her back turned out to be melanoma.

She had it removed, but three years later she discovered a lump in her abdomen.

She was then unemployed and uninsured, and so she put off going to a doctor.

She tried to buy health insurance. Every company rejected her.

Ashley eventually became eligible for California's Medicaid program, which had been expanded under the Affordable Care Act.

The 32-year-old Oakland resident credits her survival to the ACA.

Without it, ''I would likely be dead, and my family would likely be bankrupt from trying to save me.''

Before any of our Republican colleagues supporting this bill cast their vote, I urge them to reflect on the testimony of Joan, Brian, and Ashley, and to on this question posed by a constituent to Sen. COTTON of Arkansas at a recent town hall:

''I've got a husband dying and we can't afford—let me tell you something.

''If you can get us better coverage than this [Obamacare], go for it.

''Let me tell you what we have, plus a lot of benefits that we need.

''We have $29 per month for my husband. Can you beat that? Can you?

With all the congestive heart failures, and open heart surgeries, we're trying. $29 per month. And he's a hard worker.

$39 for me.''

I urge all Members to reject Trumpcare, one of the most monstrously cruel and morally bankrupt legislative proposals ever to be considered in this chamber.

To paraphrase a famous former reality television personality, ''believe me, Trumpcare is a disaster.''

We should reject it and keep instead ''something terrific'' and that is the Affordable Care Act, regarded lovingly by millions of Americans as ''Obamacare.''

MARCH 24, 2017.

Re Changes to the Affordable Healthcare Act.

THE PRESIDENT OF THE UNITED STATES OF AMERICA,
The White House,
Washington, DC.

GREETINGS MR. PRESIDENT: Today is a very crucial and important day for the residents of the City of Houston's District D, where I serve as the elected City Council Member, which also falls under Congressional Districts 18 and 7. As a local elected official whose mother is on a fixed income, this will not only impact her but many other senior citizens who I represent.

In the news, we see how the Affordable Healthcare Act is proposed to be changed. Under the new revisions to the healthcare bill, which is called The American Health Care Act, about $337 Billion will be cut from the current plan over a 10 year period causing 24 million Americans, including Democrats, Republicans, Independents, poor and the middle class, to lose their healthcare. This proposed health care bill is receiving criticism from the health care providers, some conservatives and a united Democratic Party. The Congressional Budget Office even showed how this current proposed plan will negatively impact everyone. What is most concerning to me in regards to this program is the impact that it will have on our senior citizens.

52% of my District is made up of Senior Citizens who are on fixed incomes. These senior's will have to pay more for their health care under this proposed American Health Care Act. In no way is this acceptable. I am an advocate for my seniors and I refuse to quietly sit back while this is being considered.

I have encouraged everyone to reach out to their Members of Congress to let them know that this isn't something that we stand for and to work on their behalf to vote this item down today.

Sincerely,

DWIGHT BOYKINS,
Houston City Counsel,
District D.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin (Mr. GROTHMAN), who is also a member of the Budget Committee.

Mr. GROTHMAN. Mr. Speaker, I would encourage my colleagues to vote for the bill. The reason I ask you to vote for the bill is kind of like the reverse: What is going to happen if this bill fails?

If this bill fails, you won't be able to have the huge increase in funding in HSAs, a free-market, patient-centered tax provision which is going to help many people and particularly allow flexibility for older married couples.

If this bill doesn't pass, we are going to continue to levy fines on young people who don't want health insurance, as so many people have not had when they are young. We will continue to levy fines on small business that can't afford health insurance.

If this bill fails to pass, we are not going to allow States to put work requirements on Medicaid. Quite frankly, Medicaid, in many ways, is a more generous policy than the one that people who do work are able to afford through their insurers.

If this bill doesn't pass, we won't be able to stop the bleeding on Medicaid funding. We are approaching a $20 trillion debt. Of course, the bulk of that spiraling debt is caused by mandatory spending, of which Medicaid is one of the worst parts.

Finally, for the first time in years, we are passing a law that will make a significant dent in that mandatory spending.

If this bill isn't passed, we prevent putting a provision in here requiring documentation of citizenship for Medicaid. Right now, we are becoming the healthcare provider for the world. We cannot afford to become the healthcare provider of the world.

Under this bill, we are providing funds, seed money for high-risk pools for States, which will hold down insurance costs, which is the underlying problem we have here.

If this bill doesn't pass, we continue to fund abortion providers. I think this is the best bill in decades for those of us who wish we would stop funding these organizations.

We are providing assistance for people who can't get insurance through their employer. It is high time the Tax Code provided equality for people who get insurance from their employer and those who don't.

Finally, if we don't pass this bill, we don't end ObamaCare.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mrs. BLACK. Mr. Speaker, I yield an additional 30 seconds to the gentleman.

Mr. GROTHMAN. Already a third of the counties only have one provider. If we don't pass this bill now, we are going to go into the next year and we are going find a lot of people who think they have ObamaCare but have nothing because there will be no providers left.

We have got to step in to save those people and provide insurance in those counties in which ObamaCare will leave no insurance companies remaining.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 44,600 people from his congressional district in Wisconsin losing health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Illinois (Ms. SCHAKOWSKY), a distinguished member of the Budget Committee and the Energy and Commerce Committee.

Ms. SCHAKOWSKY. Mr. Speaker, I sincerely ask my Republican colleagues: Did you really come here to take health care away from 24 million people?

Over 40,000 people in my district will lose their coverage.

Did you come to Congress to make insurance more expensive for my constituent, Mary, who has a preexisting condition and now pays half of what she used to pay for insurance because of the tax credits she got from ObamaCare?

Did you come to Congress to impose a crippling age tax on Americans 50 to 60 years old?

Your bill would increase their premiums an average of $8,000 a year. According to the Congressional Budget Office, within 10 years, nearly 30 percent of those 50-to 64-year-olds would be without any insurance.

Did you really come to Congress to take nursing home and home care away from the elderly and the disabled?

Did you get elected in order to take health care from mothers?

Your bill would kick them off of Medicaid if they don't find a job 60 days after they give birth.

We have heard over and over that patients need choices and should be empowered to choose the care that they want. But, apparently, that doesn't apply to women. The bill would block millions of women from choosing Planned Parenthood, a trusted healthcare provider to 2.5 million patients every year.

The American people are not clamoring for you to repeal ObamaCare. Only 17 percent of Americans say that you should vote to repeal ObamaCare. The average American overwhelmingly wants you to vote ''no.''

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Kansas (Mr. MARSHALL), who is a physician.

Mr. MARSHALL. Mr. Speaker, Kansas voters sent me to fix health care. Doing nothing is not an option. I cannot sit here idly while the ACA destroys and bankrupts America's healthcare system.

This bill eliminates nearly a trillion dollars of taxes. This bill eliminates funding for Planned Parenthood. This bill will save many hospitals in Kansas from closing by increasing funding for Medicare patients. This bill allots $100 billion for high-risk pools. This bill specifies another $15 billion specifically for maternity coverage, which is near and dear to my heart; newborn care; mental health care; and substance abuse disorders.

Mr. Speaker, this is the best bill that we can get through this process. I am excited to be part of it. This is the first chapter of a new book, with many more chapters to come. We will fix health care.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 50,000 people from his congressional district in Kansas losing health coverage and care.

Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, in concluding the presentation from the Budget Committee, I just have to say that the bill we are considering today is a mess. It is not a healthcare bill at all.

This bill is driven by a desire to cut taxes for the wealthiest Americans and many wealthy corporations by nearly $1 trillion in all. It is paid for by making health care unaffordable for millions of people.

This is irresponsible. It is not what the American people want, it is not what they deserve, and it is certainly not what they can afford.

We are not the only ones opposing this legislation. It is opposed by an amazing array of American organizations and individuals, including the American Medical Association, the American Hospital Association, the American Nurses Association, the National Rural Health Association, AARP, the National Disability Rights Network, the American Diabetes Association, American Cancer Society, and Easterseals, virtually every healthcare and consumer advocacy group, Governors from both sides of the aisle, and a growing list of our Republican colleagues.

Mr. Speaker, I thank the Budget Committee staff for the incredible job they have done throughout this process.

Mr. Speaker, I reserve the balance of my time, and I ask unanimous consent that the gentleman from New Jersey (Mr. PALLONE), chairman of the Energy and Commerce Committee, control the balance of my time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kentucky?

There was no objection.

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

Mr. Speaker, I want to remind my fellow colleagues that, currently, when we look at the access to care for people, one-third of our counties only have one provider; two-thirds of our counties only have two providers. In my State of Tennessee, there are 14 counties where they will have no insurance provider on the marketplace. So when we talk about people losing their insurance, they are losing their insurance by not having access to even purchase the insurance.

One of my former colleagues, the gentleman from Minnesota, asked: What are my colleagues on the other side of the aisle trying to preserve?

I want to point to this chart here to ask that question, because these are the broken promises of ObamaCare.

Why are you trying to preserve something where they say premiums will decrease by $2,500, and we see the average family premiums have soared by $4,300, making insurance unaffordable for many families?

Another broken promise: the cost of health care will go down.

We see some deductibles that have gone up as much as 60 percent. In my own State, they have gone up by 63 percent, making coverage unaffordable.

You can keep your doctor—70 percent of the plans consist of narrow networks, which means they cannot keep their doctor. I cannot tell you the number of people who have called me because their doctor was not on their inept plan.

Finally, ''middle class Americans won't see a tax increase.'' This was a promise by former President Obama. ObamaCare penalties were put in place, so people are receiving a tax penalty.

These are the broken promises that the other side of the aisle wants to continue to protect. As opposed to that, we

want a system that is going to be open with patient care and give affordability so people can get the services that they want with a cost that they can afford.

I also thank the Budget Committee for the work that they have done, and all the staff that have worked endless hours to make it possible for this to be here on the floor today.

Mr. Speaker, I yield 30 minutes to the gentleman from Oregon (Mr. WALDEN), and I ask unanimous consent that he may control that time.

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

There was no objection.

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

After 7 years, we have heard the stories of our constituents, patients, friends, and family who have suffered under ObamaCare. We have heard from those who have benefited in some respects.

I think of the struggles of constituents like Indra from Bend, Oregon. She lost her private insurance and her preferred doctor. When she went to look for a new plan under ObamaCare, she found the plans were too expensive, and she went without insurance for almost 2 years. See, her story should not be lost in this debate either.

□ 1230

Then there is April. Last fall, she found out her insurer would not be offering her plan this year. The most comparable plan available would raise her monthly premium by $564 per month, bringing her total monthly premium to $1,503.

You see, there is a whole other group of Americans out there who are suffering these effects of ObamaCare. The American Health Care Act represents a better way for patients like Indra and April all across our country. Our plan will rescue and revitalize the market and lower costs and increase flexibility for patients to choose. They will have more choices for health care and keep a health insurance plan that works for them and for their family.

This legislation creates the Patient and State Stability Fund. Now, this is an innovative approach to give States the financing and flexibility to repair the damage done to the insurance markets by ObamaCare and meet the unique needs of their citizens. More importantly, we provide an additional $15 billion, Mr. Speaker, to States devoted for maternity coverage. We heard from people who said we need to do more in this area: newborn care, mental health, and substance disorders.

We are also taking action to strengthen Medicaid. We want to put Medicaid on a sustainable path so it can better care for those it was intended to serve, a path through this per capita program for States that, frankly, was at one time embraced by Democrats, including President Clinton.

The most vulnerable in our communities need this help. It represents the most substantive reform to the Medicaid program since its creation and will restore power to our States and local communities and governments where they can make better decisions than a one-size-fits-all here in Washington. We want to give our States more control in how they manage these people that they are closest to.

In closing, I want to thank our colleagues and the President of the United States and the Vice President and Secretary Price. They have worked day in and day out, tirelessly, without hesitation, to help get to the best policy possible here and to work and listen to our colleagues, as we have all done, to craft the best bill we can, given the constraints under which we must operate.

The end result highlights the diverse ideas of our Conference that come from the American people and the determination that we share to save this market and make it work again.

Remember, we are talking about a narrow slice of the insurance market, that driven by ObamaCare, that, last year, there were 225 counties in America where, if you were looking for insurance on that exchange, you had one option. This year, it is 1,022 counties. That is one out of every three in America. And that was before Humana pulled out and other companies said this market is about gone.

We need to fix this market. That is what this legislation seeks to do.

Mr. Speaker, I want to thank our terrific staff that has worked day and night to get us to this point. We know there is a lot more work to do. This should not be taken in isolation as the only healthcare reform on our list. We are going to go after the cost drivers. We are going to go after prescription costs. We are going to go after hospital costs.

Wherever it is in the health system, if you have nothing to hide, you won't have to fear our investigations. But we are going to get costs down. We are going to get costs down.

The American Health Care Act is just the first step in our mission to rescue the American people from the failures of the underlying law. We know they are there. We are going to fix this. We are committed to it.

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

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

Mr. Speaker, I remind my colleague, my chairman, GREG WALDEN, that his vote for this bill will result in 64,300 people from his congressional district in Oregon losing health coverage and care.

Mr. Speaker, President Trump and congressional Republicans are not leveling with the American people when they say no one will be worse off under this repeal bill. TrumpCare dismantles the health and economic security that millions of hardworking Americans have gained over the last 7 years, and it should be defeated.

There is a reason this bill was hatched up in the back rooms only to be finalized last night, and that is because congressional Republicans did not want the American people to see what was in it.

TrumpCare provides less coverage, fewer protections, and higher costs.

TrumpCare is Robin Hood in reverse, taking benefits and financial assistance from hardworking, middle class Americans and our most vulnerable in order to give tax breaks to the wealthiest and the corporations.

TrumpCare cuts a combined $1 trillion from Medicare and Medicaid. These cuts are devastating, Mr. Speaker.

TrumpCare will ration care for the 76 million Americans who rely on Medicaid, including seniors with long-term care needs, Americans with disabilities, pregnant women, and vulnerable children.

I fear for seniors, Mr. Speaker, those in nursing homes. When States get less money, what will they do? They will give less money to nursing homes. We will go back to the days that I remember in New Jersey when nursing homes were terrible places, where there weren't enough nurses, where there were fires because of lack of maintenance of the nursing home.

Working families are going to pay more for less. They will see their premiums and deductibles skyrocket. My GOP colleagues talk about high deductibles and copays. Well, you ain't seen nothing yet.

You are going to see that this repeal repeals the limits on deductibles and copays that exist under the current law. Out-of-pocket costs are going to go through the roof. The deductibles will go even higher. The copays will go even higher. The out-of-pocket costs will go even higher.

And the bottom line is Americans between the ages of 50 and 64 will pay an age tax and be forced to pay premiums five times higher than what younger people pay for their coverage.

I have heard my colleagues on the other side say, well, that is only fair. Well, I don't think it is fair that seniors should have to pay a lot more, that those between 50 and 64 should have to pay a lot more.

Also, TrumpCare leaves the sickest and vulnerable Americans at the mercy of insurance companies, allowing them to charge a 30 percent penalty or sick tax to those who are unable to maintain continuous coverage. So if you fail to pay your insurance for a month and then you want to get it again, even if you have a preexisting condition, which is often the case, you are going to pay a 30 percent penalty, or sick tax. I don't think that is very fair.

Last night, in order to garner votes from the extreme right in their party, House Republicans added a provision that eliminates protections for essential health benefits. Now, maybe people don't understand that, but let me explain it.

The ACA ensured that, when a consumer purchased health insurance on the individual market or gained coverage through Medicaid expansion, their plan would cover 10 critical, essential benefits.

TrumpCare eliminates this guarantee, meaning that unscrupulous insurance companies can sell skeletal plans, junk insurance, without benefits for hospitalization, maternity care, mental health, drug treatment services, and Americans won't even know what they are getting. They won't realize that they have worthless insurance until they get sick and it is too late.

The bottom line is this bill should be defeated for so many reasons because so many more people will not have health insurance, because their costs are going to go up, and because they won't even know what insurance they are buying. We are going go to back to the old days of the Wild West when insurance companies could sell whatever junk insurance they want and the public won't even know what they are getting. It is a disaster for the American people.

I urge my colleagues to vote ''no,'' and I reserve the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield myself 20 seconds.

The irony of that argument is it was just a year or so ago that every Member of this House who was here at the time and the Senate, by a unanimous vote, agreed to waive the essential benefits he just listed off for the employment market between 51 and 100—and, by the way, those essential benefits don't apply to the large group market—so this has already been done.

I yield 1½ minutes to the gentleman from Texas (Mr. BARTON), the vice chairman of the full committee.

Mr. BARTON. Mr. Speaker, I supported this bill when it came out of the Energy and Commerce Committee 2 or 3 weeks ago, and I want to thank Chairman WALDEN for his excellent leadership.

As he knows, I had some concerns about the bill at the time. I didn't think it addressed all the problems that we needed to address.

At the start of this week, I was a ''no'' vote—a friendly ''no'' vote, but I was a ''no'' vote. Our Republican leadership in the House and the President and his senior advisers continued to involve themselves in constructive discussions with people like myself. Yesterday they agreed to put back in the repeal of the essential health benefits provision, and that is a big win for conservative values, so I am now a ''yes'' vote.

My friends on the left seem to think the only way to get a benefit is to have the Federal Government mandate it and then have the Federal Government pay for it. I am here to tell you, Mr. Speaker, that markets work. If we create a healthcare market where people can choose their insurance that fits their needs, there will be plans that provide for every so-called essential health benefit. But there will also be plans that provide for specific markets of young people without children or elderly couples or whatever it is.

Mr. Speaker, markets work, and you don't have to mandate benefits for those markets to work.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. WALDEN. Mr. Speaker, I yield an additional 15 seconds to the gentleman from Texas.

Mr. BARTON. Mr. Speaker, we always want to score a touchdown. Sometimes we take a field goal. What we don't want to do today is take a safety.

Vote for this bill. Let's send it to the other body and continue to work to improve it. It is a good bill. Please vote ''yes.''

Mr. PALLONE. Mr. Speaker, I remind my colleague that, in Mr. BARTON's case, his vote for this bill will result in 64,900 people from his congressional district in Texas losing health coverage and care.

I yield 2 minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, the American people are very smart. They listen up. They kind of knit their eyebrows together. They listen to the debate. They want the facts, and then they make up their mind. What our colleagues on the other side of the aisle have brought forward today is a disaster for the American people, and the American people know it.

You have 17 percent of the American people that are for your plan, and the reason why? They know there are going to be higher costs. Families are going to have to pay more and get less—pay more for their premiums, more for their deductibles, and more in their out-of-pocket costs.

You are taking health care away from 24 million Americans. That is more than the entire population of Australia. Who comes to Congress to hurt people?

The promise of the Affordable Care Act was no one—no one ever again—will be able to take away your insurance the way the insurance companies did 7-plus years ago. Now it is only the Republican Party that can take away Americans' insurance.

There isn't one developed country in the world that has your plan. It is a combination of all kinds of things to get votes.

What free markets? What are you talking about? There is hypocrisy here because you all have the Affordable Care Act insurance. Every single Member of Congress does. So I guess it is good enough for you but it is not good enough for your constituents.

This is a matter of life and death. You are playing with people's lives. It is a profound issue. This doesn't deserve one vote in the House of Representatives. Vote it down.

The SPEAKER pro tempore. The Chair would remind all Members to direct their remarks to the Chair.

Mr. WALDEN. Mr. Speaker, I yield myself 10 seconds before I yield to the gentleman from Michigan.

I would just suggest that the American people are very smart. Unfortunately, under ObamaCare, 19.2 million Americans said: I am not going to buy ObamaCare. I am going to pay a penalty to the IRS instead.

You see, we are trying to fix it so they will want to buy it.

I yield 2 minutes to the gentleman from Michigan (Mr. UPTON).

Mr. UPTON. Mr. Speaker, you know, there is an old Upton family quote that my grandfather would always say: Was you always perfect? No, none of us are.

And you know what? This is not a perfect bill. That is for sure. But ObamaCare is broken. One out of three counties has only one provider, and it looks like it is going to get worse as other major insurance companies are on the verge of pulling the plug.

Nearly two dozen of the nonprofit CO-OPS have already gone belly up. In my home State, folks saw their premiums increase by nearly 17 percent. Some States have had premium increases of more than 100 percent. Most had double-digit increases, many over 20 percent, and some forecast 40 to 50 percent increases come fall if nothing happens.

The calls on both sides of the aisle have often used the R word—on this side, ''replace''; on your side, the Democratic side, ''repair.'' Let's both agree. The status quo is not acceptable. But this, this bill, is the only train leaving the station. Is it going to improve if it gets to the Senate? Of course it will. We should all work for that goal.

For me, I worked with Medicaid expansion States like Michigan providing a reasonable transition until 2020 and then grandfathering all those folks until they are off. Some of my colleagues called to end Medicaid expansion even this year. They want total repeal.

□ 1245

What would total repeal mean? Total repeal would mean taking away the ability of HHS to provide flexibility to the States to administer this critical program. It would mean taking away insurance for young kids on their parents' policies. It would reinstall a cap on insurance. And, yes, it would allow insurance companies to discriminate against those with preexisting illnesses.

This bill still allows all of those important protections to stay in place. A number of us will continue to work with HHS to provide even more flexibility to States like Michigan. This has to be a key component of moving forward.

At the end of the day, I would like to think that we could work together on a bipartisan basis. High premiums and a lack of access impact us all. Let's work together. You can't get to second base unless you get to first.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Michigan that his vote for this bill will result in 43,500 people from his congressional district in Michigan losing health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Speaker, when people look at these bills, they want to know what they are going to pay. What this bill does is simple—you pay more and you get less. That is the bottom line—pay more and get less.

The President promised better health care for more people at a lesser cost. But my Republican colleagues can no longer claim with any credibility that their plan achieves these goals.

Twenty-four million people will lose coverage. People 50 to 64 will be hit with an age tax and pay premiums five times higher than everybody else. Deductibles will go up. And protections that make sure insurance companies offer minimum value will be thrown out.

Again, the Republican bill, TrumpCare—pay more, get less—but it gives billionaires a tax break. That is really important; isn't it? With the Affordable Care Act, we set out to give Americans more affordable, higher quality health care.

Is the law perfect? No. We should be working together to tweak the law. We should be working together to improve the law, not putting in a clunker like this bill, which will roll back the time on people's coverage. Roll back the time, give people less coverage, and let them pay more. That is not what the American people want. I urge my colleagues to vote ''no.''

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Mississippi (Mr. HARPER), the chairman of the House Administration Committee, and a valuable member of the Energy and Commerce Committee.

Mr. HARPER. Mr. Speaker, ObamaCare has failed. Contrary to what was promised, premiums have gone up and there are fewer health insurance options. This bill addresses a crisis that before now had no end in sight.

Not only does this bill work to solve the problems we see in the private insurance market, it addresses one of our Nation's most vital programs—Medicaid. This program is a critical lifeline for hundreds of thousands of Mississippians.

Medicaid is a safety net program that was designed for children, the elderly, pregnant mothers, and the disabled. This bill will refocus attention back on the program's initial goals, but will modernize it to better serve these patients.

We should move decisionmaking authority down to those who are best positioned to address these problems. A program run primarily by the States with assistance from the Federal Government will best be able to help those who need it most.

By giving States more tools to address costs, this bill will allow States to explore ways to make accepting Medicaid more attractive to providers, leading to better health outcomes. Without addressing the current problems facing the Medicaid program, it will not survive. This bill puts Medicaid on a path to sustainability. An insolvent safety net will harm those it intends to help.

This is our moment. We have a historic opportunity to enact the biggest entitlement reform in our lifetime. We have a chance to save Medicaid.

I urge my colleagues to vote for this bill.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Mississippi that his vote for this bill will result in 69,600 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GENE GREEN), the ranking member of the Health Subcommittee.

Mr. GENE GREEN of Texas. Mr. Speaker, this is outrageous. TrumpCare will rip health insurance from 24 million Americans, almost as many people who live in the State of Texas.

TrumpCare is a direct assault on the President's promise to the American people. It will saddle families across the country with massive health costs. It will lead to higher premiums, less benefits, and more people uninsured.

Under this bill, premiums increase 15 to 20 percent in each of the next 2 years. It will particularly be terrible for the near-elderly Americans because TrumpCare allows insurance companies to charge them five times higher than what others would pay for coverage. It destroys protections for Americans with preexisting conditions. It guts the essential benefits so consumers won't know what coverage they have. Plans would not have to cover things like emergency care, hospitalization, or even prescription drugs.

What do you do when you leave people with that? Junk plans that are insurance in name only. What is the point of having insurance if it doesn't cover anything?

For those who aren't one of the 24 million who lose insurance, many will be left with plans that are more expensive but don't have to cover things like prescription drugs or mental health and substance abuse.

This bill will make it harder for people to get treatment. It will destroy the Medicaid program, the bedrock of our social safety net that insures 74 million Americans, including children, pregnant women, and one in seven seniors on Medicare.

TrumpCare harms Medicare. It will make the program insolvent 3 years earlier, directly causes part B premiums to go up $8.7 billion, and takes away funds that seniors depend on for long-term care. It is impossible to overstate how terrible TrumpCare will be for the American people.

This is a dangerous bill. It is opposed by physician groups and hospital associations.

I urge my colleagues to vote ''no.''

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Kentucky (Mr. GUTHRIE), the former head of the Medicaid task force.

Mr. GUTHRIE. Mr. Speaker, about 7 years ago, I was on the floor talking on the Affordable Care Act. And I remember talking about, I had just left the State Senate, and bringing up that my colleagues are in Frankfort and they are doing work on the budget; and, in the future, it is going to make it more difficult for them to pass budgets because of the expansion in Medicaid, and that is coming to pass. It will be in the next budget session they have to deal with moving forward, if we don't address this situation.

So people keep talking about a rush process. Over a year ago, we put together a Medicaid task force, met with groups of people, met with Governors, we took a lot of information, and put together a plan that addresses the needs of Medicaid. Medicaid is growing. It will be over a $1 trillion program within 10 years if we don't deal with it. It is going to implode. So we actually worked to put it on a sustainable budget. It is growing. People talk about cuts to Medicaid. Only in Washington, D.C., is slowing the growth of a program looked at as a cut. So we have worked hard to move that forward.

The other thing I want to talk about is, last year, small businesses were going to be hit by the minimum essential benefits. Small businesses were saying: We like our plans, and we want to keep it. We are going to have our prices go up, and we are not going to be able to afford to provide coverage.

So we all came together, bipartisan, to address that to exempt the small-business plans for those programs. It passed by voice vote in the House, unanimous consent in the Senate, and signed by then-President Obama.

So the question is, if small businesses can design and keep their own plans, I think individuals can, too.

I agree with my friend from California that the American people are smart. I disagree with my other colleague who says: They will buy things, and they won't even know what is in it.

They are smart, and I urge support for this bill.

Mr. PALLONE. Mr. Speaker, I remind my friend from Kentucky that his vote for this bill will result in 44,000 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, President Trump promised his healthcare plan would be ''much better health care at a much lower cost.'' Secretary of Health and Human Services Tom Price even promised ''nobody will be

worse off financially.'' In reality, of course, the TrumpCare bill will leave just about everybody worse off, with less care at a higher cost.

This bad bill would rip health insurance money away from millions of people—24 million over 10 years, and 14 million next year alone.

Americans who are lucky enough to hold on to coverage if this bill becomes law will pay more for it in premiums, deductibles, and other out-of-pocket costs, especially people age 50 and up.

Mr. Speaker, the deals that were cut last night to win more Republican votes for TrumpCare would be even more devastating. Trips to the emergency room, mental health and substance abuse treatment, maternity care both before and after birth, prescription drugs, lab tests, and more essential services could be cut.

Apparently, some people don't think these services deserve guaranteed health insurance. They would let insurers sell skimpy plans that don't even cover patients' basic needs.

Democrats believe we can, and should, work together to improve the ACA, not to work on a misguided bill that would gut it.

We owe this to folks like Amanda Miller of Denver. Amanda changed jobs last year. During her period of unemployment, she and her husband decided the smart thing to do was to get coverage to fill the gap. Thank God they did.

Shortly after that, she and her husband got into a serious car accident. Amanda walked away unscathed, but her husband was badly injured. She could see more of his skull than she could see of his scalp. Luckily, there were some nurses in a car behind them, and they stabilized him and took him to the emergency room.

Their hospital bill of $16,000 was paid in full, thanks to Amanda's coverage through the ACA. What do we say to Amanda? Can we guarantee her better insurance and a better financial situation? I don't think so.

Let's defeat this bill, and let's start working towards a good one that will cover everybody.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Indiana (Mr. BUCSHON).

Mr. BUCSHON. Mr. Speaker, when ObamaCare was debated 7 years ago, I wrote my Member of Congress to urge him to vote against what I saw as a government takeover of our healthcare system.

At that time, I was a practicing physician, and I could foresee the disastrous consequences of this law and what it would do to patients across this country, including my own. And I wasn't alone.

Citizens from every corner of America stood up and demanded that Congress reject the ObamaCare bill, but we were ignored. Since then, out-of-pocket costs for families have skyrocketed, patient-choice has evaporated, and ObamaCare has inched closer to the brink of collapse.

In that time, those same Americans who fought against passage of ObamaCare have delivered Republicans majorities in the House, in the Senate, and put a Republican in the White House. They did so, in part, based on our promises to repeal and replace ObamaCare.

And here we stand, 7 years after ObamaCare passed, with the opportunity to finally deliver on that promise, and to bring relief to patients across this country who haven't been able to find the care they were promised at a cost they can afford.

It is an opportunity for us to fulfill our promise to our constituents. Let's be clear: a vote against this bill today is a vote for preservation of the ObamaCare disaster, a vote to keep critical healthcare decisions in the hands of bureaucrats in Washington, D.C., and a vote against the largest entitlement reform in a generation.

I urge all of my colleagues to do the right thing and vote for this bill.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Indiana that his vote for this bill will result in 37,800 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. MICHAEL F. DOYLE).

Mr. MICHAEL F. DOYLE of Pennsylvania. Mr. Speaker, for the last 7½ years, Republicans have promised Americans something better than the ACA. Instead, today, they are giving us something much worse.

Twenty-four million people lose their insurance? Stripping away guaranteed benefits? Putting maternity, mental health, and pediatric care at risk? Shame on you.

Pitting the elderly against children, the disabled, and the mentally ill in the Medicaid program? Placing a tax penalty on veterans? Charging a crushing age tax on 50- to 64-year-olds, forcing them to pay five times more than what others pay? Shame on you.

This isn't a healthcare bill. This is a tax cut bill masquerading as a healthcare bill. This bill does nothing to lower premiums, copays, or deductibles.

You cut taxes by almost $1 trillion for corporations and the rich, while ransacking Medicaid and the Medicare trust fund. That is shameful.

Americans will not forget who did this to them today.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Texas (Mr. FLORES), a real leader on the Energy and Commerce Committee.

□ 1300

Mr. FLORES. Mr. Speaker, we have heard numerous comments from the left extolling the virtues of ObamaCare, and I think it is instructive to hear the words of a former Democratic President that is beloved by the left. Here is what he said less than 6 months ago: ''So you've got this crazy system where all of a sudden 25 million more people have health care and then the people who are out there busting it, sometimes 60 hours a week, wind up with their premiums doubled and their coverage cut in half. It's the craziest thing in the world.''

Mr. Speaker, hardworking American families in my district, they don't want crazy. They want the American Health Care Act, a sane plan that gives them their freedom back.

In a few minutes, Mr. Speaker, you are going to hear somebody from the other side say that a bunch of my constituents are going to lose coverage. That is absolutely false. Those constituents are getting their freedom back to choose whether or not they want healthcare coverage and what kind of healthcare coverage they want. I say vote ''yes.''

Mr. PALLONE. Mr. Speaker, I remind my colleague from Texas that his vote for this bill will result in 61,900 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BUTTERFIELD).

Mr. BUTTERFIELD. Mr. Speaker, over the last few days, 110 organizations have written to me in opposition to TrumpCare. You know who they are: AARP, American Hospital Association, American Heart Association, American Medical Association, American Academy of Physicians, American Academy of Pediatrics, American Psychiatric Association, National Association of School Nurses, Alliance for Retired Americans, American Federation of Teachers, National Association of School Psychologists, National School Boards Association, National Education Association, the Children's Defense Fund, March of Dimes, the National Committee to Preserve Social Security and Medicare, the American College of Physicians North Carolina Chapter, North Carolina Society of Addiction Medicine, Consumers Union, United Steelworkers, AFL–CIO, Families USA, Center for American Progress, National Association of Pediatric Nurse Practitioners, and the list goes on and on.

Mr. Speaker, I include in the RECORD a list of entities opposing TrumpCare.

1. AARP
2. American Hospital Association
3. American Heart Association
4. American Medical Association
5. American Academy of Physicians
6. American Academy of Pediatrics
7. American Psychiatric Association
8. National Association of School Nurses
9. Alliance for Retired Americans
10. American Federation of Teachers
11. National Association of School Psychologists
12. National School Boards Association
13. National Education Association
14. Children's Defense Fund
15. March of Dimes
16. National Committee to Preserve Social Security and Medicare
17. American College of Physicians North Carolina Chapter
18. North Carolina Society of Addiction Medicine

19. North Carolina AIDS Action Network
20. Consumers Union
21. SEIU
22. United Steelworkers
23. AFL–CIO
24. Families USA
25. Center for American Progress
26. Southern HIV/AIDS Strategy Initiative
27. National Association of Pediatric Nurse Practitioners
28. Children's Hospital Association
29. National Rural Health Association
30. American Lung Association
31. ACLU
32. National Urban League
33. Black Women's Health Imperative
34. Communications Workers of America
35. International Brotherhood of Teamsters
36. National Rural Education Association
37. National Association of Social Workers
38. National Association of Pediatric Nurse Practitioners
39. Lutheran Services in America
40. NETWORK Lobby for Catholic Social Justice
41. Children's Dental Health Project
42. Family Voices
43. First Focus Campign for Children
44. American Psychological Association
45. National Council for Behavioral Health
46. National Hemophilia Foundation
47. American Congress of Obstetriticians and Gynecologists
48. American Sexual Health Association
49. Big Cities Health Coalition
50. National Women's Law Center
51. Human Rights Campaign
52. Partnership for America's Children
53. Friends Committee on National Legislation
54. National Partnership for Women & Families
55. Planned Parenthood Action Fund
56. National Center for Learning Disabilities
57. Save Medicaid in Schools Coalition
58. HIV Medicine Association
59. Drug Policy Alliance
60. League of Conservation Voters
61. Natural Resources Defense Council
62. Green Latinos
63. Green For All
64. Safe Climate Campaign
65. Climate Reality Project
66. Center for Reproductive Rights
67. Interfaith Disability Advocacy Collaborative
68. International Federation of Professional and Technical Engineers
69. Trust for America's Health
70. AIDS United
71. AFSCME
72. Cystic Fibrosis Foundation
73. AASA, The School Superintendents Association
74. Accelify
75. American Foundation for the Blind
76. Association of Assistive Technology Act
77. Programs Association of Educational Service Agencies
78. Association of School Business Officials International
79. Association of University Centers on Disabilities
80. Autistic Self Advocacy Network
81. Center for American Progress Center for Public Representation
82. Clearinghouse on Women's Issues
83. Colorado School Medicaid Consortium
84. Conference of Educational Administrators of Schools and Programs for the Deaf
85. Council for Exceptional Children
86. Council of Administrators of Special Education
87. Disability Rights Education & Defense Fund
88. Division for Early Childhood of the Council for Exceptional Children (DEC)
89. Health and Education Alliance of Louisiana
90. Healthy Schools Campaign
91. Higher Education Consortium for Special Education
92. Judge David L. Bazelon Center for Mental Health Law
93. LEAnet, a national coalition of local education agencies
94. Learning Disabilities Association of America
95. Lutheran Services in America Disability Network
96. Michigan Association of Intermediate School Administrators
97. Michigan Association of School Administrators
98. National Association of Pediatric Nurse Practitioners
99. National Association of State Directors of Special Education (NASDSE)
100. National Association of State Head Injury Administrators
101. National Black Justice Coalition
102. National Center for Learning Disabilities
103. National Disability Rights Network
104. National Down Syndrome Congress
105. National Health Law Program
106. National Respite Coalition
107. Paradigm Healthcare Services
108. School Social Work Association of America
109. School-Based Health Alliance
110. Society for Public Health Education
111. Teacher Education Division of the Council for Exceptional Children

Mr. BUTTERFIELD. What is it about this, Mr. Speaker, that you don't understand?

You are wrong on this. Don't let your base push you over the cliff on this bill.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentlewoman from Indiana (Mrs. BROOKS).

Mrs. BROOKS of Indiana. Mr. Speaker, I appreciate the passion I have heard from colleagues on both sides of the aisle and from Hoosiers on all sides of this issue. The issue of health care is personal for people, and it should be. But today, health care isn't personal. Under ObamaCare, healthcare coverage has been a one-size-fits-all approach.

I have heard from so many of my constituents in my more than 4 years in Congress about how ObamaCare has cost them and their families—lost doctors, higher premiums and deductibles, and a lack of options for coverage.

As an example of just one of those Hoosiers, Lon told me his premiums and deductibles doubled last year when he lost his healthcare plan. He has had to change his insurance 3 times in 3 years. That is not how healthcare coverage should work.

The American Health Care Act makes healthcare coverage more personal for every American. This bill empowers you, and every American, to choose the best health care for you and your family. It empowers our Governors and our State legislatures to meet the individual healthcare needs of their citizens, including the people struggling to make ends meet and the most vulnerable: the elderly, pregnant moms, kids, and people with disabilities.

I applaud our Hoosier Governor Holcomb, who wrote a letter to Congress with other Governors from around the country who support this bill, he, too, believes it is in the best interest of Hoosiers. I agree and I urge my colleagues to join me in support of the American Health Care Act.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Indiana that her vote for this bill will result in 37,700 people from her congressional district losing health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. CASTOR), the vice ranking member of our committee.

Ms. CASTOR of Florida. Mr. Speaker, my neighbors back home in Florida work very hard for their health coverage. When they pay their hard-earned copayments and premiums, they expect something meaningful in return: real health care. That is what the Affordable Care Act provided; not just a piece of paper, but real health services, an end to discrimination against preexisting conditions, and all sorts of other consumer protections.

But in the middle of the night last night, the Republicans turned back the clock. They have eliminated from the basic health insurance policy coverage for emergency room visits, hospitalization, prescription drugs, and more.

They have really embraced the moniker of pay more for less. And on top of it, remember, this bill rips health insurance away from millions of our neighbors back home. It raises costs on hardworking Americans, especially our older neighbors. It is practically an age tax, if you are over 50 years old. It breaks that fundamental guarantee that has existed for 50 years, that if your family is struck with an Alzheimer's diagnosis, a child with a complex condition, a handicap, that you are not going to live your remaining years in poverty, all the while, taking your tax dollars and shifting it to millionaires and billionaires and corporations.

TrumpCare is a recipe for disaster. It is a fundamental violation of the values we share as Americans, and it should meet its demise today.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from New York (Mr. COLLINS), a real leader on our committee.

Mr. COLLINS of New York. Mr. Speaker, today is a historic day, make no mistake about it. The American Health Care Act changes the trajectory of health policy in this country. Here are just a few of the highlights:

This bill eliminates the individual mandate penalty; eliminates the employer mandate penalty; eliminates the ObamaCare subsidies in 2020; eliminates ObamaCare tax increases; eliminates insurance mandates so we can lower premiums; provides refundable tax credits for individuals and families who do not get their health insurance through their employer or the government, and allows them to choose the health care that works for them; almost doubles the contribution limits

for health savings accounts; provides $115 billion for the Patient and State Stability Fund to lower patient cost and stabilize the insurance market; and enacts the most significant reforms to Medicaid in history, ensuring that Medicaid is sustainable and available for the most vulnerable among us for generations to come.

The American Health Care Act is a monumental step toward freedom, choice, and individual responsibility in health care.

Mr. Speaker, I will proudly vote for this bill today, and I urge all of my colleagues to do the same.

Mr. PALLONE. Mr. Speaker, I remind my colleague from New York that his vote for this bill will result in 58,000 people from his congressional district losing healthcare coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. SARBANES).

Mr. SARBANES. Mr. Speaker, this is a terrible bill. It is a terrible bill. It is wrong for the country.

Why would the President, why would the leadership on the Republican side here in Congress, why would they choose as the first order of business taking healthcare coverage away from 24 million Americans?

It is wrongheaded. It is immoral. It is inhumane. It makes no sense. It is wrong for America.

In the people's House, we need to vote it down.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Michigan (Mr. WALBERG).

Mr. WALBERG. Mr. Speaker, for 7 years, I have heard story after story from people in my district about how the Affordable Care Act is anything but affordable.

Families and small businesses are paying more for less, and insurers are dropping out of the marketplaces, leaving behind fewer options. Government-run health care isn't working, and we are repealing and replacing ObamaCare like we promised our constituents we would do.

The American Health Care Act is the first step of a three-step process to repair our broken healthcare system. This bill moves power away from Washington and puts doctors and patients at the center of their healthcare decisions. It reforms and strengthens Medicaid and gives States the flexibility to innovate and best meet the needs of their citizens.

This patient-centered approach will bring costs down, increase choice and competition, and provide important protections for patients with preexisting conditions.

Mr. Speaker, these are the types of things we promised, and doing nothing is not an option. May I remind my colleague from the other side of the aisle: I have seen those numbers. My constituents will not simply walk away and do nothing just because the other side says that they will be uncovered. Now they will have a choice. Those thousands of people will not walk away. They will choose something better for them. There will be thousands of people that have insurance that covers their needs, and not what, Mr. Speaker, my colleague says they will do. They are not that stupid. They won't walk away.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Michigan that his vote for this bill will result in 39,500 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. MCNERNEY).

Mr. MCNERNEY. Mr. Speaker, since the implementation of the ACA, over 3.9 million women age 18 to 64 have gained health coverage through Medicaid. The ACA ended gender rating, meaning that the insurance companies cannot charge women more than they charge men for the same coverage. TrumpCare also eliminates Medicaid funding for Planned Parenthood, reducing access to health care for women. Millions of women rely on Planned Parenthood for both routine and life-saving care, such as preventative services, family planning, and preventing unwanted pregnancies. When the GPO strips Planned Parenthood funding, health care of women will suffer.

TrumpCare and its Medicare cuts also hurts seniors. Older Americans account for over 60 percent of Medicare spending. Insurance companies will now be able to charge more based on their age, which will increase premiums by thousands.

Mr. Speaker, watching Republicans sell this bill is like buying a used car from a guy with a crooked smile, even they don't believe in it. I ask my Republican colleagues to withdraw this horrible bill and work with Democrats to improve the ACA instead of trying to sell this atrocity.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Georgia (Mr. CARTER), our resident pharmacist on the committee.

Mr. CARTER of Georgia. Mr. Speaker, I am joyous to be here today on such a historical day. You see, for the past 7 years, I have practiced in ObamaCare, I have practiced under ObamaCare, and I have practiced in that setting; and I can tell you that what it promised, it has not delivered on.

There has not been increased accessibility, no. Instead of that, we have got five States in our country that only have one plan to offer. We have a third of the counties in our country that only have one plan to offer. We have 16 counties in Tennessee that don't even have a plan, and now we are going to have the opportunity to have access. Now we are going to have choice.

We have also been told about affordability. Well, let's talk about affordability. We see what ObamaCare did. It increased premiums 25 percent this year alone; 50 percent in seven States. That is unsustainable.

What is our plan going to do?

It is going to give affordability. It is going to give competition. We are going to have choices.

And what else?

It is going to remove red tape. It is going to remove the barriers between healthcare professionals and patients. It is going to empower patients. That is what health care in America is about: people making healthcare decisions with their healthcare practitioners. That is what we are going to do. That is what this does.

The two worst things that ObamaCare did to the healthcare system in America, first of all, is it took the free market out of America. It took the free market out of health care in America. It also expanded Medicaid, a safety net program that was intended for the aged, the blind, the disabled, children, and mothers, and extended it to able-bodied adults—something that it was never intended to do.

Mr. Speaker, I look forward to hearing how many people in my district are going to be empowered now from the gentleman from New Jersey.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Georgia that his vote for this bill will result in 62,800 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from Vermont (Mr. WELCH).

Mr. WELCH. Mr. Speaker, those of us who support the Affordable Care Act know that the work of improving health care and making it more affordable and accessible is never done. It matters. It really matters to the mothers and fathers we represent and to the children that they love. But this bill, stripping 24 million Americans of health care, a $1 trillion tax cut to the wealthiest among us, making people 50 to 64 pay five times as much as other Americans, obviously, is a giant step backwards.

One of those Americans is Linda from Burlington. She left an abusive marriage, but had to leave her health care behind. The Affordable Care Act rescued her, and she has gone on to revive her life and her future.

□ 1315

Our community hospitals that do so much good in our communities have gone from red ink to black ink by the help that the Medicare expansion provided.

It is a sad day for this institution. We did all of this without hearing from a single patient, a single doctor, a single person. We had no hearings.

Mr. Speaker, can we do better than that?

Mr. WALDEN. Mr. Speaker, I yield 2 minutes to the gentlewoman from North Carolina (Ms. FOXX), the chairwoman of the Education and the Workforce Committee.

Ms. FOXX. Mr. Speaker, skyrocketing cost, diminished choices for patients, small businesses destroyed, fewer jobs, and lower wages, that is

ObamaCare's legacy. That is what Democrats imposed on our country.

We believe the American people deserve a better way, and that is what this legislation will deliver. The American Health Care Act puts the American people back in control of their health care. It restores choices, protects the most vulnerable, encourages lower healthcare costs, empowers States, and frees families and small businesses from costly taxes and mandates.

Let's keep our promise to provide a better way on health care by voting ''yes'' on the American Health Care Act.

Mr. Speaker, I ask the gentleman from Oregon (Mr. WALDEN) to engage in a brief colloquy.

Health sharing ministries play an increasingly important role in the lives of many Americans, particularly in the devastating wake of ObamaCare. In recent days, constituents have expressed concerns about the future of these healthcare plans, particularly as it relates to whether they would be considered credible coverage under the bill's continuous coverage provisions.

Will Chairman WALDEN work with me, as the bill moves forward, to ensure we address the concerns of those who benefit from health sharing ministries?

Mr. WALDEN. Will the gentlewoman yield?

Ms. FOXX. I yield to the gentleman from Oregon.

Mr. WALDEN. Mr. Speaker, I would be delighted to work with the gentlewoman from North Carolina.

Health care sharing ministries are a vital part of our healthcare system. They are a shining example of how communities can come together without government mandates or dictates to provide innovative healthcare solutions.

I look forward to working with Chairwoman FOXX on these concerns that have been raised and will work with the Senate to get repeal and replacement of ObamaCare to the President's desk.

Mr. PALLONE. Mr. Speaker, I remind my colleague from North Carolina that her vote for this bill will result in 80,600 people from her congressional district losing health coverage and care.

I yield 1 minute to the gentleman from New Mexico (Mr. BEN RAY LUJÁN).

Mr. BEN RAY LUJÁN of New Mexico. Mr. Speaker, my Republican colleagues have called TrumpCare everything from an act of mercy to a rescue mission. Now, I might live at the end of a long dirt road, but I didn't fall off the turnip truck yesterday and neither did the American people.

Congressional Republicans are jamming their catastrophic bill that will take health insurance away from 24 million Americans, raise your premiums, raise your deductibles, raise your out-of-pocket costs, and will slap a crushing age tax on those over the age of 50.

Republicans in Congress promised they would lower costs, but this mess raises costs on families. Not only does the CBO tell us premiums will increase 15 to 20 percent, but TrumpCare will allow insurance companies to increase deductibles and out-of-pocket costs.

Under the guise of State flexibility, Republicans say they are shifting responsibilities to States. Here is what that means: TrumpCare will force States to raise taxes and ration care. It will repeal the requirement for insurance plans to cover doctor visits, emergency room care, prescription drug coverage, and even mental health services.

Everyone is entitled to their own opinions but not their own facts. The fact is TrumpCare will raise your premiums, raise your deductibles, and hurt millions of hardworking families.

I urge my colleagues to vote ''no.''

Mr. WALDEN. Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. MURPHY), our resident psychologist who does a remarkable job on mental health care issues and all of these healthcare issues.

Mr. MURPHY of Pennsylvania. Mr. Speaker, in my district over the time span since the Affordable Care Act, ObamaCare, was passed, I fielded many, many a call from persons who said they could not afford health care. In some of those instances, even though a person was able to afford the premium, they could not afford the deductible.

A gentleman aged 55 and his wife said they would have to pay $27,000 out of pocket between premium deductibles and copays before they could use their first benefits. He was one of the 19.2 million Americans who chose to pay the fine rather than get on the Affordable Care Act, ObamaCare. We suspect that many more will continue on with saying they would rather pay a fine or find a way out rather than continue to pay for it if this continues on as is.

In the past, we have been battling many things under this with regard to mental health care. The past administration attempted to strip the protected drug class status for lifesaving psychiatric medications. We fought back on that. We also worked together, however, in a bipartisan way to make sure we had assured things for mental health care.

This bill has several provisions which are extremely important. It has $100 billion which States may use to help in their stabilization fund to fund mental health care. There is another $15 billion focused on mental health care. There is $500 billion for substance abuse. Funding will be in there.

My hope is that States make a decision. It is in their hands with the passage of this bill so they can make the right choice to continue mental health care, and I trust they will do that.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Pennsylvania that his vote for this bill will result in 37,100 people from his congressional district losing health coverage and care.

I yield 1 minute to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Speaker, a resounding ''no'' to TrumpCare, President Trump's broken promise to our great America. There is no disputing the devastation this bill will cause for America's working families.

TrumpCare will rip health insurance away from 24 million people.

It will raise costs for consumers and lower standards of care, with premiums rising and deductibles increasing by an average of $1,500.

TrumpCare will eliminate required mental health and addiction benefits, jeopardizing recovery for millions of Americans in the midst of this opioid epidemic.

It imposes a crushing new age tax on seniors and those approaching retirement, amounting to tens of thousands of dollars.

TrumpCare steals from Medicare, and it cuts Medicaid by $839 billion, mercilessly putting children, the elderly, the disabled, and our most vulnerable at risk.

It does all this to give a $1 trillion tax cut to millionaires, billionaires, and corporations.

The American people overwhelmingly reject this bill.

Defeat TrumpCare. Vote ''no.''

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

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from New York (Ms. CLARKE).

Ms. CLARKE of New York. Mr. Speaker, I rise today in strong opposition to this sham American Health Care Act.

I am from Brooklyn, and in Brooklyn we know: Men lie; women lie; the numbers don't. Here are the numbers:

This reckless and destructive bill leaves 24 million Americans without coverage. It will cause the uninsured rate for my district to skyrocket over 12 percent and leave over 400,000 Brooklynites without coverage.

Because of age discrimination in this bill, the age tax, it will put our seniors in the terrible position of having to choose between eating, visiting their doctors, or purchasing medication.

Which one do you, Mr. Speaker, suggest they choose?

I also vehemently oppose the Empire State kickback language put in this bill as an attempt to get Republican votes. This language is a dressed up earmark that specifically targets New York City. It targets my home.

This would further reduce Medicaid funds for New York by an additional $2 billion. The trade-off, raising city taxes to cover the gap.

For most Americans, Medicaid benefits are not the end goal but rather [provides] temporary support, but for our seniors Medicaid can mean the difference between nursing home care, family home care and dying alone.

I urge my colleagues to consider the harmful real life impact of this legislation and to oppose it. Brooklyn Resists . . . America must resist.

Thank you and I yield the balance of my time.

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

Mr. PALLONE. Mr. Speaker, may I inquire how much time remains on both sides?

The SPEAKER pro tempore (Mr. COLLINS of Georgia). The gentleman from New Jersey has 68 minutes remaining, and the gentleman from Oregon has 65½ minutes remaining.

Mr. PALLONE. Mr. Speaker, what did the Chair say?

The SPEAKER pro tempore. One hour and eight minutes remaining.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Iowa (Mr. LOEBSACK).

Mr. LOEBSACK. Mr. Speaker, I am disheartened by what Congress is doing here today.

My number one goal has always been to ensure Iowans have access to quality, affordable care. This legislation does not do that. It implements an age tax, raising costs on older Americans. It cuts nearly $900 billion from the elderly, nursing homes, and disabled children.

This is unacceptable. Exactly those who need health coverage the most—middle class families, people with disabilities, and those who are less fortunate—are the ones who lose out in this Republican bill.

I remain committed to working to improve healthcare coverage so it works better for Iowans and all Americans. We cannot go back to a time when Iowa families had to choose between putting food on the table and getting medical care for their children. Unfortunately, that is just what this bill does.

I urge my colleagues to vote this bill down.

Mr. WALDEN. Mr. Speaker, if I could get an indication in terms of the amount we are down on each side here? I think we were allocated a half an hour.

The SPEAKER pro tempore. Is the gentleman referring to the time in which he is acting as the designee of the gentlewoman from Tennessee on behalf of the Committee on Energy and Commerce?

Mr. WALDEN. Yes.

The SPEAKER pro tempore. The gentleman from Oregon has 9½ minutes remaining in the Energy and Commerce portion of this debate.

Mr. WALDEN. Mr. Speaker, and the minority side? Or is that what is remaining split equal?

The SPEAKER pro tempore. The gentleman will suspend.

The gentleman from Kentucky has not assigned designees on the basis of committee affiliation. The rule provides for four total hours of debate.

Mr. PALLONE. Mr. Speaker, could we just ask the total because then maybe we can figure it out on the minority side?

The SPEAKER pro tempore. The Chair has provided the total time remaining for the minority. So that is the total time we are working back off of. The Chair will consult with the gentleman on the committee time.

The gentleman from Oregon has 9½ minutes remaining in the Energy and Commerce time.

Mr. PALLONE. What is the total time remaining currently?

The SPEAKER pro tempore. There are 67 minutes remaining for the gentleman from New Jersey as the designee of the gentleman from Kentucky. That is 1 hour and 7 minutes.

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

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. SCHRADER).

Mr. SCHRADER. Mr. Speaker, after all these late nights and backroom deals, here we are. This version of the bill was just dropped on our lap this morning, so we ought to take a careful look at what is in front of us.

First of all, the bill defunds access to preventative health care and wellness. All the programs that we made progress on will be gone.

It shortchanges the Medicare trust fund. Seniors might be paying thousands more than they are now to get the care they need.

It returns us to a system with skimpy benefits without serious coverage for maternity care and mental health.

Most dramatically, the bill dismantles the Medicaid system as we know it, which has been a success across much of the country.

In Oregon, children and families finally have access to care that fits their needs. People living with disabilities are leading productive lives now. Hospitalizations and emergency room visits have been cut in half, and costs are down.

We are all going to do this—take health care away from 24 million Americans, 14 million just this next year—and not going to save any more money than under the original ACA?

Look, I know there are parts of the ACA that need fixing. While millions of people got coverage for the first time, premiums are still too high in the individual market. That is only 5 percent.

Vote ''no'' on this bill, and let's make the system better.

□ 1330

Mr. WALDEN. Mr. Speaker, I don't believe I have any other speakers, so I will continue to reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts (Mr. KENNEDY).

Mr. KENNEDY. Mr. Speaker, 5 years ago, I got the phone call everyone dreads. My wife had collapsed at work and was being rushed to an emergency room. It is a moment that is painfully familiar to far too many. Time stops. You fight to push your breath down your throat. Your brain gets stuck in that highlight reel of worst-case scenarios. You are terrified.

Fortunately, we were among the lucky ones. Lauren was okay. Most critically, our health coverage gave us the support that we needed to be able to focus on the one thing that mattered most, her recovery.

For families in America, that is the simple expectation of our country's healthcare system, a commitment that our society makes to care for one another in our time of deepest need because our health is our great equalizer.

No matter your power or privilege, no one among us escapes our time here on Earth without watching someone we love fight for their life. So we fortify this social contract, not just out of sympathy for the suffering, but so that it is there for us, too, when we need its sturdy brace.

''Blessed are the merciful, for they shall be shown mercy.''

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

Mr. PALLONE. Mr. Speaker, I yield to the gentlewoman from California (Ms. LOFGREN) for a unanimous consent request.

(Ms. LOFGREN asked and was given permission to revise and extend her remarks.)

Ms. LOFGREN. Mr. Speaker, I rise in opposition to this terrible bill that will hurt my constituents in California.

Mr. Speaker, each one of us was elected by our constituents to stand up for them here in Washington. Today, I will stand up for people who live in the 19th Congressional District by voting no on this terrible bill.

It's small wonder that polling shows only 19 percent of Americans are in favor of this bill. With the bill, 24 million fewer Americans will have health care insurance. Families will pay increased out of pocket costs with higher deductibles.

Incredibly, it allows insurance companies to penalize people older than 50 by allowing them to charge 5 times more for insurance than younger Americans.

It hurts Seniors in other ways too. . . . by shortening the life of the medicare trust funds, by increasing costs for medicine for medicare recipients and by smashing the safety net for nursing home care which the Medicaid program provides.

Incredibly, it also has a special penalty for veterans, by barring veterans from receiving tax credits if they are nominally eligible for VA care, even if there is no room for them at the VA.

Let's stand together for our hardworking Americans all over our country and in our own districts by voting no on this poorly crafted bill that cuts taxes for the richest Americans and leaves regular Americans on the short end of the stick when it comes to health care.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. CÁRDENAS).

Mr. CÁRDENAS. Mr. Speaker, I rise today to urge my colleagues to own up to their bad bill. It is clear this is not what the American people deserve or what the American people are asking for.

This legislation guts Medicaid. It steals from Medicare. It crushes our seniors and our working families. And

just when you thought it couldn't get worse, they went after veterans and their children.

What's more, this bill means insurance companies won't cover new mothers, newborn babies, and prescription drugs. The Republicans are making health care for Americans worse and worse and worse.

The Republicans have secretly wheeled and dealed in back rooms at the expense of millions of Americans in our great country, while giving tax breaks to millionaires and billionaires.

Mr. Speaker, I urge my colleagues to own up to this bill and oppose it for the sake of the American people.

God bless us.

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

One of the great tragedies of this debate is some of the scare tactics we have heard. And to listen to the gentleman from California talk about how removing essential benefits from the Federal mandate from the law is going to cause all that to happen is tragic because he, on March 25 of 2015, cosponsored legislation that did precisely that, removed the same Federal mandates for workers in the 51–100 pool of employees for employers. He said it was too much of a mandate then on those businesses, when they provide insurance.

So every Member of the House who was here then, and every Senator, including the Democrat leader of the Senate at the time, voted for that, passed unanimously.

By the way, the Congressional Budget Office said that those regulations that we are pulling back here would have made nongroup premiums 27 percent to 30 percent higher in 2016, than they otherwise would have been. So we are basically taking what CBO said is a good policy and implementing it here once again.

Last time, in 2015, that was bipartisan. It was a voice vote. Today, you would think the world was falling around us, the sky was falling. Yet, everybody who was here in 2015 said, that is okay, it is the right thing to do because it will lower premiums, like CBO said, by 27 to 30 percent.

So we thought what was good for those in the work world, for everybody who is insured through a large group plan, which is about 155 million Americans—they don't live under this mandate, yet they have all those services and benefits—that that would make sense to lower premiums for individuals on the ObamaCare exchange, because what I hear is, premiums are too high, deductibles go up.

Nobody sees this thing coming down. We are making changes here because those exchanges are collapsing. We want to bring the premiums down. We want to make the changes that will bring them down. CBO says doing this on essential benefits would have resulted in nongroup premiums 27 to 30 percent lower than they would have otherwise been. They basically say they would be higher in 2016 than they would have otherwise been. So we are taking that, using that and saying: let's drive them down; let's get premiums down.

It is unfortunate that you were willing to do that 2 years ago. It was bipartisan. Today, it is some extraordinary thing we are doing that is bad. It is not. We want to get lower premiums.

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

Mr. PALLONE. Mr. Speaker, Chairman WALDEN is completely mischaracterizing the bill that was led by Mr. CÁRDENAS.

I yield 1 minute to the gentleman from California (Mr. RUIZ).

Mr. RUIZ. Mr. Speaker, the majority of my patients in the emergency department are age 50 and older. This bill's age tax will devastate Americans ages 50 to 64 who have worked their whole lives, planned for retirement, and now are wondering how they will make ends meet.

The age tax will force older Americans to pay premiums up to five times higher than others, no matter how healthy they are, no matter how responsibly they have lived, making coverage too expensive, and forcing them to be uninsured.

For example, Rex, from my district, wrote me that he was worried about choosing between affordable insurance or saving for his retirement. Insurance for older Americans like Rex will be too expensive, leaving them uninsured when they need coverage the most.

Under this bill, a 64-year-old like Rex, with an income of $26,500, in the individual market, will pay up to $14,000 for health insurance. That is more than half of their income on premiums alone, leaving little for food, for medicine, rent, and other basic necessities.

I stand with our older Americans, and I urge everyone, Democrats and Republicans, to stand with older Americans. Put ideology, partisanship, and politics aside and do the right thing.

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

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. PETERS).

Mr. PETERS. Mr. Speaker, I came to Congress ready to help improve our healthcare system. And as our colleagues on Chairman WALDEN's side have pointed out, there are some insurance markets that aren't providing the choice and the low cost that consumers want, so let's fix them.

But that is not what this bill does. This bill takes away health insurance from 24 million Americans, including 37,000 people in my district in San Diego. And the last-minute changes made will cost the Federal Government even more money, without increasing coverage or reducing premiums. Is that really the best we can do?

The only reason we are in this mess is because the Speaker of the House only ever sought 218 Republican votes. That is why we are left with a bill that is opposed by doctors, nurses, hospitals, and just about everyone because it makes the problems in our healthcare systems worse, not better. That is what happens when you never even reach out to the other side.

Whether this bill dies today, or in the Senate, I hope we can get to work together, Republicans and Democrats, to do better for the American people.

Mr. WALDEN. Mr. Speaker, I yield myself 30 seconds.

Actually, we did reach out to Democrats. We have always reached out to Democrats. The vice chair of the Committee held lunches with Democrats to say: How can we work together on this? And we were told: No, we can't work with you on this particular measure. I hope we can. I agree, there is a lot we need to do together. It is what the American people expect.

We have had these individual conversations out of the bright lights of the cameras. Let's get together. Let's get this done. A lot hangs in the balance.

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

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentlewoman from Michigan (Mrs. DINGELL).

Mrs. DINGELL. Mr. Speaker, today, the House will vote on a bill that will take us back in our Nation's history. My family has worked for decades for affordable quality health care for every American. It took a long time to achieve the progress we have made today.

We began with Social Security, then we created Medicare, developed the National Institutes of Health, the children's healthcare program, and many other efforts that have helped every single one of our communities across this country.

Hearing after hearing, amendment after amendment, the Affordable Care Act was eventually developed. Coverage was expanded. Costs were lowered. Certainty was brought to uncertainty.

Let me remind you that before the Affordable Care Act, many had to decide between bankruptcy and death. Children hit lifetime caps. Cancer and being a woman were preexisting conditions where it costs too much money for premiums, or you couldn't get them at all.

Millions now have coverage who didn't, lifesaving screenings, preventative care, and, today, we are talking about taking it back by eliminating essential services. Please vote ''no'' for America's heart and soul.

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

Mr. PALLONE. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, I think it is very telling that the gentleman from Oregon has no more speakers on his side for what they claim to be a very significant bill, and it certainly is significant; but the reason for that, in my opinion, is because this Republican bill is hurting real people.

Don't tell the real people, don't tell the Americans in my district or the rest of the country who are coming to your doors and going to your legislative offices and calling you by the thousands to tell you not to pass this bill, don't tell them your answer that I hear over and over again: Well, trust us. Trust us.

The problem is we have to look at the bill that is before us today. This is a terrible bill. Millions of people, 24 million people, are going to lose their insurance. Many more are going to pay a lot more out of pocket with higher deductibles and higher copays.

And the worst part of all is you are allowing the insurance companies to sell junk insurance that doesn't even cover their care; it doesn't even necessarily provide any coverage.

So I ask my colleagues on the other side, think of the people. Think about your heart. Think about what this really means. And if you look at it, you will know that this is a bad bill and should be defeated.

Vote ''no.'' I urge my colleagues to vote ''no.''

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

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

Mr. Speaker, here is what I would say: What you have heard from the other side is everything is working perfectly; leave it alone.

Democrats created ObamaCare. Democrats created the exchange. They said: We are going to tell you the kind of insurance you have to buy; we are going to force you to buy it, or you will answer to the IRS and pay a penalty. They mandated that.

Then they came back and said: Well, that didn't work so well, so we had better get rid of the essential benefits for the workers and employers, 51–100 employees in a company; we are going to take that off because that will drive up premiums. And they voted unanimously to do that. Today, they come back and say: Oh, that would be horrible. But they did it before, so they were for it before they were against it.

But let me talk about what really matters here. First of all, there is lot of scare tactics out there by a lot of high-paid organizations. The first is, we preserve your right as a citizen to acquire health insurance regardless of your health condition.

□ 1345

So here is the deal: preexisting conditions, we protect that; lifetime caps, we protect that so that insurance companies can't go over the top of you; keep your kids on until they are 26, we protect that. Those were good things. We agree in a bipartisan way those should be protected. We do that.

But we also recognize that 19.2 million Americans looked at the Democrats' healthcare exchanges and plans, went the other direction, and said no. They have walked with their wallets and their feet and said: I don't like what you are selling and I can't afford what you are selling. I will even pay the IRS $600 or $700 not to take ObamaCare.

Meanwhile, Mr. Speaker, the insurers have said that the way the Democrats created the insurance markets all over the country, we can stay in them. We are losing too much money, and we are out.

That is why in one out of three counties today in America you only have one choice, and that is called a monopoly. We are trying to fix this market so people will have choices that are affordable. We are trying to make sure people have access to coverage they want and can afford. This is the first step, not the last step, toward fixing this market.

I look at it like we have poured the foundation. Construction projects are a little messy when you are just pouring the foundation. Now we are going to put up the walls, we are going to put the roof on, and we are going to build this out in multiple steps throughout this year and next.

Meanwhile, we provide complete coverage. We do all the protections ObamaCare continues in its support for people while we fix the market and allow it to come back. We have timed this out. I know there are some on my side of the aisle who wanted to get rid of those protections, and we brought them around or they are going to vote ''no.'' But we said: No; we have to have those protections in place—existing conditions, no more lifetime caps, keeping your kids on until they are 26.

We have a product here that needs to go to the next step. We will all work on it and continue to make it better as we go forward. But if we do nothing and let it fail today, these markets are going to get worse and worse under the Democrats' ObamaCare plans, and people won't have a choice in States and counties all over America.

I wish we could join together today and put forward a bipartisan vote to save these markets and help our constituents going forward. Mr. Speaker, we owe it to them. They have asked for it for 7 years. Let's get it done.

Mr. Speaker, I urge support for this legislation, and I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield the balance of my time to the gentleman from Massachusetts (Mr. NEAL), and I ask unanimous consent that he be allowed to control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mrs. BLACK. Mr. Speaker, I yield 30 minutes to the gentleman from Texas (Mr. BRADY), and I ask unanimous consent that he may control that time.

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

There was no objection.

Mr. BRADY of Texas. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, last month, President Trump stood right here in this room and said to Congress: ObamaCare is collapsing. He called on us to take decisive action to protect all Americans.

Today we have a choice to make: will we answer the President's call to action and pass this legislation to repeal and replace ObamaCare? Or will we allow ObamaCare to remain fully in place and deny our constituents the relief they urgently need?

I, for one, refuse to allow my constituents in Texas to suffer ObamaCare's impacts any longer. For the past 7 years, we have watched ObamaCare fail Americans on every single promise, and throughout this time, as the Obama administration turned a deaf ear to the American people, House Republicans were listening. We were listening to all those facing severe premium increases, people like Lauren in my district, in my hometown of The Woodlands. Lauren recently emailed me to say that her premiums this year have gone up by nearly 70 percent. Now they are $900 a month.

We were listening to all those who can no longer see the doctor of their choice or access the care they need at an affordable price, people like Elizabeth from Conroe, Texas, another constituent of my mine. Her family pays about $800 a month in healthcare premiums, yet they can no longer see any of the doctors they know and trust. This includes the primary care doctor that Elizabeth and her husband have been seeing for over a decade. It includes her children's longtime pediatrician. All of these doctors are now out of reach, thanks to ObamaCare.

That is the thing with this law. It has helped some, no doubt, but far more people have been hurt, people like Lauren and Elizabeth, who are paying significantly more for significantly less access to health care.

It doesn't have to be this way. After 7 years of listening carefully to the American people, we have now arrived at this moment of decisive action. With the American Health Care Act, we have the best opportunity since ObamaCare's enactment to repeal this harmful law, clear the deck, and begin over with a step-by-step process to deliver a healthcare system based on what patients and families truly want and need, not what Washington thinks is best.

This bill gets us off to an excellent start. First, it delivers swift relief to the American people by immediately repealing ObamaCare's most harmful provisions. The individual mandate—the tax penalty—is gone. The employer mandate tax penalty is gone. Nearly $900 billion in ObamaCare tax hikes that have driven up costs and reduced access to care for families, patients, and jobs, those tax hikes are gone.

From here, the American Health Care Act takes significant action to replace ObamaCare with patient-focused solutions that expand choice, lower

costs, and enhance competition. This is where we reclaim control of health care from Washington and put it back where it belongs—with patients, families, and States.

We expand health savings accounts, making them more flexible and more user-friendly. We protect health coverage for the more than 150 million Americans who receive it through their job. We deliver the largest entitlement reform in decades, giving power to States to improve and streamline Medicaid so they can better serve the needs of local patients and families.

For low- and middle-income Americans who don't receive coverage through work or a Federal program, we offer an advanceable, refundable tax credit that people can use immediately to help purchase coverage that is tailored to their needs. These tax credits provide a conservative, free-market alternative to inefficient ObamaCare subsidies that exist today. They deliver support to low- and middle-income Americans. At the same time, they will encourage real competition and choice in the health insurance market.

Finally, as a committed pro-life conservative, I am pleased to say this bill defunds Planned Parenthood while funding the community health centers for women's truly needed health care, and takes vital action to protect the right to life. No Federal funding can be used for elective abortions. The language is crystal clear.

The American Health Care Act represents a critical first step in our multiphase effort to tear down ObamaCare and reinstate patient-focused solutions that help all Americans. But we know there is more work to do. ObamaCare was a massive government takeover of health care. To fully uproot the law, it is going to take a sustained, coordinated, and relentless effort from both Congress and the administration. Fortunately, we have incredible partners in President Trump and Secretary Price at the Department of Health and Human Services. They are already beginning work on the next phases of the process, stripping away ObamaCare's regulations so we can enact additional free-market solutions. These include consensus conservative proposals, such as allowing insurance to be sold across State lines.

But to see success in the next phases, we have to take the first step today. We have to pass the American Health Care Act, deliver immediate relief to the American people, and provide a conservative path forward.

In closing, I thank all the leaders in the House who worked hard to craft the bill before us today: Chairman GREG WALDEN, Chairman DIANE BLACK, and so many others.

I also want to offer my gratitude to everyone from the Congressional Budget Office, the Joint Committee on Taxation, and the House Office of Legislative Counsel who provided analysis and support as we developed this legislation.

I would like to give a special thanks to Emily Murry, Stephanie Parks, and all of our hardworking staff on the Ways and Means Committee.

At the end of the day, on this day, we will have our first true vote to repeal ObamaCare. History will record where we stand. This is a clear choice. We can stand with President Trump and more freedom for Americans to buy health care they choose, or stand with ObamaCare and more government that gets in the way. I proudly stand with President Trump and more freedom for the American people.

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

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

Recently, President Trump said: Who knew that health care could be so complicated?

Well, 70 years ago, Harry Truman knew how complicated it could be when he first proposed national health insurance. Lyndon Johnson knew more than 50 years ago when he proposed, successfully, Medicare and Medicaid. Richard Nixon knew when he proposed the individual mandate. Bob Dole knew when he proposed the individual mandate. In Massachusetts, Mitt Romney knew when he proposed the individual mandate.

Mr. Speaker, recently, within the last week, the great on-the-street writer, Jimmy Breslin, died. Amongst the great columns and the great books he wrote, one of them that he wrote that will be with us in a timeless manner was ''The Gang That Couldn't Shoot Straight.''

That is what this institution has been like for the last 10 days. There were caucuses and there were conferences. People were running back and forth with new CBO scores and coming back to the floor with new proposals. Members are put in the position of being offered special arrangements so that they might be brought over the goal line—that, after 61 times they have voted in this House to try to repeal the Affordable Care Act.

Well, here is what we have in front of us this afternoon: a CBO score says that 24 million Americans will see either an increase in premiums or they will lose their insurance, there will be an imposition of an age tax on older Americans, and a tax cut of $1 trillion. This bill has gone from bad to worse.

If that wasn't enough, to get the votes to pass the bill, they want to cut prescription drug benefits, mental health benefits, hospital benefits, and maternity care; and, yes, every one of us in this institution knows a family who is struggling with a loved one's addiction, and they want to roll back that benefit.

Recently, the conservative columnist Bill Kristol tweeted:

> The healthcare bill doesn't, A, lower costs that they have; B, it doesn't improve insurance; C, it doesn't increase liberty; D, it doesn't make health care better. So what is the point?

Here is the point: it is a $1 trillion tax cut so that they can change the baseline for their tax cuts that are coming down the road. That is what this is about.

Now, the President said he wanted an insurance plan that covered all members of the American family. What they are offering up today is a plan that cuts health insurance for 24 million American family members. It does not increase coverage, it does not lower costs, and it does not strengthen consumer protections.

So what does it do?

Sadly enough, back to the old argument that we have had in this institution for years: a $1 trillion tax cut for the people at the top and special interests.

The former speaker here a minute ago, the chairman of the Energy and Commerce Committee, spoke about perfection. I was here when this legislation was authored, and I helped to write it. I can tell you this right now: we knew it was not about perfection, but we subscribed to the idea, as was the case with Social Security, Medicare, and Medicaid, that we would improve it as time went on. We would fix it so that all members of the American family might benefit from the basic notion of access and affordability as it relates to health care.

So what do we have here?

$839 billion of cuts to Medicaid, which is now long-term care for members of the American family.

Do you know why?

Sixty percent of Medicaid dollars go to nursing home care, and they want to cut $839 billion to provide a $1 trillion tax cut. Let me tell you, members of the American family can understand that.

In Massachusetts, where proudly I can say 100 percent of the children in our State are covered, 97 percent of the adults in Massachusetts are covered. And guess what? It polls regularly in the high seventies as to consumer satisfaction. A Republican Governor of Massachusetts has advised them to go slowly and to go carefully, that this is not the path that they want to travel down, as well as other Governors across the country who happen to be a Republican.

□ 1400

The hard truth here today is they are asking the American family to pay more to get less. Dozens of Republicans have said so today.

Secretary Mnuchin recently said that ''there will be no absolute tax cut for the upper class.'' I hope that the Republican Conference confers with Secretary Mnuchin so that they might get their facts straight on this issue.

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

Mr. BRADY of Texas. Mr. Speaker, I yield 3 minutes to the gentleman from Ohio (Mr. TIBERI), the chairman of the Health Subcommittee, who played an invaluable role in solutions to lower healthcare costs for Americans.

Mr. TIBERI. Mr. Speaker, I thank the gentleman for his leadership in this important matter, and I echo his words with respect to the staff, Emily Murry and her team, as well as Whitney Daffner and Abby Finn in my office.

Mr. Speaker, like the chairman, I had a front row seat in 2009 and 2010 to the passage of the Affordable Care Act and a front row seat to all the promises made about this wonderful bill called the Affordable Care Act.

Then, over the last 6 years, like the chairman, I heard from my constituents and fellow Ohioans. I heard about their sad ObamaCare stories of a road of broken ObamaCare promises.

There was a lady east of Columbus who had cancer. She was a survivor. Fast-forward to a few years ago. She gets cancer again and finds out that the oncologist that she had, she could no longer have. He was not in the network. She could not go to the hospital in her community. She had to go 60 miles away.

Or there is the small-business owner and his wife and family on the individual market and now on the exchange not getting employer-provided health care and, therefore, not getting the benefit. They saw their plan price quadruple in the last several years. Mr. Speaker, we are going to take care of that person and give them a tax credit so they have the ability, just like employer-provided employee's health care.

In Ohio, last year, our CO-OP collapsed. We had 20,000 people without health care. Many saw bills not being paid. Twenty counties in my State had one provider and fewer choices.

Broken promises. Constituents can't keep their doctor, can't keep their hospital. Constituents saw emergency room visits go up. It was supposed to go down under the Affordable Care Act. Premiums and deductibles are going up, not down, in my district.

One promise wasn't broken, and that is a government-mandated, one-size-fits-all Washington plan that many of my constituents didn't want and others couldn't afford. That was their ObamaCare.

We can do better, and in this bill we do. In one step, in the first step, more steps to come, we begin creating a patient-centered healthcare system that will not only put more power in the hands of our constituents, but it will also drive down healthcare costs.

Remember what they said in Ohio newspapers in my State about ObamaCare: a tough pill to swallow, a nightmare, very taxing, just more red tape. These aren't my words, Mr. Speaker; these are hardworking Ohioans' words. They deserve better. They deserve more choices. They deserve better access, the access and the choices they want for them and their families.

We begin, Mr. Speaker, with this bill. We don't end here. There is much more to do. We are putting the people's power back in their hands, not in Washington's hands. Today, it is time for us to deliver.

Mr. NEAL. Mr. Speaker, I would remind my friend—and he is my friend—from Ohio that his vote will result in 39,500 people losing their healthcare coverage if this legislation prevails.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. LEVIN), who was a substantive and major player in the development of the ACA when it was passed.

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, I thank Mr. NEAL for his work and that of all of us on the committee on the Democratic side.

As CBO has said, under this bill, 24 million Americans would lose their health insurance next year, and 24 million over the next decade.

Today, most are invisible, but they would become seen and heard at emergency rooms, with no other place to go with more serious illnesses because of no preventive care.

They are people 50 to 64 with far higher premiums; mothers without access to affordable maternity care; elderly evicted from nursing homes, losing coverage from Medicaid, the largest source of long-term care in our Nation; and lives lost that could have been saved. I repeat: lives lost that could have been saved.

I remember some time ago I met a woman who had health insurance through her job. She contracted breast cancer and received treatment but then lost her job and insurance. Then the ACA covered her. She looked straight at us and said that, without further treatments, she would not be alive today.

Under this bill, a trillion dollars is lost for health care, and there will be a trillion dollars in tax cuts, mostly for the very wealthy and corporations.

This is not America. I repeat: This is not America.

Mr. BRADY of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from Nebraska (Mr. SMITH), the chairman of the Human Resources Subcommittee.

Mr. SMITH of Nebraska. Mr. Speaker, I rise today in support of H.R. 1628, the American Health Care Act of 2017. This legislation is the first step in a process to unravel ObamaCare's taxes and mandates and provide relief to the American people.

To understand the extent of ObamaCare's failures and their impact on hardworking Americans and their families, just look at the rapid collapse of ObamaCare's Consumer-Operated and Oriented Plans, or CO-OPs.

The story of these failed ObamaCare CO-OPs began in my home State of Nebraska, with the abrupt collapse of CoOportunity Health, which left 120,000 Nebraskans and Iowans without health insurance. I repeat: It left 120,000 Nebraskans and Iowans without health insurance.

CoOportunity Health was the first ObamaCare CO-OP to collapse, but it wasn't long before 18 more followed suit, closing their doors and leaving hundreds of thousands more without health insurance. Only 4 of the 23 CO–OPs created under ObamaCare actually remain, and these remaining 4 will likely face the same fate as they continue to struggle with dire financial challenges.

Americans were falsely promised, if they liked their insurance, they could keep it. After complying with ObamaCare's mandates, many Nebraskans could not even keep the insurance this law created.

One of my constituents in western Nebraska, Pam, who is self-employed, lost her insurance four times under ObamaCare. Prior to ObamaCare's implementation, she had a plan she liked and that actually covered her pre-existing condition. She was forced off of that original plan when ObamaCare began and then lost her coverage three more times through no fault of her own.

For Pam and millions of others across the country, ObamaCare has severely limited options for affordable care. This is simply unsustainable. Constituents in rural districts like mine are being hit the hardest by ObamaCare's dwindling insurance markets. Because of ObamaCare, Nebraskans are down to only two insurers from which to choose, and other rural areas are down to only one or even zero providers on their exchanges.

Adding insult to injury, according to the Obama administration's own report on the individual market, 2017 premiums in Nebraska increased by 51 percent.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BRADY of Texas. Mr. Speaker, I yield the gentleman an additional 30 seconds.

Mr. SMITH of Nebraska. Mr. Speaker, places like Oklahoma are experiencing premium increases of 69 percent, and it is only projected to get worse if we do not act.

Doing nothing is certainly not an option. We must come together to rescue this rapidly collapsing healthcare system. Let's come together to do right by the American people.

I urge passage of this bill.

Mr. NEAL. Mr. Speaker, I would remind my colleague that his vote for this bill will result in 50,000 people in his congressional district in Nebraska losing their health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. LEWIS), a giant in terms of the morality of our time and a good friend and individual who helped write the Affordable Care Act, as well.

Mr. LEWIS of Georgia. Mr. Speaker, I want to thank my friend for yielding.

Mr. Speaker, I rise to oppose this bill.

As elected Representatives, we have a mission, an obligation, and a mandate to fight for each and every American.

I ask you, Mr. Speaker: Who will stand for the American people? Who will speak up for those who have been left out and left behind?

Mr. Speaker, I have said it time and time again: Health care is a right. It is not a privilege reserved for a wealthy few, for what does it profit this body to pass this bill and lose our soul?

This bill is a shame. It is a disgrace.

Mr. Speaker, today my heart breaks for the disabled, for women, for seniors, and for working families. My heart aches for those who are living paycheck to paycheck. My heart mourns for innocent little children whose very lives depend on if their families can pay the bills.

This is the right and wrong of it. This is the heart and soul of the matter.

We cannot abandon our principles, Mr. Speaker. We cannot forget our values. I have fought too hard and too long to back down now.

I will fight any bill that turns the clock back to a darker time. I will fight every single attempt to turn a deaf ear, a blind eye, and a cold shoulder to the sick, to our seniors, and to working families.

Mr. Speaker, I will fight every day, every hour, every minute, and every second. I oppose this bill with every breath and every bone in my body. We must not give up. We cannot—I will not—give in, not today, not tomorrow, not never, ever.

On this bill, there is only one option, and that option is to vote ''no.'' We can do better. Mr. Speaker, we must do better. Vote ''no'' on this bill.

Mr. BRADY of Texas. Mr. Speaker, I first would remind my friend from Georgia that nearly 700,000 Georgians have chosen to either pay a fine or exempt themselves from ObamaCare because it has failed them so badly.

And to my friend from Michigan, 420,000 Michiganders, more than half, chose to exempt themselves from ObamaCare rather than accept that failed health care.

Mr. Speaker, I yield 2 minutes to the gentleman from Minnesota, (Mr. PAULSEN), a key member of the Ways and Means Committee.

Mr. PAULSEN. Mr. Speaker, today we are taking a very important step to lift the burden of the Affordable Care Act off of the backs of the American people. A key component of this is repealing the burdensome mandates and tax increases that were imposed to help fund this failed law. This includes the medical device tax, a senseless policy that placed an excise tax on lifesaving medical technology.

What did this achieve? A loss of 30,000 high-paying American jobs, less research and development, canceled projects, and postponed expansions. Most importantly, it hurt patients.

There is good news. Just a few years ago, in 2015, we came together on a bipartisan basis and suspended the tax for 2 years. We are seeing positive results. Companies are now hiring again, we have increased research and development, and we have new investments in facilities coming online.

We need to permanently repeal this onerous tax or it is going to start up again. Voting ''yes'' today means permanent repeal of the medical device tax.

Mr. Speaker, I am also encouraged to see several provisions I have authored to enhance and expand the use of health savings accounts and flexible spending accounts that are included in this legislation today.

HSAs and FSAs are now more popular than ever and used by 20 million Americans. It is time to remove the restrictions on HSAs that were imposed in ObamaCare so that we can make them more accessible and easier to use and empower Americans to take more control of their healthcare decisions.

Expanding HSAs will help us also begin to address the rising costs of health care. One recent study showed that, when a large employer switched their employees over to an HSA plan, it lowered their healthcare spending by an average of $900 per employee over a 5-year period. That is real savings, Mr. Speaker.

Let's support a better way forward to lower healthcare costs for patients and put them back in control of their healthcare decisions.

□ 1415

Mr. NEAL. Mr. Speaker, I remind my colleague that his vote for this bill will result in 49,200 people in his congressional district in Minnesota losing their healthcare coverage and care.

Mr. Speaker, I include in the RECORD a letter from Governor Charlie Baker of Massachusetts that relates to the debate we are having today.

OFFICE OF THE GOVERNOR, COMMONWEALTH OF MASSACHUSETTS,
STATE HOUSE,
Boston, MA, March 21, 2017.

DEAR DELEGATION MEMBER: Health care is once again at the forefront of national and state policy discussions; I know we all share the goal of ensuring access to quality, affordable health care coverage for the people of Massachusetts. With Congress set to take up the American Health Care Act (AHCA) imminently, I wanted to share with you my administration's analysis of the potential effects this bill would have on our state.

The Congressional Budget Office (CBO) released its score of the AHCA on March 13. This analysis is broadly consistent with concerns we have raised, with you and others, regarding the bill's impact on the state and its residents' access to affordable healthcare. Applying CBO's assumptions to Massachusetts results in at least $1 billion of reduced federal revenue beginning in 2020, and we estimate reduced revenue of $1.3 billion in 2021, and $1.5 billion in 2022, with likely a greater annual impact in the years that follow.

Specifically, our estimate extrapolated from the CBO analysis of a $1.5 billion impact for FY 2022 includes $1.3 billion of annual MassHealth federal revenue losses and $200 million in annual reduced federal subsidies for private insurance through the Connector.

Several key areas of concern for Massachusetts were not included in the CBO analysis and could further impact the Commonwealth's budget. For example, the CBO estimate does not address 1115 waiver payments that we believe this bill would put at risk. By FY22, the Commonwealth estimates an additional $425–475 million per year of reduced federal revenue in potential elimination of 1115 payments not captured under the per capita targets, including federal matching funds for a state-run ConnectorCare Wrap subsidy.

The actual experience for these and other factors is significantly dependent on how the U.S. Department of Health and Human Services implements the legislation and unpredictable factors in the future (e.g., pharmaceutical growth).

In addition to reduced federal revenue for Medicaid, the CBO also projects a reduction in employer-sponsored health insurance of 7 million people nationwide as a result of the repeal of the federal Employer Mandate. This would exacerbate a trend that Massachusetts has seen over the last several years. Massachusetts repealed the Chapter 58 Fair Share Contribution in 2013 in order to comport with the ACA. My administration has proposed reinstating an employers' shared responsibility for the costs of health care. This would be increasingly important if the federal Employer Mandate were repealed, as the AHCA proposes.

The Commonwealth does have certain protections in place that could mitigate the impact of some of these changes. Massachusetts retains its individual health insurance mandate, reducing the likelihood that many people would drop out of the insurance market due to the repeal of the federal mandate. Massachusetts also has protective insurance coverage laws that would not be superseded by the federal legislation.

The AHCA includes a provision that would prevent Medicaid from reimbursing Planned Parenthood for providing important health services such as cancer screenings. My administration opposes this provision, and has already committed to funding these services with state dollars if it should pass.

During conversations with governors across the country, the Trump Administration has expressed a general openness to providing greater state flexibility with respect to health care, including through a letter issued by HHS Secretary Price on March 14 to states. Our administration will pursue additional flexibilities to stabilize our markets and ensure continued coverage for residents and we urge you to support these efforts by leading discussions in Congress to ensure the people of Massachusetts continue to have access to a quality health care system.

Overall, our analysis indicates that the AHCA would increasingly strain the fiscal resources necessary to support the Commonwealth's continued commitment to universal health care coverage. I hope this information is helpful to you as Congress takes up the American Health Care Act.

My administration and I will continue to stay in touch with you as we work together to ensure access to quality, affordable health coverage for all Massachusetts residents.

Sincerely,

CHARLES D. BAKER,
Governor.

Mr. NEAL. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. DOGGETT), who played a major role in the substantive contribution he made to writing the ACA.

Mr. DOGGETT. Mr. Speaker, TrumpCare is big on Trump, but it is weak on care. After falsely promising that there would be coverage for everyone for less and better, TrumpCare only cares about huge tax breaks for the superrich and special interests, like

the totally unjustified $28 billion windfall for the pharmaceutical industry that they grab right out of the Medicare trust fund so that premiums will go up. Those earning $1 million within a single year get 79 percent of a $230 billion tax break, but there is no genuine relief for middle class taxpayers.

Removing the essential health benefits provisions will only enable insurers to exclude the very healthcare protections that folks thought they were getting when they paid their premiums. Insurance plans will not just be skinny, they will be a sham; a provision that at the very time you need the care, it won't be there. Many certificates of insurance will become as worthless almost as a diploma from Trump University.

This Republican bill targets our veterans by denying them tax credits. For millions of people who are just a few years too young to qualify for Medicare, their premiums will go through the roof. It will cost thousands of dollars more in order to get insurance. Yes, the Republicans have been divided and factionalized. They are divided between those who want nothing care and those who want little care. But, mostly, they don't seem to care how many millions of people lose their health insurance.

Mr. President, this is not the art of the deal. It is the art of the steal, of taking away insurance coverage from families that really need it to provide tax breaks for those at the very top. Those who understand health care, the professionals, say reject this bill, and it should be rejected.

Mr. BRADY of Texas. Mr. Speaker, I remind my friend from Texas that 2 million Texans eligible, forced into ObamaCare and getting deep subsidies, have said: No thanks. ObamaCare has failed me.

Two out of three Texans eligible.

Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. REED), a key member of our Committee on Ways and Means.

Mr. REED. Mr. Speaker, I rise today in support of this legislation. I ask my colleagues on the other side of the aisle—as I stood in front of town halls and I listened to thousands of folks across my district say what we should be working on is fixing the Affordable Care Act to a T, I have heard my colleagues on the other side of the aisle say: It is not perfect; we need to repair it.

Yet, today we take the first step in this endeavor by the legislation that is before us, and all we hear is how bad this legislation is. All we hear today, Mr. Speaker, is how bad this first step in this journey for the American people we need to go on when it comes to American health care is.

I don't hear rhetoric saying let us talk about phase 2, let us talk about phase 3, where we can come together as Democrats and Republicans for the people we represent.

The American people are lost in this bickering that we have here in this Chamber today, but I don't forget their voice. I am not going to forget the voice of the constituents that came to me as small-business owners saying: You are putting me out of business with these insurance premiums. They are going through the roof.

I won't forget the faces of the people who are saying: My copays are going through the roof. My deductibles are higher. I don't have coverage that I had 7 years, 8 years ago before ObamaCare.

Mr. Speaker, I implore all of us in this Chamber to work together for the American people as a whole. The American people want freedom. They don't want mandates. They want to choose the insurance that works best for them. They want to access their doctors that they select. They want to have the promise that was made to them, that they could have their insurance and keep it going forward honored and respected by this institution. That is what our legislation starts today.

Not a soul on our side of the aisle says the issue of health care will go away because of the first step we take today, because we have to do better for the American people when it comes not only to health insurance, but for health care in America. I know we can, and I want to be a voice to say let us join together to get this done for the American people.

Mr. NEAL. Mr. Speaker, I remind my colleague that his vote for this bill today will result in 68,300 people from his congressional district losing their health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. THOMPSON), a very thoughtful member of the Committee on Ways and Means who also helped to write the ACA.

Mr. THOMPSON of California. Mr. Speaker, I rise in opposition to this bad bill. It is not a step toward fixing the ACA, this is a step toward destroying health care. It was bad when it ripped health care away from 24 million Americans. It was bad when it created an age tax, forcing seniors to pay five times that of what other people pay. It was bad when it forced hardworking Americans to pay higher premiums and deductibles while billionaires get a trillion dollars' worth of tax cuts. And it was bad when it shortened the life of Medicare.

But today it got worse. Today Republicans gutted coverage for emergency services, prescription drugs, hospitalization, mental health coverage, and preventative coverage. This bill also prevents millions of veterans from getting health care. This is a truly bad bill. It will cost millions of Americans their health care. It will force them to pay more for fewer benefits, and it gives the richest Americans a huge tax cut. This is a tax-cut bill, not a healthcare bill. The American people deserve much better. I urge everyone to vote ''no'' on this bad bill.

Mr. BRADY of Texas. Mr. Speaker, I remind my friend from California, 1.5 million Californians forced into ObamaCare and given generous subsidies found a way to exempt themselves because ObamaCare failed.

Mr. Speaker, I am proud to yield 3 minutes to the gentleman from Pennsylvania (Mr. KELLY), a small-businessman and a key member of our committee.

Mr. KELLY of Pennsylvania. Mr. Speaker, I am proud to stand today in support of this bill. I have been told that this is a rookie mistake. I understand that. We have been working 7 years to undo that rookie's mistake. That is why we are here today. A rookie who didn't know what he was doing, but lectured to us, told us: This is what you have to do; and if you do this, you can keep your doctor, you can keep your health plan, you can just stay on board, and we are going to insure millions of you.

Nothing could be further from the truth. The big thing was you are going to save $2,300 on your premiums. He forgot to tell everybody but the people who were actually in that business. Incredible. Incredible.

Now, this isn't about me, and it is not about you. This is about people. We are in the people's House. Let me just read to you a couple letters from the people who I represent back home. By the way, out of the seven counties I represent, five have one insurer, and the rest of them got out because they couldn't stand to try and work under this onerous law.

Let me tell you what Amanda says: I am very happy to hear that you are working to repeal the Affordable Care Act. I just got an up-close-and-personal look at how dysfunctional it is while trying to shop for my own plan. It is hard enough to start a business in this country due to so many rules, regulations, and confounding taxes. This law makes it even harder. And I don't think the government should make me buy coverages I simply don't need. I know my situation, and I should be able to buy whatever I want without incurring four-figure tax penalties.

Jason says to me: Dear MIKE, I am a self-employed father of four feeling the hurtful effects of ObamaCare. For years there has been so much talk from Republicans about repealing ObamaCare. I am paying yet more money for less coverage. We are really feeling the effects of this in my family in our budget. My kids are going to bed hungry after dinner. We desperately need relief and now, not next year. I enthusiastically pulled the lever for Donald Trump and for you, and we are counting on you to make some real change in D.C. Please keep up the fight, and do it quickly.

So this is not about MIKE, it is not about John, it is not about any of us. What it is about is taking care of the people that we were sent here to represent. They are Republicans and they are Democrats, who some people could care less about any of us, but they expected us to do something for them. We are sitting here today because this law

is so bad. If it was so good, we wouldn't have to worry, but it is bad, with a capital B.

Now, I have got to tell you, growing up, as a young kid, as it got toward Christmas—and I say this to my friends, by the way, on our side—I used to make a list right before Christmas. I put on that list everything I wanted. You know what, Mr. Speaker? Come Christmas morning, I never got everything I wanted, but I was so thankful for everything I got.

We have to deliver today. We have to keep a promise today to the American people. We have to backtrack on a rookie mistake 7 years ago and make it better for the American people, not just for Republicans, not just for Democrats, not just for those who vote blue or red, but for those who expect us to do what we are supposed to do in the people's House. This is not the Republican House or the Democrat House, this is the people's House.

Isn't it time for all of us to come together to get this done?

We have a marvelous opportunity, but we could lose it. I ask you all and I urge you all to please vote for this act.

Mr. NEAL. Mr. Speaker, I remind my colleague and my friend that with his vote for this bill, 41,400 people from his congressional district in Pennsylvania will lose their healthcare coverage.

Mr. Speaker, I yield 2 minutes to the gentleman from Connecticut (Mr. LARSON), who is from an adjacent district and a close friend and a long-time member of the Committee on Ways and Means and an individual who also contributed mightily to the development and writing of the Affordable Care Act.

Mr. LARSON of Connecticut. Mr. Speaker, I associate myself with Mr. NEAL's remarks, and especially him framing this issue from the outside about the arc of history.

As we have witnessed in this Chamber time and again, dating back to Franklin Delano Roosevelt, when you look at the impact of 24 million people, you have to look at your colleagues on the other side of the aisle and say: Are you frozen in the ice of your indifference to what impacts the daily lives of people who have showed up at our forums and the forums that you have conducted?

The sheer humanity of what is taking place across this country cries out for a solution. Yet all we have heard, as Mr. NEAL said, is the helter-skelter back and forth of who is winning politically, what is happening with the Freedom Caucus, what is going to—if Trump loses, is RYAN out?

The American people don't care about that. They care about their families. And this is the institution that we were sent to to work on their behalf. It is up to us to come together and work on behalf of the American people.

This is not a healthcare bill. This is a tax bill. We are going to work on that later on, but we shouldn't start by saying that we are going to have a transfer of wealth in this Chamber from people who are begging and pleading and showing up at the townhalls and asking for our help, and our answer is a transfer of wealth in a tax bill. Everybody wants to know why we are taking this up first and not taxes. Because it is a tax bill, that is why.

□ 1430

Mr. BRADY of Texas. Mr. Speaker, I would remind my friend from Connecticut that 190,000 residents in Connecticut, two out of three eligible for ObamaCare, believed it failed them so badly they paid a tax or exempted themselves.

Mr. Speaker, I yield 2 minutes to the gentlewoman from South Dakota (Mrs. NOEM), who has weighed in in such a key way on health care.

Mrs. NOEM. Mr. Speaker, it is no surprise that the Democrats today are upset, that they are complaining that they don't like this bill, because their number one goal all along, and I have heard them say it to me in conversations over the years, their number one goal was to go to a single-payer system. They wanted government-run health care, and we are on the track to that today.

In fact, in my home State of South Dakota, at one time, we had 17 options and companies that people could shop for their healthcare policies from. Today we have two.

We are well down our road now to giving them exactly what they want. They hate this bill because it puts people back in control of their own health care. It doesn't let some bureaucrat in Washington, D.C., decide what treatment they can get in the future. It lets people decide that with their doctors.

This is a vote, today, for freedom for people who have lived under the bureaucracy of the Federal Government not giving them options on how to take care of themselves and their families.

Rising costs, shrinking options, increasing bureaucracy under ObamaCare has taken healthcare control away from patients, away from people, away from families struggling to pay their bills; and, against their best and own common sense and household budgets, they are forced to pay $10,000, $15,000, $20,000 more per year for health coverage, health coverage which has a deductible so high that they don't even utilize it then because they can no way meet the $6,500 deductible, $10,000 deductible, $12,000 deductible. So they don't even use it at all if they do have it. Their stories are reflected in all the data that we have seen.

One hundred percent of the healthcare options on healthcare.gov in South Dakota have seen double-digit rate increases. Meanwhile, the number of providers families have to choose from has gotten much, much worse.

We have a responsibility to eliminate ObamaCare's individual and employer mandates, which today's legislation does. It also abolishes the taxes that were included in ObamaCare, up to $1 trillion of taxes that were put on health care in order to pay for the bill, which will be eliminated as well.

If left in place, the health insurance tax alone will raise costs on families up to $5,000 over the next decade.

Bipartisan congressional Members have repeatedly opposed taxpayer funding of abortions, and that is fixed in this bill as well.

When we talk about health care, we are talking about something very personal, which is why I want patients put back in control.

Mr. NEAL. Mr. Speaker, I would remind my colleague that her vote for this bill will result in 63,000 people in South Dakota losing their healthcare coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. BLUMENAUER), a visionary, certainly, a forward-looking individual who also helped to write the ACA.

Mr. BLUMENAUER. Mr. Speaker, it has come to this: considering hopelessly flawed legislation that the Republicans have had 7 years to prepare for and still couldn't do it right. It may still pass, but it is never going to be enacted because most people are figuring it out. They don't like it and they are being heard. That is why this bill has been stalled and the Republicans have been forced to twist the legislation in this fashion.

But the bottom line remains: TrumpCare will cost more for people who need it the most. It will hurt older and lower-income people in order to create tax cuts for people who need them the least. TrumpCare will destabilize health insurance and will slowly but surely destroy Medicaid.

It didn't have to be that way, but as long as people continue speaking out and fighting back with us, it won't be in the future, and we can have a new era in health care and in politics.

With their help, it will be.

Mr. BRADY of Texas. Mr. Speaker, I remind my dear friend from Oregon, 153,000 Oregonians eligible for ObamaCare with generous subsidies said thank you, but no thank you.

Mr. Speaker, I yield 2 minutes to the gentleman from South Carolina (Mr. RICE), my good friend and a key member of the Ways and Means Committee.

Mr. RICE of South Carolina. Mr. Speaker, I stand in strong support of the American Health Care Act and urge my colleagues to vote in favor of the bill.

ObamaCare was built on broken promises. President Obama said you could keep your policy, keep your doctor, and it would bring down the cost of the insurance for a family of four by $2,500 per year.

It is time for the lies to stop. Let me share with Members the shameful reality of ObamaCare in South Carolina.

It turns out you couldn't keep your doctor. In fact, the Medical University of South Carolina is not an accepted provider under ObamaCare in South Carolina. That is right. South Carolinians cannot go to the Medical University of South Carolina if they are

covered by ObamaCare exchange policies.

It turns out you couldn't keep your policy. It is hard to believe, but more South Carolinians had their plans canceled by ObamaCare than have enrolled in the exchanges. 237,000 South Carolinians' policies were canceled in ObamaCare.

It turns out South Carolinians did not see a $2,500 reduction in their healthcare premiums. In fact, premiums have increased by double digits every year since the exchange opened; and this year, premiums increased 28 percent and deductibles 26 percent.

I submit to you that if you have a health insurance policy with $6,000 in deductibles and copays so high you can't afford to use your policy, regardless of the fact that statistics say you are covered, you are not covered.

206,000 South Carolinians have signed up for ObamaCare—4 percent of the population. Ninety-six percent of South Carolinians are not on ObamaCare. Three times as many people in South Carolina have chosen to pay the mandate penalty rather than to pick up ObamaCare policies.

Mr. Speaker, President Obama promised South Carolinians we would have many competitive plans to choose from, but after only 3 years of Obama's damage to our healthcare system, only one provider remains, and they are threatening to pull out.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BRADY of Texas. Mr. Speaker, I yield an additional 15 seconds to the gentleman from South Carolina.

Mr. RICE of South Carolina. The CEO of a major hospital in South Carolina stated, the way it is going right now, it is probably going to implode in the next year or two. Our State's director of insurance, last year, said companies have given their best shot and can't sustain this business model, can't make a profit. The Affordable Care Act has not worked, does not work, and cannot work under this structure in South Carolina.

Mr. NEAL. Mr. Speaker, I would remind my colleague that his vote for this bill will result in 70,000 people in his congressional district in South Carolina losing their healthcare coverage.

Mr. Speaker, I now yield 1½ minutes to the gentleman from Wisconsin (Mr. KIND), who is a thoughtful member of the Ways and Means Committee and lucky enough to have been educated in the Commonwealth of Massachusetts.

Mr. KIND. Mr. Speaker, we face a truly historic day today in the United States Congress. For the first time in our Nation's history, we have a Congress working with an administration offering the American people a healthcare reform bill that, instead of reducing the number of uninsured in this country, increases the uninsured by 24 million people, including 431,000 in my home State of Wisconsin.

And we understand why. It is a simple explanation. This is a tax cut bill for the most wealthy in the guise of healthcare reform. That is unfortunate because it is a missed opportunity of fixing what isn't currently working in the healthcare system.

If we wanted to be honest with the American people today, we would admit that there are important, good features of the Affordable Care Act that should remain and we should not end. But there are things that need to be fixed, and we have to stay focused on reducing healthcare costs for all Americans. Let's continue to work on delivery system reform and payment reform so we get better results at a better price.

But a bill before us that increases the uninsured by 24 million, that delivers huge tax breaks to the most wealthy, that applies a new older American tax, especially in rural areas like mine in Wisconsin, and that robs money from the Medicare trust fund is not only a missed opportunity, it is bad legislation.

I encourage my colleagues to vote ''no.'' We can do better. We must do better.

Mr. BRADY of Texas. Mr. Speaker, I remind my good and thoughtful friend that 290,000 Wisconsinites that chose not to get ObamaCare were willing to pay a tax to stay out of a failed healthcare system.

I am proud to yield 2 minutes to the gentlewoman from Indiana (Mrs. WALORSKI), a new member of our committee who is doing tremendous things in health care.

Mrs. WALORSKI. Mr. Speaker, I rise today in strong support of the American Health Care Act.

Yesterday marked 7 years since the ObamaCare law was signed into law. For 7 years, we have seen the same pattern: rising premiums, dwindling options, broken promises, and a collapsing system.

In the State of Indiana, four insurers left the ObamaCare exchange just this year in the past 3 months, forcing 68,000 Hoosiers to shop for a new plan, making it even harder for them to choose and keep their doctor.

But today we have the opportunity to repeal ObamaCare and replace it with a patient-centered system, lowering costs, increasing choices, and providing real protection.

This legislation dismantles ObamaCare's burdensome taxes, mandates, and the job-killing medical device tax.

It gives individuals and families access to quality, affordable health care through refundable tax credits and expanded health savings accounts.

It provides resources for States to tailor solutions to the needs of their citizens, protecting women's health, addressing the opioid crisis.

It gives States flexibility to implement innovative reforms.

It allows my home State to continue building on its patient-centered Healthy Indiana Plan.

It protects patients with preexisting conditions and ensures a stable transition so no one has the rug pulled out from underneath them.

With the American Health Care Act, we are delivering on our promise and acting on the policies of President Trump. This bill is just the first step in a three-part effort to repair our Nation's healthcare system. Coupled with administrative actions and additional legislation, the AHCA will lower costs and build a marketplace with real choices instead of a one-size-fits-all plan.

Mr. Speaker, 7 years of ObamaCare is long enough. Seven years of families seeing their premiums rise, plans canceled, and doctors dropped is enough. Today we can deliver on our promise and put our bold solutions into decisive action. The AHCA is a bill 7 years in the making. I urge my colleagues to join me in supporting it.

Mr. NEAL. Mr. Speaker, I remind my colleague that her vote for this bill will result in 42,000 people in her congressional district in Indiana losing their healthcare coverage and care.

I include in the RECORD a letter from Republican Governor Snyder of the State of Michigan raising his concerns about this legislation.

STATE OF MICHIGAN,
EXECUTIVE OFFICE,
Lansing, MI, March 21, 2017.

Hon. SANDY LEVIN,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE LEVIN: As Congress considers legislation to repeal and replace the Affordable Care Act and reform Medicaid, I want to ensure you are aware of the impact that changes may have on beneficiaries in Michigan who rely on these programs for access to care and overall health. I also want to provide my perspective on priorities for federal health reform and highlight how they have been utilized at the state level to drive meaningful reform that has increased access to cost-effective care.

In its current form, the American Health Care Act (AHCA) shifts significant financial risk and cost from the federal government to states without providing sufficient flexibility to manage this additional responsibility. The proposed legislation reduces federal resources that our state relies on to assist 2.4 million Michiganders enrolled in traditional Medicaid and the Healthy Michigan Plan, our state's innovative Medicaid expansion program.

The current federal debate has largely focused on the Medicaid expansion population, including over 650,000 childless adults and parents that are enrolled in the Healthy Michigan Plan. However, half of all children in Michigan are served by traditional Medicaid each year and roughly 67,000 of them currently reside in your district. Moreover, more than 338,000 individuals with disabilities receive their health care and support services through Medicaid and an estimated 22,000 of these individuals reside in your district. Altogether, there are 1.75 million children, seniors, pregnant women and disabled individuals served by traditional Medicaid in Michigan, and roughly 119,000 of them reside in your district. As you know, these are our state's most vulnerable citizens, friends and neighbors. The proposed AHCA will adversely impact them.

While reforming the nation's health care system is vital, it is imperative that gains in health coverage and access to care are maintained. These ideas are not mutually exclusive.

In Michigan, innovative approaches to improving quality and value are being utilized to support each individuals' personal responsibility for their health. This has resulted in significant reductions of nearly 50% in uncompensated care, a dramatic decrease in the number of individuals using the emergency room as a regular source of care, and nearly 85% of enrollees taking part in annual primary or preventive care visits. As drafted, the AHCA would eliminate coverage from the 49,000 individuals enrolled in the Healthy Michigan Plan in your district, as Michigan taxpayers assume responsibility over time for up to $800 million in additional costs. This cost shift will trigger a provision in Michigan law ending the Healthy Michigan program.

I believe Medicaid reform is necessary, however, that reform must be approached deliberately to ensure that state flexibility and innovation are valued, Michigan providers remain strong, and our most vulnerable citizens do not fall through the cracks. Ideally, this would be done by removing prescriptive program requirements that require states to seek waivers when implementing innovative ideas. Instead, states would be given performance based outcomes with federal involvement only when performance is lacking.

If Congress moves forward in passing the proposed AHCA, which shifts financial risk to state taxpayers, my administration and the Michigan Legislature must possess the flexibility necessary to manage that risk. The Trump Administration may provide additional flexibility to states, however, I am concerned that federal agencies may encounter limitations in federal statute. Ultimately, Michigan cannot rely solely on the promise of future action without seeing all of the tools that will be at our disposal to manage the program.

In addition, under the proposed AHCA, I remain concerned about the affordability of insurance coverage in the individual market. I am particularly concerned about the impact this legislation may have on older Michiganders who could see significant cost increases.

I welcome the opportunity to partner with you to provide greater federal budget predictability and improve health outcomes of Michiganders, which in turn relieves pressure on other social programs. I have worked with other Governors to develop a proposal to accomplish these objectives while also preserving coverage for Michiganders, and I hope this can serve as a blueprint for you as we work together to accomplish these goals.

I look forward to continuing our partnership to help Michiganders lead healthy and productive lives.

Sincerely,

RICK SNYDER,
Governor.

Mr. NEAL. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL), who is a well-regarded member of the Ways and Means Committee. I think it is fair to say that everybody in this institution looks forward to his time when he gets up to speak.

Mr. PASCRELL. Mr. Speaker, the question I get asked is: What the heck were they thinking about?

Let me tell you what they are thinking about. Medicaid is the source of 25 percent of all projected public and private spending for drug abuse treatment. It is about $8 billion.

Let's consider James Suber from my hometown of Paterson, New Jersey. Mr. Suber began seeking treatment when New Jersey expanded its Medicare program and provided more comprehensive access to treatment.

At least New Jersey got it half right.

Each morning Mr. Suber receives treatment at Paterson Counseling Center, which allows him to go to work as a cleaner at Well of Hope, another treatment center in Paterson serving the homeless.

Without the treatment he receives through Medicaid, he wouldn't be working. He would be using the emergency department at St. Joseph's hospital, the most expensive part of the hospital. Or maybe he wouldn't have survived.

So, Mr. Speaker, for the life of me, I don't understand why we would jeopardize treatment for James and the millions of other Americans facing similar challenges. What were they thinking?

Will this bill improve Medicaid? Nope.

Will this bill increase the number of Americans with health coverage? Nope.

Will it lower costs on the exchanges? Nope.

Will this bill bolster employer coverage? No.

Will coverage now provide more access to care, a promise time and time again by Mr. Trump, himself? No.

Will it strengthen Medicare? No.

□ 1445

Mr. Speaker, it is obvious. We know we are trying to change things and make them better.

We changed Medicare. We did it together.

We changed Medicaid. We did it together.

We changed a lot of things together, but you chose the only lonely path.

Mr. BRADY of Texas. Mr. Speaker, I remind my good friend from New Jersey that 314,000 residents of New Jersey said ''no thank you'' to ObamaCare because it failed them.

I yield 2 minutes to the gentleman from Michigan (Mr. BISHOP), a new member of the committee, who dove into this issue with great thoughtful and conscientious work.

Mr. BISHOP of Michigan. Mr. Speaker, I rise today in support of the American Health Care Act, and I want to thank the chairman for his leadership on this measure.

Mr. Speaker, I came to Washington, D.C., to make a difference. When it comes to health care, it is readily apparent that ObamaCare does not work for most Americans. We know for a fact, as we are standing here today, that the current system is collapsing upon itself.

Our Nation has endured 7 long years of this mess, and today we have the obligation and the responsibility to act. I have heard many critics of this proposal, but I was raised to do what is right, to be a part of the solution, and not sit idly by on my hands as a spectator and watch Rome burn.

I came to Congress to make a difference, to find solutions to the many issues that vex our country. I came here to reduce the size and scope of an unwieldy government, to get government out of the way of everyday citizens. I came here to address spending, a $20 trillion debt in this country, to bring back free-market principles. I came here to defend the Constitution and our founding principles, and turn power back to the States and to the people.

All that said, every single one of these principles can be found in this bill. The American Health Care Act reduces spending and cuts the taxes that have strangled businesses and individuals for the last 7 years. It represents the first real entitlement reform in the 52-year history of Medicaid. It deletes Federal mandates that rob citizens of their individual liberty.

Mr. Speaker, this bill may not be perfect, but it is a dramatic step in the right direction. And before I am lectured as to unsubstantiated facts and fear tactics as to how this is going to impact my State, I would suggest to you that 420,000 Michiganders eligible for Medicare said ''thanks, but no thanks'' to the broken promise of affordable health care.

And that is why, Mr. Speaker, I am going to vote for this bill, and I would ask my colleagues to support it.

Mr. NEAL. Mr. Speaker, I would remind my colleague that his vote for this bill will result in 38,200 people from his congressional district in Michigan losing their healthcare coverage, and 313,123 people in the State of Michigan, indeed, did sign up for the Affordable Care Act.

Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. CROWLEY), a long-time friend, a very sound member of the committee, and also the well-regarded chairman of the Democratic Caucus.

Mr. CROWLEY. Mr. Speaker, this bill is a bad policy built on horrible process. Twenty-four million Americans will lose their coverage if this bill becomes law. Premiums and out-of-pocket expenses will skyrocket, especially for older Americans because of the age tax, as hardworking Americans are forced to subsidize tax cuts for the wealthy.

It is no wonder this bill was crafted in the dead of night behind closed doors. It is so bad, even Members of the Republican Party are rejecting this bill, but President Trump and Republican leadership insisted they need to repeal ObamaCare at any cost, even if the price will be making health care out of reach for veterans, for seniors, and many of the hardest-working Americans.

So the majority made it worse, and then they made it worse again. Now they have taken away the bare minimum requirements for insurance like covering emergency room visits or prescription drugs. It will crush any protections for preexisting conditions.

There is no guarantee the treatment you need for your condition will even be covered under this bill. Image that: healthcare coverage that doesn't cover your health. Insurance that insures absolutely no peace of mind for what life may bring you.

This body blow to critical health protections was done just to win votes, like so many of the other provisions and political favors, like the Empire State kickback, the Buffalo bribe, and the Syracuse sellout. I call it simply a political ploy.

That provision, which will cut $2 billion from only New York State, has been blasted by newspapers from The Buffalo News to Newsday on Long Island. They have called it a train wreck. They have called it bloody money. Like everything else in this bill, it represents the worst kind of backroom, shady maneuvering.

This bill is bad for New York, bad for the democratic system, and bad for America. My colleagues on the other side of the aisle should be ashamed of themselves. I know many of you are. But this bill is appalling, and I urge everyone in this Chamber to vote it down. And, Mr. Chairman, I know that 2.7 million New Yorkers will lose their health care if this bill becomes law.

Mr. BRADY of Texas. I remind my friend from New York, nearly four out of five New Yorkers said no to ObamaCare because it failed them.

Mr. Speaker, I yield 1 minute to the gentleman from Iowa (Mr. KING), my dear friend.

Mr. KING of Iowa. Mr. Speaker, I want to thank the chairman for yielding to me.

Seven years ago today, I brought the first repeal of ObamaCare here to this Congress. Forty words, to rip it out by the roots as if such act had never been enacted. I would like to be here today passing the full repeal of ObamaCare. We are not, but this is the first bite at the repeal apple in a process to hopefully get all of this thing done in one day.

If I thought we could do it all in one bite, I would stand for that, but instead, here is what we have got. We have got a $1 trillion tax cut. We have got a $1.15 trillion spending cut. We have got a $150 billion deficit reduction. We have got a bill that eliminates the employer mandate, eliminates the individual mandate, and it eliminates Federal mandates in the essential health benefits package of those 10 mandates—that I despise, by the way.

It expands health savings accounts—doubles them—it allows for us to pass selling insurance across State lines, and it enables catastrophic health insurance. That is a pretty good list, and that is the list of things that I am going to support here when this goes up for a vote.

Mr. Speaker, I urge its adoption.

Mr. NEAL. Mr. Speaker, I remind my colleague that his vote for this bill will result in 40,900 people from his congressional district in Iowa losing healthcare coverage. I also want to thank the gentleman for being the first speaker on the Republican side to acknowledge that this is a tax cut.

Mr. Speaker, I yield 1 minute to the gentleman from Chicago, Illinois (Mr. DANNY K. DAVIS), a distinguished member of the Ways and Means Committee and my friend.

Mr. DANNY K. DAVIS of Illinois. Mr. Speaker, I rise in strong opposition to this draconian, Dracula-inspired health bill. It is not really a health bill at all. As a matter of fact, it is a tax cut for the wealthiest individuals in our country. This bill will decimate all of the public health gains that professional health personnel and activists have fought for the last 50 years.

This bill will take out the opportunity for those low- and moderate-income individuals who fall between the gap created by Medicaid and nothing. They are the least of those in our society. And when you take away health care for that group of individuals, history will not regard you well.

I believe that the best way to measure the effectiveness of a society is by how well it treats its young, how well it treats its old, and how well it treats those who have difficulty caring for themselves.

I will vote ''no.'' I urge us all to do so.

Mr. BRADY of Texas. Mr. Speaker, I remind my good friend from Illinois, half a million Illinoisans have said no to ObamaCare because it failed them.

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

Mr. NEAL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. SÁNCHEZ), the vice chair of the Democratic Caucus, and a very strong performer on the Ways and Means Committee.

Ms. SÁNCHEZ. Mr. Speaker, I rise today in opposition to the Republican's so-called healthcare bill.

It pains me to even call it a healthcare bill because it is actually a massive tax cut for insurance CEOs that provides nearly zero healthcare benefits for the American people.

In fact, TrumpCare ensures that 24 million Americans will lose their health insurance coverage. Seniors will be charged more, and insurance companies will once again dictate the health of the American people. On the very day that the majority tax cuts for the rich come into effect, on January 1, 2018, at least 40,000 of my own constituents would immediately lose their health care.

But that is not all. The Republican idea of health coverage will leave millions of Americans without the basic health services that they expect and that they deserve. That means that the monthly premium you pay won't cover all of the services you will need to get better if you get sick. The Republican healthcare plan won't cover your emergency room visit, the X-rays, or even the prescription drugs you need to recover.

Heaven forbid if you need prenatal or pediatric care, too. Basically, under this plan, one illness is enough to bankrupt a family for a lifetime. If you asked anyone on the street, no one in America would call this health insurance. Yet, my Republican colleagues hail this as choice—the choice to go bankrupt if you get sick or, God forbid, have an accident.

So, Mr. Speaker, I have to ask: How many Republicans are left who actually support the bill? Who wants to kick thousands of people off of Medicaid, reduce care for the disabled, and strip children of their health care because that is exactly what you are going to do if you vote for this bill. It does the exact opposite of what you, your party, and President Trump have promised the American people.

This bill doesn't provide better, cheaper health care for everyone. And guess what? Everybody knows that. By voting for this bill, you will literally force millions of Americans to pay more for less and jeopardize the health of our country for generations.

So if you vote to break all of the promises you made to the American people, then you are going to own it, and you are going to be responsible for whatever happens. Vote down this bill.

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

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentlewoman from Alabama (Ms. SEWELL), a valued member of the Ways and Means Committee.

Ms. SEWELL of Alabama. Mr. Speaker, for 7 years, our Republican colleagues have railed against the Affordable Care Act, but is this the best they can offer now: TrumpCare? The Republican bill, TrumpCare, is a bad deal for Americans, and it is a bad deal for Alabamians.

By every matrix, cost, coverage, and care, it is a bad deal. On cost, TrumpCare will cost more and give us less. For Alabama hospitals, TrumpCare will mean a $97 million increase in uncompensated cost care, and it is an age tax for seniors. Seniors will pay five times more than the young for their health insurance.

On coverage, TrumpCare will mean 24 million Americans and 243,000 Alabamians will lose their healthcare coverage. On quality of care, TrumpCare will mean that essential benefits will be lost: essential benefits like rehabilitative care, mental health, and preventive services.

Mr. Speaker, what is clear, TrumpCare is not a healthcare bill. It is a tax-cut-for-the-wealthy bill—$600 billion in tax cuts. So I say to you, my Republican colleagues know what they are against, the Affordable Care Act. But what are they for? What are they for? I ask all of you.

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

Mr. NEAL. Mr. Speaker, might I inquire as to how much time remains?

The SPEAKER pro tempore. The gentleman from Massachusetts has 5¾

minutes remaining under this committee time allocation.

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. CHU), a new member on the Ways and Means Committee, and a very thoughtful Member of Congress.

□ 1500

Ms. JUDY CHU of California. Mr. Speaker, my constituent Patty never had to worry about health care. Her husband had insurance through his job. But last year, Patty's husband passed away suddenly. Overnight, Patty found herself without health coverage for herself and her 20-year-old son, who had a preexisting condition.

Even though she was grieving over the sudden loss of her husband, Patty couldn't afford COBRA and had less than a month to find health care for her family. Thank goodness she was able to get coverage through the ACA.

Under TrumpCare, Patty could have her life upended all over again. Patty is 62 years old, and TrumpCare would cause premiums for people over 60 to increase by more than $6,000 a year, making insurance unaffordable. And under the age tax created in this bill, insurance companies could charge Patty five times as much as a young person. She could see skyrocketing costs for her hypertension and doctor's visits.

TrumpCare is a bad deal for Americans like Patty.

Mr. Speaker, I urge my colleagues to vote a resounding ''no'' to this downright cruel bill.

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

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, this so-called health bill is actually just mostly targeted for tax cuts for the wealthiest among us.

Let's look at it this way: a millionaire will get a $30,000-a-year tax cut. A 64-year-old senior who earns $30,000 a year—that is all he earns, just the tax cut the millionaire gets—they will see their premium go from $1,700 a year, to $15,000 a year. That is half their income.

They are going to have a choice: give up their house so they can buy health insurance or don't buy health insurance, pray you don't have a health emergency, and go bankrupt or die. Those are great choices.

This says a lot about the values of the Republican leadership and their obsession. Instead of fixing the problems with the Affordable Care Act, they want to kill it. It says a lot about their values. They are pathetic.

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

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. O'HALLERAN).

Mr. O'HALLERAN. Mr. Speaker, I rise in strong opposition to the so-called American Health Care Act. I am alarmed at the real consequences this bill will have on rural Arizona and rural America.

These communities will be disproportionately harmed by this bill. In Coconino County, a 40-year-old making $30,000 a year will go from a $2,400 payment to a $6,000 payment.

Getting away from my script for a second, I spent many years on the west side of Chicago looking at what the core side of poverty looks like night after night, family after family, in our cities and our towns in this wonderful America. I know a little bit about math, and I know that 20 million people insured is better than 24 million people uninsured.

Please vote ''no.''

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

Mr. NEAL. Mr. Speaker, I yield 30 seconds to the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. Mr. Speaker, this is not a healthcare bill. This is a wealth care bill.

Unfortunately, President Trump, when he spoke in Louisville, said we had to pass this bill to get the big tax cuts. It is about wealth care. It is the Ebenezer Scrooge law of this Congress.

The insurance you will get with the amendments made will be as worthless as the degree from Trump University. We do not need wealth care, but we need health care.

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

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

In closing, I want to make sure the people of America understand what we are doing here in about 1 hour. We heard during the course of a Presidential campaign the promise that everything was going to be covered and we would be tired of winning.

If winning means that 24 million Americans are going to lose their healthcare coverage, if winning means imposing an age tax on seniors, if winning means higher out-of-pocket costs for working Americans, and if winning means robbing $75 billion from the Medicare trust fund, we don't want to be part of that victory lap.

This isn't about one person making up alternative facts. Our statements today have been based upon the CBO, the National Rural Health Association, the American Medical Association, the American Association of Retired Persons, and the March of Dimes.

This bill has fewer covered, weaker protections, and higher costs. Let's call this what it is today; it is a $1 trillion tax cut for the richest amongst us.

The Republicans are now facing the art of the ordeal. They have a bad plan, and they know it. They have scrambled for the last week to try to figure out how to stitch it together, and it hasn't worked.

For those across this country, think of the following: no maternity care, fewer hospital visits, no mental health services for those families who are struggling with a family member who has an opiate addiction, which is the crisis of our time.

This is more of the same: tax cuts for the wealthiest amongst us and healthcare cuts for everyone else.

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

Mr. BRADY of Texas. Mr. Speaker, I yield myself the balance of my time to close.

Mr. Speaker, do you want to know how bad ObamaCare is?

Twice as many Americans have exempted themselves, have paid a fine, or found another way out of ObamaCare for everyone who took it.

I am a conservative, and I am proud of the conservative win in this bill. I am proud of the $1 trillion in tax relief on our small businesses, our patients, and our families. I am proud of the more than $1 trillion of spending cuts that Washington cannot afford nor sustain. I am proud of the first reforms in Medicaid since the program was created in giving States back control of that plan, including the option of a work requirement.

I am proud to repeal ObamaCare mandates that have forced Americans into health care they can't afford and don't want. I am proud to defund Planned Parenthood once and for all. And I am proud of the $150 billion of deficit reduction.

This is a clear choice, and we will stand where we stand today: the choice between President Trump and more freedom or ObamaCare and less freedom. I stand with President Trump.

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

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

I include in the RECORD a letter dated March 7, 2017, from Dr. Thomas Price, the Secretary of Health and Human Services, who sent a letter of support for the American Health Care Act to Chairmen Walden and Brady.

THE SECRETARY OF
HEALTH AND HUMAN SERVICES,
Washington, DC, March 7, 2017.

Hon. GREG WALDEN,
Chairman, Committee on Energy & Commerce, Washington, DC.

Hon. KEVIN BRADY,
Chairman, Committee on Ways & Means, Washington, DC.

DEAR CHAIRMAN WALDEN AND CHAIRMAN BRADY: On behalf of the Trump Administration, I am writing in support of the reconciliation recommendations recently released for consideration by your Committees. Together, they align with the President's goal of rescuing Americans from the failures of the Affordable Care Act. These proposals offer patient-centered solutions that will provide all Americans with access to affordable, quality healthcare, promote innovation, and offer peace of mind for those with pre-existing conditions.

Your legislative proposals are consistent with the President's commitment to repeal the Affordable Care Act; provide advanceable, refundable tax credits for Americans who do not already receive such tax benefits through health insurance offered by their employers; put Medicaid on a sustainable path and remove burdensome requirements in the program to better target

resources to those most in need; empower patients and put healthcare dollars and decisions back into their hands by expanding the use of health savings accounts; ensure a stable transition away from the Affordable Care Act; and protect people with pre-existing conditions.

Achieving all of the President's goals to reform healthcare will require more than what is possible in a budget reconciliation bill, as procedural rules on this type of legislation prevent inclusion of key policies such as selling insurance across state lines, lowering drug costs for patients, providing additional flexibility in Medicaid for states to manage their programs in a way that best serves their most vulnerable citizens, or medical legal reforms. Your proposals represent a necessary and important first step toward fulfilling our promises to the American people. We look forward to working with you throughout the legislative process, making necessary technical and appropriate changes, and ensuring eventual arrival of this important bill on the President's desk.

Yours truly,

THOMAS E. PRICE, M.D.,
Secretary.

Mrs. BLACK. Mr. Speaker, I include in the RECORD a letter that comes from 24 of our Governors in support of the repeal of ObamaCare, and I would like to read just two quick paragraphs out of the letter:

''We support efforts to Reform the system.

''To provide access to affordable and quality health care, we must reform the system. We support a plan that gives state governments maximum flexibility to reform Medicaid and the system surrounding it. The states are more effective, more efficient and more accountable to the people. What works in one state may not work in another location, and true reform will allow states to recognize and meet the unique needs of the people all across America.

''We recognize that a vote in the House of Representatives is the first step in the Repeal, Replace and Reform process. The members of the United States Senate will undoubtedly make additional improvements before final approval by the President. We also recognize that the Secretary of Health and Human Services is committed to working with state leaders to provide maximum flexibility for true reform.''

MARCH 24, 2017.

Hon. MITCH MCCONNELL,
Majority Leader, U.S. Senate,
Washington, DC.
Hon. PAUL D. RYAN,
Speaker, House of Representatives,
Washington, DC.

DEAR LEADER MCCONNELL AND SPEAKER RYAN: Thank you for your service to our country. Please allow us to offer our thoughts about the pending vote on the American Health Care Act. Americans want personalized, patient-centered healthcare that treats them as individuals not a statistic, and that demands we repeal Obamacare, replace it, and reform the system.

WE SUPPORT THE REPEAL OF OBAMACARE

Obamacare is collapsing. If we do nothing, people will lose access to health care coverage. As it stands now, one-third of the counties nationwide have only a single insurance carrier. Americans in these areas have essentially no choices, while they watch their premiums rise dramatically. The Congressional Budget Office estimates that 28 million Americans will lose coverage over the next decade if changes are not made to the Affordable Care Act.

As the Affordable Care Act continues to deteriorate, and as insurance premiums skyrocket across the nation, opposition to this failed policy grows. Governor Mark Dayton (D–MN) said, ''the Affordable Care Act is no longer affordable.'' Similarly, Bill Clinton called ObamaCare, ''. . . the craziest thing in the world.'', adding that people ''wind up with their premiums doubled and their coverage cut in half.'' The President and Congress must act now to repeal the Affordable Care Act to protect the citizens we serve in the states.

WE SUPPORT EFFORTS TO REPLACE OBAMACARE

Most Americans receive their health insurance coverage through their employer or through Medicare. These individuals will not see a direct change from the repeal of Obamacare. For those Americans who do not receive coverage through their employer, Medicare or Medicaid, we support a refundable tax credit they can use to obtain affordable health care coverage within the marketplace.

WE SUPPORT EFFORTS TO REFORM THE SYSTEM

To provide access to affordable and quality health care, we must reform the system. We support a plan that gives state governments maximum flexibility to reform Medicaid and the system surrounding it. The states are more effective, more efficient and more accountable to the people. What works in one state may not work in another location, and true reform will allow states to recognize and meet the unique needs of people all across America.

We recognize that a vote in the House of Representatives is the first step in the Repeal, Replace and Reform process. The members of the United States Senate will undoubtedly make additional improvements before final approval by the President. We also recognize that the Secretary of Health and Human Services is committed to working with state leaders to provide maximum flexibility for true reform.

Governors are pleased to have an administration and a Congress willing to collaborate with the states to address the legitimate needs of our people. We have compassion for those concerned about the uncertainty surrounding the changes. This is why it is imperative that the Congress act quickly on Repeal, Replace and Reform.

This is a multi-stage process. There is much more work to be done, and process can only begin with a vote in the House of Representatives. With this in mind, we humbly request that you vote to repeal and replace Obamacare and to reform the system going forward. Thank you.

Sincerely,

Governor Scott Walker, Wisconsin; Governor Robert Bentley, Alabama; Governor Rick Scott, Florida; Governor C.L. ''Butch'' Otter, Idaho; Governor Eric Holcomb, Indiana; Governor Terry E. Branstad, Iowa; Governor Sam Brownback, Kansas; Governor Matt Bevin, Kentucky; Governor Paul R. LePage, Maine; Governor Phil Bryant, Mississippi; Governor Eric R. Greitens, Missouri; Governor Pete Ricketts, Nebraska; Governor Christopher T. Sununu, New Hampshire; Governor Doug Burgum, North Dakota; Governor Ralph Torres, Northern Mariana Islands; Governor Mary Fallin, Oklahoma; Governor Henry McMaster, South Carolina; Governor Dennis Daugaard, South Dakota; Governor Bill Haslam, Tennessee; Governor Gary R. Herbert, Utah; Governor Matthew H. Mead, Wyoming.

Mrs. BLACK. Mr. Speaker, I include in the RECORD a list of groups supportive of the American Health Care Act. We have many groups, from conservative groups to pro-life groups, to industry groups; and among those would be several insurance providers, such as Blue Cross Blue Shield, Anthem, and others.

GROUPS SUPPORTIVE OF THE AMERICAN HEALTH CARE ACT

CONSERVATIVES

American Legislative Exchange Council
Americans for Tax Reform
Association of Mature American Citizens
Center of the American Experiment
Citizens Against Government Waste
Independent Women's Voice
Institute for Liberty
Log Cabin Republicans
Market Institute
National Taxpayers Union—Key Vote
Obamacare Repeal Coalition
Six Degrees Project
Small Business & Entrepreneurship Council
Taxpayers Protection Alliance

PRO-LIFE GROUPS

American Center for Law and Justice
Catholic Medical Association
Concerned Women for America
Faith & Freedom Coalition—Key Vote
National Right to Life—Key Vote
Susan B. Anthony List

INDUSTRY

Advanced Medical Technology Association (AdvaMed)
America's Health Insurance Plans (AHIP)
American Benefits Council
American Builders and Contractors
American College of Cardiology
American Supply Association
Anthem Insurance
Associated General Contractors of America—Key Vote
Blue Cross Blue Shield
Consumer Healthcare Products Association
Corporate Health Care Coalition
Employers Council on Flexible Compensation
ERISA Industry Committee (ERIC)
Food Marketing Institute
Health Leadership Council
HSA Council
International Franchise Association (IFA)
Medical Device Manufacturers Association (MDMA)
National Association of Manufacturers (NAM)
National Association of Wholesale Distributers (NAW)—Key Vote
National Business Group on Health
National Club Association
National Council of Chain Restaurants
National Federation of Independent Businesses—Key Vote
National Grocers Association
National Restaurants Association
National Retail Federation—Key Vote
National Roofing Contractors Association
One Nation Health
Self-Insurance Institute of America, Inc.
The Association of Chief Human Resource Officers (HR Policy)
US Chamber of Commerce—Key Vote

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. HENSARLING), the chair of the Financial Services Committee.

Mr. HENSARLING. Mr. Speaker, tragically, I receive correspondence every week like this. I heard from Rita in east Texas, who writes me:

Since ObamaCare took effect, my insurance no longer covers my colonoscopies as

preventative care. I now pay $1,000 and more out of pocket versus $100 outpatient fee.

I heard from Frances in the Dallas area near where I live. A few years ago she was tragically diagnosed with tonsil cancer. The good news is she had a good policy; $600-a-month premium and a maximum out of pocket of $3,500. But thanks to ObamaCare, her insurance company dropped her twice, and she wrote:

They dropped me again because they are leaving the Dallas market.

Her premiums and deductibles doubled. She lost her oncologist, and she writes that this is all because of ObamaCare, the Affordable Care Act.

I heard from Tonya in Van Zandt County, in my district:

We had five family members covered by insurance at around $800 a month until ObamaCare. Our insurance premiums skyrocketed to $1,500 a month, equivalent to a house payment, with a $15,000 deductible, and we cannot see the doctors that know our medical history. Repeal it. I should not be forced to pay for something I cannot use. This has been a nightmare.

Mr. Speaker, ObamaCare has been a nightmare. It is collapsing as we speak. People are losing their coverages. Insurance plans are pulling out of States and counties. Tens of millions of our fellow countrymen have been forced to buy health insurance plans they cannot afford, they do not want, and that do not work for them.

Right here, right now, we have a choice: failed ObamaCare or the American Health Care Act that begins the process of providing Americans with guaranteed access to quality, affordable, patient-centered health care.

It clearly advances the cause of freedom, and all Members should support it and end the nightmare of ObamaCare.

Mr. SCOTT of Virginia. Mr. Speaker, I ask unanimous consent that I be allowed to manage the balance of the time remaining.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, as we talk about the Affordable Care Act, I think it is important to remind ourselves of the situation before it passed: costs were going through the roof, those with preexisting conditions could not get insurance, women were paying more than men, and every year millions of people were losing their insurance.

We passed the Affordable Care Act. Since then, the costs have continued to go up, but at the lowest rate in 50 years. Those with preexisting conditions can get insurance at the standard rate. Women are no longer paying more than men. Instead of millions of people losing their insurance every year, more than 20 million more people now have insurance.

The full name of the Affordable Care Act is the Patient Protection and Affordable Care Act.

Now your coverage can't be canceled if your insurance company decides that it has paid too much. Preventive services, such as cancer screenings, are free with no copays and deductibles. We are closing the doughnut hole. Those under 26 can stay on their parents' policies.

We also funded community health centers, made investments in education to produce more doctors, nurses, and other professionals. Through all of that, the Medicare trust fund is more solvent than it was before.

Still, the law is not perfect. But if we are going to make any changes, we ought to improve the law, not make it worse.

Incredibly this bill makes it worse. Now, the CBO has separated promises and press releases from reality. Twenty-four million fewer people will have insurance, and the Republicans call this choice in freedom to be uninsured. Most everybody else will pay more and get fewer benefits. All of those consequences will occur if the proposal actually works.

□ 1515

A number of States have done what this bill tries to do, and that is cover people with preexisting conditions without universal coverage. All of those attempts failed.

So the question we must ask is: Who will be better off if this bill passes? Certainly not older people who will face the bill's age tax. Certainly not veterans who will lose benefits. Certainly not senior citizens in nursing homes and people with disabilities because Medicaid is cut. Even the solvency of the Medicare trust fund will be worse.

But millionaires will get tax cuts.

Mr. Speaker, we have been hearing a lot of complaints and shortcomings about the Affordable Care Act, but if we are going to make any changes, we should improve it. Unfortunately, this bill makes things worse: 24 million will lose their insurance, most everybody else will pay more and get less. This bill should be defeated.

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

Mrs. BLACK. Mr. Speaker, it is now my honor to yield 2 minutes to the gentleman from Virginia (Mr. GOODLATTE), the distinguished chairman of the Judiciary Committee.

Mr. GOODLATTE. Mr. Speaker, I want to tell you why I am supporting this legislation, the American Health Care Act.

Kaye, from Roanoke, contacted me about President Obama's promise that she could keep her health care. She shared that she received a letter from her insurer stating that her policy was going to increase by $600 per month—increase by $600 per month. Since she wasn't of age to be on Medicare but wasn't working because she was at home caring for her sick husband, she was frustrated with her situation.

Kaye couldn't afford the extra money she owed on top of the bills for her husband's medical treatment. She told me: ''So I will now have to pay the fine, drop my insurance, and hope I do not get sick.''

I told Kay I would vote to repeal and replace ObamaCare.

A nurse from Warren County wrote to me: ''The care that I give my patients is founded on their ability to choose their course of care. We advocate every day for our patients to have more choices in their care, and it will be very painful for us to deny them those options and to deny them care.'' She asked me to stand against ObamaCare, and I told her I would.

Susan, from Bedford County, told me her health insurance premium increased 156 percent and her deductible increased 766 percent in just 2 years. She asked how we could make her pay such high rates. I told Susan I would vote to repeal ObamaCare.

Mr. Speaker, I told my constituents that I would stand for them to repeal this law that has hurt their ability to get the affordable care they want and need. Passing the American Health Care Act is the first step in repealing ObamaCare and replacing it with solutions that put patients first. I urge my fellow Members to support this bill.

ObamaCare has failed far too many in the Sixth District of Virginia. The status quo cannot continue.

Mr. SCOTT of Virginia. Mr. Speaker, I remind my distinguished colleague from Virginia that his vote for this bill will result in 56,100 more people from his congressional district in Virginia losing health care.

Mr. Speaker, I yield 1 minute to the gentleman from the Mariana Islands (Mr. SABLAN).

Mr. SABLAN. Mr. Speaker, I oppose the American Health Care Act because it fails to increase coverage for 3.8 million Americans in the insular areas: American Samoa, Guam, the U.S. Virgin Islands, Puerto Rico, and my own district, the Mariana Islands.

President Trump promised, ''Everybody's going to be taken care of much better than they're taken care of now,'' but that is not happening. Instead of taking the opportunity to take care of all Americans, the American Health Care Act ignores the insular areas:

We are not included in the new Medicaid per capita funding proposal. As a matter of fact, in a year, we would see our Medicare funding reduced by 68 percent.

We are not included in the new Patient and State Stability Fund. And the new tax credit for insurance premiums is actually a new cost, an unfunded Federal mandate, imposed by Congress on territorial governments.

Everyone in this Chamber wants affordable, quality health care for all Americans. This bill fails to do that. So let us begin again. Let us work together on legislation to reach the goal the President has set and many of us share: insurance for everyone, not just the rich.

Mrs. BLACK. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Florida (Mr. DUNN).

Mr. DUNN. Mr. Speaker, I rise to repeal ObamaCare by supporting the American Health Care Act. We are here to take health care back from the bureaucrats and give it to the people.

The previous administration enacted ObamaCare, and we saw its effects: higher premiums, less choice, lost coverage, and broken promises. The deductibles are so high it is like not having insurance at all.

The people who sent me to Congress sent me with strict orders: End this law. And on the American Health Care Act, I can report, it does.

With this bill, the Federal Government no longer forces you to buy a product you can't use and don't want. The individual mandate is gone, so is the job-killing employer mandate. Gone are a host of taxes on prescription meds, over-the-counter drugs, insurance premiums, and lifesaving medical devices.

It ends ObamaCare's Medicaid expansion, and it puts Medicaid on a budget and focuses State efforts on those people truly in need. This is the biggest entitlement reform in a generation.

Of course the bill is not perfect. There is more to do. But I spent 30 years as a surgeon. In medicine, as in life, you do not get to choose the perfect option. You learn not to make perfect the enemy of great.

With this vote we decide whether ObamaCare is our healthcare future or not. We can live with its failures and broken promises or create a market-based system that actually lowers the cost of health care and serves patients, not bureaucrats.

So I support the American Health Care Act, Mr. Speaker, and I urge that all Members do the same.

Mr. SCOTT of Virginia. Mr. Speaker, I remind my colleague that his vote for this bill will result in 63,900 people from his congressional district in Florida losing healthcare coverage and care.

I yield 1 minute to the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY. Mr. Speaker, in a few minutes, the American people will see clearly what each and every Member of this House is made of. Will we vote to willfully strip healthcare coverage for 24 million Americans, older Americans, working Americans, Americans with chronic illness and developmental disabilities and now, incredibly, we even know, Americans who wore the uniform of this Nation?

In a few minutes, we will see who will vote to raid the Medicare trust fund in order to cut Medicare taxes for the rich, and we will see who will vote to cut Medicaid's coverage for patients struggling with the curse of opioid addiction.

Mr. Speaker, this is not just a vote. This is a gut check of who we are as people and whether our purpose, as elected officials, is to serve the public interest or, rather, feckless special interests.

Show the Nation that we care more about people than politics, that we care more about the long arc of American history toward justice rather than the short news cycle of who is up and who is down in Washington.

Make no mistake: History is watching this vote. Vote ''no.''

Mrs. BLACK. Mr. Speaker, I yield 1½ minutes to the gentleman from Louisiana (Mr. ABRAHAM), who is a family practitioner and knows a little about medicine.

Mr. ABRAHAM. Mr. Speaker, as a practicing physician in the Louisiana and Mississippi delta, I have some of the best patients, but some of the poorest. They can't afford to see me because they can't afford ObamaCare, increased costs, skyrocketing premiums, high deductibles. I can't cure a disease if I can't see the patient. The cost is just too high for ObamaCare.

We have heard about Medicaid expansion here today. That is a second-class insurance for first-class people. I can't get my patients to see a specialist. They have to go to the hospital. They have to go to the emergency room. Prices go through the roof.

I have heard my colleagues on the other side of the aisle reference the Hippocratic Oath. With all due respect, I don't think they would know what the Hippocratic Oath says if their life depended on it. Guess what? It does. Google it.

Let me educate you. Let me educate our colleagues. It says I will always seek a path to a cure for all diseases. ObamaCare will not let me do that.

We have got to do better. We cannot cram people into a healthcare system that has failed just so politicians can thump their chest and have some type of mysterious victory that is hollow and very, very small.

We need to pass this American Health Care Act. ObamaCare has failed. It is a sham of an insurance. Americans deserve better. We deserve better as Americans. My patients deserve better.

Mr. SCOTT of Virginia. Mr. Speaker, I remind my colleague that his vote for this bill will result in 51,700 people in his district losing their coverage and care.

Mr. Speaker, I include in the RECORD a letter from the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the American Congress of Obstetricians and Gynecologists, and the American Osteopathic Association in opposition to the legislation.

[From the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, The American Congress of Obstetricians and Gynecologists, American Osteopathic Association, Mar. 7, 2017]

AMERICA'S FRONT LINE PHYSICIANS EXPRESS SERIOUS CONCERNS WITH THE AMERICAN HEALTH CARE ACT

WASHINGTON, DC—After the release of the two budget reconciliation bills today, the physician leaders of our organizations, representing over 500,000 physicians and medical students, visited with members of the House of Representatives to urge that they ''First, do no harm'' to our patients by rolling back key coverage, benefits and consumer protections as required under current law, including the Affordable Care Act. We are concerned that by rushing to a mark-up tomorrow in the Energy and Commerce and Ways and Means Committees, there will be insufficient time to obtain non-partisan estimates of this legislation's impact by the Congressional Budget Office, or for medical organizations like ours and other key stakeholders in the health care community to offer substantive input on the bill.

During our meetings with members of the House of Representatives today, we shared our joint principles for health care reform. They reflect our collective expertise, and represent the health care needs patients present to our members every day. We urge Representatives to utilize these principles to evaluate any legislation to modify current law, and ensure that patients and providers are not adversely affected. While each of our organizations individually are still reviewing the changes proposed by the American Health Care Act, released just hours ago, we share a concern that it will not meet our principles because it will likely result in less access to coverage and higher costs for millions of patients.

We urge House Speaker Paul Ryan (R–WI) and the chairs of these two committees to reconsider the decision to move forward with mark-up, and instead allow the time needed for a thorough review of the bill to ensure that it meets our overarching principle, ''First, do no harm'' to patients.

ABOUT THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Founded in 1947, the AAFP represents 124,900 physicians and medical students nationwide. It is the only medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits—that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine, the AAFP's positions (5 page PDF) on issues and clinical care, and for downloadable multi-media highlighting family medicine, visit www.aafp.org/media. For information about health care, health conditions and wellness, please visit the AAFP's award-winning consumer website, www.FamilyDoctor.org (www.familydoctor.org).

ABOUT THE AMERICAN ACADEMY OF PEDIATRICS

The American Academy of Pediatrics is an organization of 66,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well-being of infants, children, adolescents and young adults. For more information, visit www.aap.org and follow us on Twitter @AmerAcadPeds.

ABOUT THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians is the largest medical specialty organization in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Follow ACP on Twitter and Facebook.

ABOUT THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (The College), a 501(c)(3) organization, is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization of more than 57,000 members. The College strongly advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. The American Congress of Obstetricians and Gynecologists (ACOG), a 501(c)(6) organization, is its companion.

ABOUT THE AMERICAN OSTEOPATHIC ASSOCIATION

The American Osteopathic Association (AOA) represents more than 129,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; and is the accrediting agency for osteopathic medical schools. Visit DoctorsThatDo.org to learn more about osteopathic medicine.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentlewoman from Ohio (Ms. FUDGE).

Ms. FUDGE. Mr. Speaker, what is a life worth? What does it cost to save the life of a sick child or a senior citizen?

For all of the rhetoric about freedom and choices, this bill sends a clear message to every American as to where Republican priorities lie. Tax breaks to the wealthy have been deemed more valuable than lifesaving care.

They are telling hardworking families that insurance that only benefits the wealthy, the healthy, and the young is more important than access to nursing homes, to pediatric care, mental health services, substance abuse treatment, and the overall peace of mind that, if you get sick, you can afford care.

Speaker RYAN calls this ''an act of mercy.'' This is by no means merciful, Mr. Speaker. Mercy is caring for the sick, the poor, for our elders. Mercy is extending a hand to those in need. This is heartless.

Human decency demands a ''no'' vote on TrumpCare. Vote ''no.''

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. CONAWAY), the chairman of the Agriculture Committee.

Mr. CONAWAY. Mr. Speaker, we are faced with an unenviable choice of the fact that there is infinite demand for health care. There is no top on the amount of healthcare cost necessary to provide all the health care that we want for everybody in this country, and we have limited resources within which to do that.

The real question is: Does ObamaCare take up that task by asking government to make those hard choices, or do we as individuals and families and caregivers make those harder choices for ourselves?

I believe that the bill that we will get to vote on today moves us toward that direction. This isn't about health care, per se; this is about how do you pay for it.

Insurance is not a magic bullet anywhere across the spectrum. Insurance is simply a scheme in which we risk-manage together. We put a certain amount of money into a bucket, assuming not all of us will suffer the risks that we want to cover. If we do, we have got to put more money in; if we don't, then the system works.

This is about having to confront that choice that there is way too much cost for the amount of resources that are available in any of these circumstances, and it is hard.

Many of my constituents ask: Why did Republicans spend 6 years railing against ObamaCare and not have the fix available on Inauguration Day? Well, this is Exhibit A. This is hard stuff. Even among Republicans, we have got more than 218 votes among us, and we can't agree among ourselves necessarily what ought to go forward.

But I do know this, that we are down to the final choice: Do we keep ObamaCare and the failure that is confronting us and will continue to be there, or do we take a chance on moving toward something different, moving toward freedom, moving toward choice, giving States back the opportunity to decide for their indigent population how they should take care of them?

I don't think anybody in Washington, D.C., can come up with a plan that fixes that for all 50 States. I trust my colleagues in Austin to make that happen far better than anybody I would trust in D.C., and this bill moves that direction, and that is the right direction for us to go.

This is a hard choice, but for me it is relatively straightforward. You keep ObamaCare with a ''no'' vote. You move toward a brighter future for health care in this country and the way we pay for it, who pays for it, and how we get that done by a ''yes'' vote. I encourage my colleagues to vote ''yes'' on this bill.

Mr. SCOTT of Virginia. Mr. Speaker, I remind my colleague that his vote for this bill will result in making things worse by 58,600 people in his district losing their healthcare coverage and care.

Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. WILSON).

Ms. WILSON of Florida. Mr. Speaker, I would like to begin by asking my Republican colleagues one simple question: Don't you have constituents who get sick and need insurance?

Everyone gets sick, rich and poor, Black and White, men, women, and children.

Having insurance gives us peace of mind. It helps ensure that a medical crisis is not exacerbated by a financial crisis. It often makes a difference between life and death. If the Affordable Care Act is repealed, your constituents and millions of people will be kicked off the insurance roll, and that is a shame. They will suffer, and their families will suffer.

I have health insurance, and so does every Member of Congress. We even have a clinic and doctors at our disposal right here in this Capitol.

Doesn't every American deserve the same treatment as Members of Congress?

Instead of moving backwards, Republicans should partner with Democrats to amend and strengthen the existing law. By working together, we can create a plan that works for all Americans, not just the Members of Congress. Vote ''no.'' Vote ''no.''

Ms. KAPTUR. Mr. Speaker, the Affordable Care Act needs to be repaired, not repealed. In 2010, Democrats passed health care reform in an effort to move toward health insurance for all Americans. Though we have made progress and more work to do, we cannot move America backward. Tens of thousands of people in northern Ohio and millions across America will lose insurance if TrumpCare becomes law.

This bill is cruel. It will take away care from some of our most vulnerable citizens like those who suffer from opioid addiction, mental illness or have disabilities. This bill will undermine Medicare and cut $28 billion from Ohio's Medicaid program, the majority of which is spent on nursing home care. If Republicans succeed in repealing the Medicaid expansion, one in four Ohio hospitals would close according to the Ohio Hospital Association.

Our goal should be to make our health care system better, not worse. This merciless bill is not a health care bill. This bill is an $800 billion tax cut for corporations and the very rich. How that giveaway provides better health care to working and middle-class families is beyond me.

For Lent I gave up chocolate, I recommend the Republicans try giving up tax cuts to the rich!

Let me share a story about a young man in Ohio who was diagnosed with an extremely rare form of cancer one month before his 26th birthday.

Once he turned 26 he lost coverage under his parent's health care policy.

But after visiting an Ohio Jobs and Family Services office, he learned about his eligibility for the Ohio Medicaid expansion, which allowed him to receive the cancer treatment he needed to survive.

Frankly, without the Affordable Care Act's multi-layered protections, he would be dead.

The Affordable Care Act and its Medicaid expansion has allowed him to return to finish law school.

This bill shifts the burden of health costs to the working and middle class, all so the rich can have a trillion dollar tax cut. A tax cut for the super rich doesn't help working people and seniors pay for health care. Astoundingly, the falsely labeled, so called ''health'' bill actually rewards billionaires and corporations with hundreds of billions in tax giveaways.

This bill does nothing to control costs for health insurance. Millions will lose coverage. It will actually result in higher costs too all while undermining Medicare and slashing Medicaid.

Congress ought to repair not repeal the ACA. We cannot move backward. This GOP bill is cruel and some of our most challenged

citizens like the mentally ill or disabled will lose care. Premiums for those over 50 could increase by 5 fold. As the old saying goes; ''this dog won't hunt.''

Ohio embraced the ACA and 866,000 people were finally able to receive health care coverage. What will this poorly conceived Republican tax giveaway bill do to Ohio:

1. About 47,000 people will lose health insurance because they are insured through the ACA in Ohio's 9th district.

2. The district's uninsured rate has gone from 13.3% to 7.0% since the ACA was implemented. This 6.3 percentage point drop in the uninsured rate could be reversed if the ACA is entirely or partially repealed.

3. 318,900 individuals in the district who now have health insurance that covers preventive services like cancer screenings and flu shots without any co-pays, coinsurance, or deductibles stand to lose this access if the Republican Congress eliminates ACA provisions requiring health insurers to cover important preventive services without cost-sharing.

4. 370,700 individuals in the district with employer-sponsored health insurance are at risk of losing important consumer protections like the prohibition on annual and lifetime limits, protection against unfair policy rescissions, and coverage of preexisting health conditions, if the ACA is entirely or partially repealed.

This Republican bill, hastily prepared, should be defeated. It is cruel, will leave millions of our fellow citizens bankrupt and destitute, and if implemented, will be responsible for more death and illness coast to coast. Vote no on TrumpCare.

Mr. LYNCH. Mr. Speaker, I rise in strong opposition to H.R. 1628, the American Health Care Act of 2017.

Mr. Speaker, I have received countless visits, calls, letters and emails from constituents about this bill. I have heard from hospitals, doctors, patients, nurses, parents of children with serious illnesses, researchers and the list goes on. They have one thing in common: they are afraid of what TrumpCare could do to their patients and to their families.

H.R. 1628 will not bring down health care costs or improve access. Indeed, by slashing Medicaid by $880 billion, it will force States to ration care for our most vulnerable populations. In Massachusetts, this cut will put the health of 1.9 million people at risk, including 650,000 children, 170,000 seniors and 280,000 people with disabilities. My state is also being hit hard by the opiate addiction crisis and cutting Medicaid will cripple our ability to address that problem. It is also a disgrace that the funding being cut out of Medicaid is being handed over to insurance companies and the wealthiest Americans in a $1 trillion tax break for the rich.

TrumpCare slashes $175 billion from the Medicare Trust Fund, cutting its solvency by three years and hurts seniors by letting insurance companies charge older Americans five times more than they do young ones. The yearlong bar on reimbursements to Planned Parenthood for non-abortion services means that women will have to go without health screenings, pre-natal care and well-woman visits. And according to the C.B.O., 24 million Americans will no longer have health insurance coverage.

All this begs the question, how does this bill provide better care for Americans?

But you do not have to take my word for it when I say that this bill will hurt Americans. Groups like the American Medical Association, the American College of Physicians, the American Academy of Pediatrics and the American Nurses Association, just to name a few, are urging Congress to stop TrumpCare. These are the men and women who are out there on the front lines everyday treating and healing our fellow Americans.

To make things worse, TrumpCare is being rushed to the floor with minimal deliberation. It was introduced less than three weeks ago and we have not held a single hearing or heard from a single expert witness on it. Now we are being asked to vote on it despite receiving the newest version of the manager's amendment late last night. This is not the regular order and transparency that the Republicans promised.

Mr. Speaker, this bill pushes the cost of health care onto those who can least afford it while providing massive tax cuts for the wealthy. I urge my fellow members to defeat this misguided bill and let us begin the serious work of making real improvements in the Affordable Care Act for all Americans.

Mrs. BEATTY. Mr. Speaker, I rise today to express my opposition to TrumpCare and my strong support for the Affordable Care Act.

Since the ACA was enacted seven years ago, more than 20 million Americans have gained access to affordable and high quality health insurance, including nearly one million Ohioans.

We thought 129 million Americans with preexisting conditions would be able to keep their health care coverage. We thought 105 million Americans would no longer have to worry about annual or lifetime limits. Yet, we are here today winding back the clock on all the progress we have made based on a bill that wasn't released to the public until last night.

What's the rush to pass a bill that affects so many people without letting the public view it? What's the rush to pass a bill that affects so many people without a new CBO score?

Mr. Speaker, we know that TrumpCare will cause Americans to pay more for less coverage. We know that TrumpCare will provide a massive tax cut to the super rich 400 families and leave the other 99.9 percent of people behind. We know that TrumpCare will cause 24 million Americans to lose their health insurance, including tens of thousands of my constituents in the Third Congressional District of Ohio. We know that TrumpCare will slash Medicaid funding by $880 billion. We also know that TrumpCare will put 13 million children, people with disabilities and adults just one emergency visit away from financial catastrophe.

Mr. Speaker, these cuts hurt people all across the country. TrumpCare will not make healthcare more affordable.

Democrats believe healthcare is a right, not a privilege. I join my colleagues in fighting for affordable healthcare for all Americans. I will vote no, and urge all my colleagues to vote no as well.

Mr. SMITH of New Jersey. Mr. Speaker, while the Affordable Care Act has been in effect since 2010, it has only provided actual access to health insurance benefits through the exchange and Medicaid expansion for a little over 3 years—beginning in 2014.

In that short period of time, however, serious problems and flaws have been exposed, yet in recent months the law's systemic problems have been trivialized or ignored by many.

Today, buying an insurance policy on the exchanges with high premiums, high copays, and most importantly, exceedingly high deductibles make the actual utilization of health benefits far costlier than originally advertised.

Americans were told repeatedly that the ACA would save up to $2,500 in premium payments per family per year. President Obama said: ''I will sign a universal health care bill into law by the end of my first term as president that will cover every American and cut the cost of a typical family's premium by up to $2,500 a year.''

That didn't happen—not even close.

Nationwide, since 2016, gross premiums before subsidies in the Bronze-priced tier rose a whopping 27 percent, silver 24 percent and gold 32 percent.

That should come as no surprise. As early as August 2012, Politifact found President Obama's promise to be untrue and labeled the statement a ''promise broken'' in a Politifact report entitled: NO cut in premiums for typical family.

Health insurance consumers were promised they could keep their insurance plan if they liked it and keep their trusted doctors as well. That didn't happen either.

As a matter of fact, several million were kicked off insurance plans they were very satisfied with—like my wife and I—only to be forced into an Obamacare plan that we didn't want and was more expensive.

Also, in New Jersey—like much of the nation—insurance companies are pulling out of the exchanges. Insurers continue to exit the individual market and the exchange has experienced a net loss of 88 insurers. Today, five states only have one insurer option. At home, last year five insurance carriers offered plans on the New Jersey exchange, today only two remain. The exodus of insurance companies from the individual market is an unsustainable and ominous trend.

Mr. Speaker, almost twice as many Americans have paid the financial penalty—pursuant to what is euphemistically called the ''individual mandate''—for not buying a health insurance plan—or have received an exemption from the individual mandate as those who have actually purchased a plan through the exchange. By the numbers that means 19.2 million taxpayers either paid the individual mandate penalty or claimed an exemption, compared to 10.3 million individuals who paid for plans on the Obamacare exchanges.

Obamacare also increased taxes by about one trillion dollars.

For example, beginning in 2020, a new 40% excise tax on employer provided comprehensive health insurance plans is scheduled to take effect. Any plan provided by an employer exceeding $10,200 for individuals and $27,500 for families will be taxed at 40 percent for each dollar above those numbers. According to the Kaiser Family Foundation this so-called Cadillac tax will hit 26 percent of employers by 2020.

According to the IRS, approximately 10 million families took advantage of the chronic care tax deduction which is now been redefined out of reach for many. New taxes combined with skyrocketing premiums, copays and deductibles underscores the need for serious review, reevaluation and reform.

That said Mr. Speaker, I remain deeply concerned—and will vote no today—largely because the pending bill cuts Medicaid funding

by an estimated $839 billion over ten years according to the Congressional Budget Office (CBO), rolls back Medicaid expansion, cancels essential health benefits such as maternity and newborn care, hospitalization, pediatric services, and mental health and substance use treatment, and includes ''per capita caps''—all of which will likely hurt disabled persons, the elderly and the working poor.

For years, I have supported Medicaid expansion as a meaningful way of providing access to health care for struggling individuals and families living above the poverty line but still poor despite being employed—80 percent of all Medicaid enrollees in New Jersey are families with at least one working adult in 2017.

Although more than 800,000 children are served by Medicaid in my state, the bulk of Medicaid funds are spent assisting the disabled and the elderly. In New Jersey approximately 74 percent of all Medicaid spending goes directly to assist persons with disabilities and senior citizens. Two out of every five people in nursing homes are on Medicaid.

According to the New Jersey Department of Human Services, in New Jersey total enrollment in Medicaid in February 2017 was 1.77 million people. Of that a significant number are newly enrolled under Medicaid expansion—663,523 ''newly eligible.''

These people are in need and deserve our support. Current law provides states that opted to embrace Medicaid Expansion—like New Jersey—95 percent of the costs for the ''newly enrolled.'' The federal share drops to 90 percent by 2020.

The proposed American Health Care Act continues Medicaid expansion however only until 2020. Those enrolled before December 31, 2019 would be grandfathered in at the 90 percent match rate but the federal-state match formula would then be reduced to a range between 75 percent–25 percent to 50 percent–50 percent or any new enrollee.

What does that mean?

The United State Conference of Catholic Bishops wrote each of us on March 17th: ''. . . it is our assessment that some provisions are commendable (and they reference the pro-life safeguards and other noteworthy provisions in the bill) . . . while others present grave challenges that must be addressed before passage . . . millions of people who would be eligible for Medicaid under current law will be negatively impacted due to reduced funding from the per capita cap system proposed in the legislation, according to the CBO. Those struggling families who currently receive Medicaid coverage from the recent expansion will see dramatic changes through the AHCA as well, without clear indication of affordable, adequate coverage to replace their current options. Many states begin their legislative sessions every cycle by attempting to overcome major deficits. State and local resources are unlikely to be sufficient to cover the gaps that will be created in the health care system as financial responsibility is further shifted to the states. Congress must rework the Medicaid-related provisions of the AHCA to fix these problems and ensure access for all, and especially for those most in need.''

A letter led by the Consortium For Citizens with Disabilities, and signed by over 60 organizations states:

''Dramatic reductions in federal support for Medicaid will force states to cut services and/or eligibility that puts the health and wellbeing of people with disabilities at significant risk. In fact, people with disabilities are particularly at risk because so many waiver and home- and community-based services are optional Medicaid services and will likely be the first services cut when states are addressing budgetary shortfalls. The health, functioning, independence, and wellbeing of 10 million enrollees living with disabilities and, often, their families, depends on funding the services that Medicaid provides. Likewise, Medicaid Expansion provides coverage for millions of people with disabilities and their caregivers who previously fell into healthcare coverage gaps. For many people with disabilities, being able to access timely, needed care is a life or death matter. The drastic cuts to Medicaid that will result from per capita caps and the ultimate elimination of Medicaid Expansion will endanger millions.''

Autism Speaks, a leading autism awareness, science, and advocacy group, further articulated another concern, that ''the choice of 2016 as a baseline year for per capita caps may prevent states from addressing the needs of children with autism. In July 2014 the Center for Medicaid and CHIP Services issued an informational bulletin clarifying Medicaid coverage of services to children with autism, including benefit requirements for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Although EPSDT is a mandatory Medicaid program, few states in 2016 funded autism services at the required standard of care. Locking in 2016 as a baseline year can only perpetuate this historic underfunding of EPSDT benefits.''

Ms. ROYBAL-ALLARD. Mr. Speaker, for my constituents and all Americans, Trumpcare would result in higher costs, less coverage, a crushing age tax for persons 50 to 64, a shorter Medicare life span, and the ransacking of the Medicaid funds that enable seniors to get the long term care they need. And last night, Republicans added a provision that would prohibit our veterans who are eligible to receive VA care from receiving any tax credits to help pay for their care outside the VA, even if they are not enrolled in the VA.

In my congressional district, the uninsured rate dropped from 31.7 to 17.5 percent due to Obamacare.

Among my constituents who benefited are a young mother from Bell Gardens, California, and her 15-month-old daughter, Olivia, who was born with Down Syndrome.

Because of Obamacare's Medicaid expansion in California, Olivia was able to have her congenital heart defect repaired shortly after birth. She is now being followed by a cardiologist to ensure her ongoing care for a healthy heart.

Obamacare's Medicaid expansion also makes it possible for baby Olivia to receive early intervention and physical therapy services to enhance and accelerate her development.

Olivia's mom is terrified that if Trumpcare passes, her daughter may not be able to receive these services, which help her remain healthy and make it possible for her to reach critical developmental milestones.

Republicans like to call Obamacare a failed disaster. That is simply one more example of their ''alternative facts.''

The Republican Trumpcare bill before us is the disaster waiting to unfold for countless families like Olivia's, and millions of Americans across our country.

I urge my colleagues to vote no on behalf of the American people.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in strong opposition to H.R. 1628, the American Health Care Act, which not only seeks to repeal the Patient Protection and Affordable Care Act, but reform entitlements, redistribute wealth, and strip coverage from millions of people.

The American Health Care Act would reduce coverage for Americans while increasing out-of-pocket costs for the sickest and the elderly. Health plans would fail to meet the needs of Americans with chronic or complex conditions. The bill also eliminates protections against annual and lifetime caps. With a last-minute manager's amendment to repeal the Essential Health Benefits, the ten coverage rules set up by the Affordable Care Act, this ruthless bill has gotten even worse.

The Affordable Care Act required insurers to cover ten ''Essential Health Benefits'' from maternity care, mental health, and prescription drugs, to hospitalization and outpatient care. If this is repealed, comprehensive health insurance will become virtually unavailable in the individual market. This means that individuals with pre-existing conditions would not be protected. Younger and healthier people benefit, older and sicker people suffer.

While the new additions to this measure are startling, the original bill is just as shocking. Slashing and capping the Medicaid program will ration care and give tax breaks to the wealthy. This bill cuts $880 million from Medicaid and then caps the program so that it cannot expand and contract as needed. By the end of 2019, the Medicaid expansion program will freeze and this bill will shift costs to states for the elderly, children, individuals with disabilities, and low-income adults.

This bill will kick 24 million people off their health insurance by 2026, and 7 million people will lose their employer-based coverage. While the Affordable Care Act subsidies were based on income and when premiums rose, the federal subsidy also rose to pay for premium costs, the American Health Care Act replaces those subsidies with a fixed credit amount. The age-based tax credits are a refundable tax credits that is larger for older individuals, however, it allows insurers to charge older enrollees five times more than a younger enrollee.

Mr. Speaker, the public has spoken about this so-called ''replacement'' bill. People will live or die as a result of this legislation. This bill will force Americans to pay more for their premiums, more for their care, more on out-of-pocket expenses and deductibles; all the while giving tax breaks directly to the wealthy. The Republican leadership has rushed this bill to the floor without any consideration and I urge you all to consider its harmful effects. Your constituents are asking you to work with us to repair the Affordable Care Act. Work with us.

Mr. AL GREEN of Texas. Mr. Speaker, although Trumpcare is a terrible Healthcare plan, it is a terrific Wealthcare plan.

Trumpcare is terrific Wealthcare because in the final analysis, it allows the 400 richest families to get $7 million a year ad infinitum, $7 million a year forever.

In the final analysis, 79% of the cuts become Wealthcare dollars for the very rich, not healthcare dollars for the very poor.

In the final analysis, it sacrifices $1 trillion from Medicare and Medicaid to enrich the lives of millionaires and billionaires.

In the final analysis, it provides more money for Wealthcare and less money for Healthcare.

Mr. Speaker, Trumpcare is more Wealthcare and less Healthcare.

Mr. CONYERS. Mr. Speaker, I've been here a while and it's hard for me to recall a time when we've voted on something so obviously and willfully harmful to children, seniors and working Americans.

This bill strips healthcare from 24 million people.

It requires some seniors to pay 100 percent or more of their income in premiums.

This legislation dramatically cuts Medicaid, directly contradicting President Trump's claim not to.

In Michigan, HALF of all children rely on Medicaid.

In my district alone, 56,000 people will lose coverage, including 16,000 children.

Let's be clear: if we pass this bill, children, seniors, and working people will suffer and some will die, so that the wealthy can get a tax cut.

Healthcare is a right, not a privilege. That's why I support a single-payer, Medicare-for-All plan, and why I will be voting ''no'' on this mean spirited legislation.

Mr. Speaker, as Ranking Member on the House Judiciary Committee, I include in the RECORD a legal analysis prepared by committee staff that concludes that the provision of H.R. 1628 that requires New York State to change how its counties fund the State's portion of Medicaid expenses is not related to a legitimate Federal interest, that no rational Federal purpose has been proffered for the provision, and that it would severely intrude on traditional state prerogatives. As such, this provision would violate Constitutional limits on the Federal Spending Power, the Due Process and Equal Protection Clauses and the Tenth Amendment (reserving all undelegated powers to the States) and would likely be held unconstitutional if challenged in court.

MEMORANDUM

To: Interested Members.

From: House Judiciary Committee Democratic Staff.

Re: Constitutionality of Faso-Collins Amendment.

Date: March 24, 2017.

The Faso-Collins amendment, incorporated into the Manager's amendment, would violate Constitutional limits on the Federal Spending Power, the Due Process and Equal Protection Clauses and the Tenth Amendment (reserving all undelegated powers to the States). Requiring New York State to change how its counties Fund its portion of Medicaid expenses is not related to a legitimate Federal interest, no rational Federal purpose has been proffered for the provision, and it would severely intrude on traditional state prerogatives.

If the Faso-Collins amendment were ever enacted, it quickly would be invalidated by the Federal courts. The irony of this ''buyout'' is that the ''payment'' supposedly being delivered in exchange for votes—the unconstitutional provision—is the legislative equivalent of a check on a closed bank account, which will never deliver the promised benefits.

For the last 51 years, New York State has chosen to fund a portion of its share of the Medicaid Program by using funds from county property taxes. Fifteen other States structure Medicaid funding through a similar legally authorized system.

The Faso-Collins amendment specifies that any State that had an allotment of Disproportionate Share Hospital (DSH) funds that was more than 6 times the national average, and that requires subdivisions with populations of less than 5,000,000 to contribute toward Medicaid costs, shall have its reimbursement reduced by the amount of contributions by such subdivisions. (This effectively limits the application to New York State, and carves out New York City.) Under the amendment, New York State is at risk of losing $2.3 billion of its $32 billion in Federal Medicaid funds.

This provision is unconstitutional, and could be struck down for several reasons:

Violation of Limits on Spending Power—Article I of the Constitution grants Congress spending power to ''provide for the . . . general Welfare.'' In South Dakota v. Dole, 483 U.S. 203 (1987), the Supreme Court held that any spending condition imposed on the States must be related to the Federal interest in that particular project or program and that Congress cannot coerce the States into compliance with the Federal government's objectives. In NFIB v. Sebelius, 132 S. Ct. 2566 (2012), the Supreme Court found provisions of the Affordable Care Act which required all States to comply with the law's Medicaid expansion violated this spending authority, noting the ''Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress' instructions.'' The Faso-Collins language does not appear to be related to any Federal interest in the use or allocation of Federal Medicaid funds: it does not further Medicaid's purposes and has nothing to do with ensuring the proper disbursement of Federal funds. Indeed, because the provision applies to counties in a single State—and leaves the very same system undisturbed in 15 other States—it could not possibly be justified by any legitimate Federal interest.

An additional line of Supreme Court cases, including *New York* v. *United States*, 505 U.S. 144, 167, 172 (1992), has held that conditions on Federal grants must be ''reasonably related to the purpose of the [Federal] expenditure'' because otherwise ''the spending power could render academic the Constitution's other grants and limits of Federal authority.'' Likewise, in *Massachusetts* v. *United States*, 435 U.S. 444, 461 (1978), the Supreme Court noted that it has ''repeatedly held that the Federal Government may impose appropriate conditions on the use of Federal property or privileges and may require that State instrumentalities comply with conditions that are reasonably related to the Federal interest in particular national projects or programs.'' Under these precedents, the Faso-Collins language would be held to be an arbitrary exercise of Federal power which intrudes on only one particular State's sovereign tax powers, and is unrelated to any Federal interest or purpose in the Medicaid Program.

As Yale Law School Professor Abbe Gluck wrote in a post on the Balkinzation blog today, the Faso-Collins ''amendment is likely unconstitutional. The protection from federal interference of the internal functions of a state government is one of the bedrocks of state sovereignty protected by the limitations on Congress's powers in Article I of the Constitution and the reservation of power to the states in the Tenth Amendment.'' She further reasoned that ''Even if one could argue that this is an exercise of the federal spending power under Article I, for Congress to legally use that power, the conditions on a state's use of federal funding have to be tied to a reasonable federal propose . . . It is hard to see a reasonable federal purpose here other than garnering more GOP votes for the struggling repeal bill.'' (available at https://ballkin.blogspot. com/2017/03/ is-gop-aca-repealer- unconstitutional- on.html?m=1)

Violation of Due Process and Equal Protection—Under the Fifth Amendment, the Federal government is not permitted to deprive its citizens of equal protection or due process of law. Those clauses have been interpreted on numerous occasions to prevent the government from discriminating between the treatment of the sovereign States absent a rational basis. For example, in *Helvering* v. *David*, 301 U.S. 619, 640 (1937), the Supreme Court warned that Congress does not possess the right to demonstrate a ''display of arbitrary power'' in its treatment of the various States. In this regard, in 2009, when an earlier Senate version of the Affordable Care Act sought to provide special treatment for Nebraska with respect to Medicaid reimbursements, 13 Republican State attorneys general wrote to Congress (available at http://www.law. columbia.edu/sites/ default/files/microsites/ career-servicesifiles/ Letter%20to% 20the%20 Honorable%20Nancy %20Pelosi%20 and%20the %20Honorable%20Harry %20Reid.pdf) asserting the provision was unconstitutional (the provision was ultimately dropped). In the case of the Faso-Collins language, there is no legitimate policy justification for developing a special rule limiting Medicaid funds for New York as compared to all other States, including 15 States which have sharing agreements with their counties. Nor has a justification been offered for why New York City should be excluded from the application of the special rule. As such, it is clear that the provision is discriminatory, ''arbitrary'' and has no rational basis.

Abrogation of Tenth Amendment Principles—The Tenth Amendment provides in relevant part that powers not delegated to the Federal government or prohibited to the States are reserved for the States. This has been read to prevent the federal government from ''commandeering'' the states to serve its own purposes. In Printz v. United States, 521 U.S. 898 (1997), the Supreme Court held that Congress cannot commandeer State officers to implement Federal policy—in that case requiring criminal background checks for handgun purchases pursuant to the Brady Handgun Violence Prevention Act. The Faso-Collins language commandeers New York State government to facilitate the partisan political ends of a faction in the U.S. Congress, which would seem well outside the proscriptions of Printz. In fact, by essentially ordering New York to reorganize its internal affairs, the Faso-Collins amendment may run even further afoul of Tenth Amendment principles than was the case in Printz given the lack of a Federal purpose and the interference with the core sovereign function of how a State chooses to use its taxing power.

It is of particular constitutional concern that the Faso-Collins provision directly interferes with New York's internal decisions about how to structure its own tax and spending policies, and how to allocate those responsibilities between the State and its subdivisions—which is a core function of a sovereign entity protected by the Tenth Amendment (and potentially Article IV §4 of the Constitution, which provides that the ''United States shall guarantee to every State in this Union a Republican Form of Government.''). This is constitutionally significant because in *Reynolds* v. *Sims*, 377 U.S. 533, 575 (1964), the Supreme Court held that political subdivisions such as counties and cities ''have been traditionally regarded as subordinate governmental instrumentalities created by the State to assist in the carrying

out of State governmental functions.'' In *Hunter* v. *City of Pittsburgh*, 207 U.S. 161, 178 (1907), the Court noted that these subdivisions are ''created as convenient agencies for exercising such of the governmental powers of the state, as may be entrusted to them'' and that the ''number, nature, and duration of powers conferred upon these [entities] and the territory over which they shall be exercised rests in the absolute discretion of the state.'' The Faso-Collins amendment purports to invoke Federal power to displace New York's sovereign exercise of this ''absolute discretion'' and, for that reason, violates the Constitution. As Chief Justice John Marshall long ago explained in *Gibbons* v. *Ogden*, 22 U.S. 1, 198–200 (1824), the States' ''power of taxation is indispensable to their existence. . . . In imposing taxes for State purposes, [States] are not doing what Congress is empowered to do. Congress is not empowered to tax for those purposes which are within the exclusive province of the States.''

OFFICE OF THE ATTORNEY GENERAL,
STATE OF SOUTH CAROLINA,
December 30, 2009.

Hon. NANCY PELOSI,
Speaker, House of Representatives, Washington, DC.
Hon. HARRY REID,
Majority Leader, U.S. Senate, Washington, DC.

The undersigned state attorneys general, in response to numerous inquiries, write to express our grave concern with the Senate version of the Patient Protection and Affordable Care Act (''H.R. 3590''). The current iteration of the bill contains a provision that affords special treatment to the state of Nebraska under the federal Medicaid program. We believe this provision is constitutionally flawed. As chief legal officers of our states we are contemplating a legal challenge to this provision and we ask you to take action to render this challenge unnecessary by striking that provision.

It has been reported that Nebraska Senator Ben Nelson's vote, for H.R. 3590, was secured only after striking a deal that the federal government would bear the cost of newly eligible Nebraska Medicaid enrollees. In marked contrast all other states would not be similarly treated, and instead would be required to allocate substantial sums, potentially totaling billions of dollars, to accommodate H.R. 3590's new Medicaid mandates. In addition to violating the most basic and universally held notions of what is fair and just, we also believe this provision of H.R. 3590 is inconsistent with protections afforded by the United States Constitution against arbitrary legislation.

In Helvering v. Davis, 301 U.S 619, 640 (1937), the United States Supreme Court warned that Congress does not possess the right under the Spending Power to demonstrate a ''display of arbitrary power.'' Congressional spending cannot be arbitrary and capricious. The spending power of Congress includes authority to accomplish policy objectives by conditioning receipt of federal funds on compliance with statutory directives, as in the Medicaid program. However, the power is not unlimited and ''must be in pursuit of the 'general welfare.' '' South Dakota v. Dole, 483 U.S. 203, 207 (1987). In Dole the Supreme Court stated, ''that conditions on federal grants might be illegitimate if they are unrelated to the federal interest in particular national projects or programs.'' Id. at 207. It seems axiomatic that the federal interest in H.R. 3590 is not simply requiring universal health care, but also ensuring that the states share with the federal government the cost of providing such care to their citizens. This federal interest is evident from the fact this legislation would require every state, except Nebraska, to shoulder its fair share of the increased Medicaid costs the bill will generate. The provision of the bill that relieves a single state from this cost-sharing program appears to be not only unrelated, but also antithetical to the legitimate federal interests in the bill.

The fundamental unfairness of H.R. 3590 may also give rise to claims under the due process, equal protection, privileges and immunities clauses and other provisions of the Constitution. As a practical matter, the deal struck by the United States Senate on the ''Nebraska Compromise'' is a disadvantage to the citizens of 49 states. Every state's tax dollars, except Nebraska's, will be devoted to cost-sharing required by the bill, and will be therefore unavailable for other essential state programs. Only the citizens of Nebraska will be freed from this diminution in state resources for critical state services. Since the only basis for the Nebraska preference is arbitrary and unrelated to the substance of the legislation, it is unlikely that the difference would survive even minimal scrutiny.

We ask that Congress delete the Nebraska provision from the pending legislation, as we prefer to avoid litigation. Because this provision has serious implications for the country and the future of our nation's legislative process, we urge you to take appropriate steps to protect the Constitution and the rights of the citizens of our nation. We believe this issue is readily resolved by removing the provision in question from the bill, and we ask that you do so.

By singling out the particular provision relating to special treatment of Nebraska, we do not suggest there are no other legal or constitutional issues in the proposed health care legislation.

Please let us know if we can be of assistance as you consider this matter.

Sincerely,

Henry McMaster, Attorney General, South Carolina; Rob McKenna, Attorney General, Washington; Mike Cox, Attorney General, Michigan; Greg Abbott, Attorney General, Texas; John Suthers, Attorney General, Colorado; Troy King, Attorney General, Alabama; Wayne Stenehjem, Attorney General, North Dakota; Bill Mims, Attorney General, Virginia; Tom Corbett, Attorney General, Pennsylvania; Mark Shurtleff, Attorney General, Utah; Bill McCollum, Attorney General, Florida; Lawrence Wasden, Attorney General, Idaho; Marty Jackley, Attorney General, South Dakota.

Mr. NADLER. Mr. Speaker, for seven years, the Republicans have tried and failed to repeal the Affordable Care Act. So now, with a Republican-controlled House, a Republican-controlled Senate, and a Republican in the White House, what have they presented us to vote on today? Republicans complained that premiums were skyrocketing, so they offer a bill that raises premiums. They complained that deductibles were too high, so they propose allowing insurance companies to charge more. They complained that too many people were losing their insurance, so they have embraced a plan that will take away health care from 24 million Americans.

This bill imposes a devastating age tax on older Americans and does next to nothing to protect Americans with pre-existing conditions. It gives nearly $900 billion in tax cuts to the insurance companies and the wealthy, while refusing coverage for services as basic as hospitalization. It's simple: Americans will pay more and get less under this bill.

In New York, 2.7 million people will lose insurance and the state will lose $4.6 billion in Medicaid funding. Compounding those cuts is a cynical so-called deal several upstate Members made to secure their votes on this bill. Under the bill, New York State, and ONLY New York State, will no longer be allowed to ask counties to provide a portion of state Medicaid funding.

Don't be fooled—this is no deal at all for New York and will actually gut the State's Medicaid program, forcing hundreds of hospitals to close and rationing health care for millions of New Yorkers.

But my colleagues who have traded their vote for this provision have made an empty bargain. This provision is flatly unconstitutional and will never be enacted. They are giving away health insurance for millions of New Yorkers for an empty promise.

My Republican colleagues claim we need to pass this bill to give people ''freedom'' to buy health insurance. Let me tell you, freedom to buy health insurance and actually being able to afford health insurance are two very different things.

They keep talking about ''access'' to health care. Access is not coverage. When they talk about access and freedom, they are conceding that this bill does nothing to ensure that Americans have affordable, comprehensive health insurance to cover them no matter what their health care needs are.

The Republicans so clearly believe that Americans just need freedom to buy insurance, that when asked what a pregnant woman should do if her state no longer requires insurance companies to cover maternity care, OMB Director Mick Mulvaney said she can ''figure out a way to change the state [she] lives in.'' How callous are my Republican colleagues to believe that is a real option for Americans?

This bill is a cowardly, cynical effort to lower taxes on the rich and dismantle Medicare and Medicaid as we know it. I urge my colleagues to oppose this bill.

The SPEAKER pro tempore. Pursuant to clause 1(c) of rule XIX, further consideration of H.R. 1628 is postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 3 o'clock and 31 minutes p.m.), the House stood in recess.

□ 1630

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. HOLDING) at 4 o'clock and 30 minutes p.m.

TERRORIST AND FOREIGN FIGHTER TRAVEL EXERCISE ACT OF 2017

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the unfinished business is the question on suspending the rules and passing the bill (H.R. 1302) to require an exercise related to terrorist and foreign fighter travel, and for other purposes.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Arizona (Ms. MCSALLY) that the House suspend the rules and pass the bill.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill was passed.

A motion to reconsider was laid on the table.

ADJOURNMENT FROM FRIDAY, MARCH 24, 2017, TO MONDAY, MARCH 27, 2017

Mr. BERGMAN. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet on Monday, March 27, 2017, when it will convene at noon for morning-hour debate and 2 p.m. for legislative business.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. PAYNE (at the request of Ms. PELOSI) for March 23 on account of medical condition.

PUBLICATION OF BUDGETARY MATERIAL

AGGREGATES, ALLOCATIONS, AND OTHER BUDGETARY LEVELS OF THE FISCAL YEAR 2017 BUDGET RESOLUTION RELATED TO LEGISLATION REPORTED BY THE COMMITTEE ON THE BUDGET

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC, March 24, 2017.

Mr. Speaker, pursuant to section 4001(b)(2) of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3, 115th Congress), I hereby submit for printing in the Congressional Record the 302(a) allocations to the authorizing committees of the House consistent with that concurrent resolution.

Section 4001(b)(2) of S. Con. Res. 3 authorized the House Committee on the Budget to file 302(a) allocations consistent with the budgetary levels established in S. Con. Res. 3. This filing authority was necessary because there was no joint statement of managers accompanying S. Con. Res. 3. Under section 301(e)(2)(F) of the Congressional Budget Act of 1974, the allocations are to be included in the report accompanying the budget resolution.

These allocations are enforced by section 302(f) of the Congressional Budget Act of 1974, which prohibits the consideration of legislation that would cause the applicable allocation of new budget authority to be exceeded for the budget year, fiscal year 2017, or for the total period of fiscal years 2017 through 2026.

These aggregates, allocations, and other budgetary levels apply to bills, joint resolutions, and amendments thereto or conference reports thereon, considered by the House subsequent to this filing.

Associated tables are attached. If there are any questions on these aggregates, allocations, and other budgetary levels in the concurrent resolution on the budget for fiscal year 2017, please contact Jim Bates, Chief Counsel of the Budget Committee.

Sincerely,

DIANE BLACK,
Chairman, Committee on the Budget.

FISCAL YEAR 2017 BUDGET TOTALS

(On-budget amounts, in millions of dollars)

	FY 2017	2017–2026
Appropriate Level		
Budget Authority	3,308,000	n.a.
Outlays	3,264,662	n.a.
Revenues	2,682,088	32,351,660

n.a. = Not applicable because annual appropriations acts for fiscal years 2019–2026 will not be considered until future sessions of Congress.

SPENDING AUTHORITY FOR HOUSE AUTHORIZING COMMITTEES

(On-budget amounts, in millions of dollars)

		FY 2017	2017–2026
Agriculture:			
Current Law	BA	17,118	716,540
	OT	16,788	707,615
Resolution Change	BA	0	0
	OT	0	0
Total	BA	17,118	716,540
	OT	16,788	707,615
Armed Services:			
Current Law	BA	158,746	1,842,682
	OT	159,079	1,839,456
Resolution Change	BA	0	0
	OT	0	0
Total	BA	158,746	1,842,682
	OT	159,079	1,839,456
Financial Services:			
Current Law	BA	13,125	100,422
	OT	1,652	−47,968
Resolution Change	BA	0	0
	OT	0	0
Total	BA	13,125	100,422
	OT	1,652	−47,968
Education & Workforce:			
Current Law	BA	383	49,072
	OT	−5,026	18,899
Resolution Change	BA	0	0
	OT	0	0
Total	BA	383	49,072
	OT	−5,026	18,899
Energy & Commerce:			
Current Law	BA	457,733	6,015,424
	OT	447,493	6,015,912
Resolution Change	BA	0	−1,000
	OT	0	−1,000
Total	BA	457,733	6,014,424
	OT	447,493	6,014,912
Foreign Affairs:			
Current Law	BA	36,154	310,990
	OT	30,599	295,396
Resolution Change	BA	0	0
	OT	0	0
Total	BA	36,154	310,990
	OT	30,599	295,396
Oversight & Government Reform:			
Current Law	BA	118,066	1,359,052
	OT	116,351	1,324,818
Resolution Change	BA	0	0
	OT	0	0
Total	BA	118,066	1,359,052
	OT	116,351	1,324,818
Homeland Security:			
Current Law	BA	2,392	24,890
	OT	2,217	25,797
Resolution Change	BA	0	0
	OT	0	0

SPENDING AUTHORITY FOR HOUSE AUTHORIZING COMMITTEES—Continued

(On-budget amounts, in millions of dollars)

		FY 2017	2017–2026
Total	BA	2,392	24,890
	OT	2,217	25,797
House Administration:			
Current Law	BA	38	341
	OT	9	106
Resolution Change	BA	0	0
	OT	0	0
Total	BA	38	341
	OT	9	106
Natural Resources:			
Current Law	BA	5,503	60,044
	OT	5,826	62,006
Resolution Change	BA	0	0
	OT	0	0
Total	BA	5,503	60,044
	OT	5,826	62,006
Judiciary:			
Current Law	BA	27,330	134,953
	OT	13,561	142,304
Resolution Change	BA	0	0
	OT	0	0
Total	BA	27,330	134,953
	OT	13,561	142,304
Transportation & Infrastructure:			
Current Law	BA	74,386	733,930
	OT	16,301	175,727
Resolution Change	BA	0	0
	OT	0	0
Total	BA	74,386	733,930
	OT	16,301	175,727
Science, Space & Technology:			
Current Law	BA	101	1,017
	OT	101	1,017
Resolution Change	BA	0	0
	OT	0	0
Total	BA	101	1,017
	OT	101	1,017
Small Business:			
Current Law	BA	0	0
	OT	0	0
Resolution Change	BA	0	0
	OT	0	0
Total	BA	0	0
	OT	0	0
Veterans Affairs:			
Current Law	BA	1,217	109,461
	OT	7,017	117,667
Resolution Change	BA	0	0
	OT	0	0
Total	BA	1,217	109,461
	OT	7,017	117,667
Ways & Means:			
Current Law	BA	1,058,819	15,224,020
	OT	1,057,533	15,218,580
Resolution Change	BA	0	−1,000
	OT	0	−1,000
Total	BA	1,058,819	15,223,020
	OT	1,056,533	15,217,580

PUBLICATION OF BUDGETARY MATERIAL

REVISIONS TO THE AGGREGATES AND ALLOCATIONS OF THE FISCAL YEAR 2017 BUDGET RESOLUTION

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC, March 24, 2017.

Mr. Speaker, I hereby submit for printing in the Congressional Record revisions to the budget allocations and aggregates established by S. Con. Res. 3, the Concurrent Resolution on the Budget for fiscal year 2017. S. Con. Res. 3 permits the Chairman of the Committee on the Budget to adjust the appropriate allocations, aggregates, and functional levels established by that resolution for legislation related to health care by the amounts provided in such legislation for that purpose.

These adjustments are designated for H.R. 1628, the American Health Care Act of 2017, as reported by the Committee on the Budget on Monday, March 20, 2017.

These revisions represent an adjustment for purposes of budgetary enforcement. These revised allocations and aggregates are to be considered as the aggregates and allocations established in the budget resolution, pursuant to S. Con. Res. 3. Pursuant to section 4003 of S. Con. Res. 3, the adjustments apply only while H.R. 1628 is under consideration or upon its enactment.

Sincerely,

DIANE BLACK,
Chairman,
Committee on the Budget.

TABLE 1—REVISION TO ON-BUDGET AGGREGATES

[Budget aggregates—(On-budget amounts, in millions of dollars)]

	Fiscal year	
	2017	2017–2026
Current Aggregates:		
Budget Authority	3,308,000	[1]
Outlays	3,264,662	[1]
Revenues	2,682,088	32,351,660
Adjustment for H.R. 1628:		
Budget Authority	−6,300	[1]
Outlays	−6,700	[1]
Revenues	−6,600	−893,500
Revised Aggregates:		
Budget Authority	3,301,700	[1]
Outlays	3,257,962	[1]
Revenues	2,675,488	31,458,160

[1] Not applicable because annual appropriations acts for fiscal years 2019–2026 will not be considered until future sessions of Congress.

TABLE 2—REVISION TO COMMITTEE ALLOCATIONS *

[Authorizing committee 302(a) allocations—(On-budget amounts, in millions of dollars)]

House Energy and Commerce	2017		2017–2026 Total	
	Budget authority	Outlays	Budget authority	Outlays
Current Allocation	457,733	447,493	6,014,424	6,014,912
Adjustment for H.R. 1628	−6,300	−6,700	−1,202,800	−1,216,600
Revised Allocation	451,433	440,793	4,811,624	4,798,312

*The score for H.R. 1628 does not allocate the changes in direct spending by committee. For purposes of this adjustment, the changes to direct spending are allocated to the House Energy and Commerce Committee.

BILL PRESENTED TO THE PRESIDENT

Karen L. Haas, Clerk of the House, reported that on March 23, 2017, she presented to the President of the United States, for his approval, the following bill:

H.R. 1228. To provide for the appointment of members of the Board of Directors of the Office of Compliance to replace members whose terms expire during 2017, and for other purposes.

ADJOURNMENT

Mr. BERGMAN. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 4 o'clock and 31 minutes p.m.), under its previous order, the House adjourned until Monday, March 27, 2017, at noon for morning-hour debate.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of rule XIV, executive communications were taken from the Speaker's table and referred as follows:

914. A letter from the General Counsel, Federal Housing Finance Agency, transmitting the Agency's final rule — Minority and Women Outreach Program (RIN: 2590-AA87) received March 23, 2017, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Financial Services.

915. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Exclusive Economic Zone Off Alaska; Exchange of Flatfish in the Bering Sea and Aleutian Islands Management Area [Docket No.: 150916863-6211-02] (RIN: 0648-XE878) received March 23, 2017, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

916. A letter from the Acting Director, Office of Sustainable Fisheries, NMFS, National Oceanic and Atmospheric Administration, transmitting the Administration's temporary rule — Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; 2016 Commercial Accountability Measures and Closure for South Atlantic Greater Amberjack [Docket No.: 100812345-2142-03]) (RIN: 0648-XE896) received March 23, 2017, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

917. A letter from the Acting DDA for Regulatory Programs, NMFS, Office of Protected Resources, National Oceanic and Atmospheric Administration, transmitting the Administration's final rule — Taking and Importing Marine Mammals; Taking Marine Mammals Incidental to Russian River Estuary Management Activities [Docket No.: 160929897-7222-02] (RIN: 0648-BG37) received March 23, 2017, pursuant to 5 U.S.C. 801(a)(1)(A); Public Law 104-121, Sec. 251; (110 Stat. 868); to the Committee on Natural Resources.

REPORTS OF COMMITTEES ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. SESSIONS: Committee on Rules. House Resolution 228. Resolution providing for consideration of the bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017 (Rept. 115–58). Referred to the House Calendar.

Mr. SMITH of Texas: Committee on Science, Space, and Technology. H.R. 1430. A bill to prohibit the Environmental Protection Agency from proposing, finalizing, or disseminating regulations or assessments based upon science that is not transparent or reproducible (Rept. 115–59). Referred to the Committee of the Whole House on the state of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions of the following titles were introduced and severally referred, as follows:

By Mr. BROOKS of Alabama:

H.R. 1718. A bill to repeal the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010; to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and the Workforce, Natural Resources, the Judiciary, House Administration, Rules, and Appropriations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. DESAULNIER (for himself, Mr. KING of New York, Mr. POLIS, Mr. MCGOVERN, Ms. ESHOO, Mr. LANGEVIN, Mr. LOWENTHAL, Ms. MATSUI, Mrs. NAPOLITANO, Mr. HUFFMAN, Mr. SWALWELL of California, Mr. BEYER, Mr. POCAN, Mr. SCHIFF, Mr. CARTWRIGHT, Ms. SPEIER, and Mr. GARAMENDI):

H.R. 1719. A bill to authorize the Secretary of the Interior to acquire approximately 44 acres of land in Martinez, California, and for other purposes; to the Committee on Natural Resources.

By Mr. KING of New York (for himself and Mr. PASCRELL):

H.R. 1720. A bill to amend the Internal Revenue Code of 1986 to modify the rules applicable to length of service award plans; to the Committee on Ways and Means.

By Mr. ROUZER:

H.R. 1721. A bill to direct the Secretary of Veterans Affairs to designate at least one city in the United States each year as an ''American World War II City'', and for other purposes; to the Committee on Veterans' Affairs.

By Mr. AUSTIN SCOTT of Georgia (for himself, Mr. DUNCAN of South Carolina, Mr. GOSAR, Mrs. COMSTOCK, Mr. STEWART, Mr. HARPER, Mr. CALVERT, Mr. SCHWEIKERT, Mr. FLEISCHMANN, Mr. GOHMERT, Mr. LAMALFA, Mr. GRAVES of Georgia, Mr. BABIN, Mr. FARENTHOLD, Mr. LOUDERMILK, Mr. FLORES, Mr. YOHO, Mrs. BLACKBURN, Mr. HUIZENGA, Mr. KELLY of Pennsylvania, Mr. FERGUSON, Mr. CARTER of Georgia, Mr. GIBBS, Mr. OLSON, and Mr. ALLEN):

H.R. 1722. A bill to amend the National Labor Relations Act to modify the authority of the National Labor Relations Board with respect to rulemaking, issuance of complaints, and authority over unfair labor practices; to the Committee on Education and the Workforce.

By Mr. TAKANO (for himself and Mr. CONYERS):

H.R. 1723. A bill to amend the Federal Election Campaign Act of 1971 to provide for a limitation on the time for the use of contributions or donations, and for other purposes; to the Committee on House Administration.

By Mr. TAKANO (for himself, Mr. ELLISON, Mr. MCGOVERN, Ms. SCHAKOWSKY, Ms. MOORE, Ms. NORTON, Mr. COHEN, Mr. GRIJALVA, and Mr. NADLER):

H.R. 1724. A bill to amend title V of the Omnibus Crime Control and Safe Streets Act of 1968 to prohibit Edward Byrne Memorial Justice Assistance Grants from being made available to a State or unit of local government that has a contract with a person that charges a fee to pay-only probationers, and for other purposes; to the Committee on the Judiciary.

By Mr. WALZ (for himself, Mr. DENHAM, Mr. LANGEVIN, Ms. MCSALLY, Mr. JOHNSON of Ohio, Mr. COSTELLO of Pennsylvania, and Ms. KUSTER of New Hampshire):

H.R. 1725. A bill to amend title 38, United States Code, to improve the treatment of medical evidence provided by non-Department of Veterans Affairs medical professionals in support of claims for disability compensation under the laws administered by the Secretary of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 7 of rule XII of the Rules of the House of Representatives, the following statements are submitted regarding the specific powers granted to Congress in the Constitution to enact the accompanying bill or joint resolution. firm.

By Mr. BROOKS of Alabama:

H.R. 1718.

Congress has the power to enact this legislation pursuant to the following:

Article 1 of the United States Constitution.

By Mr. DESAULNIER:

H.R. 1719.

Congress has the power to enact this legislation pursuant to the following:

Article 1, Section 8.

By Mr. KING of New York:

H.R. 1720.

Congress has the power to enact this legislation pursuant to the following:

Article I, Section 8, Clause 1

The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States.

By Mr. ROUZER:

H.R. 1721.

Congress has the power to enact this legislation pursuant to the following:

Article I Section 8

This bill is enacted pursuant to the power granted to Congress under Article I, Section 8, of the US Constitution

By Mr. AUSTIN SCOTT of Georgia:

H.R. 1722.

Congress has the power to enact this legislation pursuant to the following:

Article 1, Section 8 of the United States Constitution.

By Mr. TAKANO:

H.R. 1723.

Congress has the power to enact this legislation pursuant to the following:

Article 1, Section 8 of the Constitution of the United States.

By Mr. TAKANO:

H.R. 1724.

Congress has the power to enact this legislation pursuant to the following:

Article 1, Section 8 of the Constitution of the United States.

By Mr. WALZ:

H.R. 1725.

Congress has the power to enact this legislation pursuant to the following:

Clause 18 of Section 8 of Article 1 of the Constitution.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions, as follows:

H.R. 24: Mr. ARRINGTON.

H.R. 44: Mr. FRANCIS ROONEY of Florida.

H.R. 80: Mr. ARRINGTON.

H.R. 82: Mr. ARRINGTON and Mr. MCKINLEY.

H.R. 112: Ms. WASSERMAN SCHULTZ.

H.R. 136: Ms. ROS-LEHTINEN.

H.R. 175: Mr. JOHNSON of Louisiana.

H.R. 299: Mr. CAPUANO, Ms. BARRAGÁN, Mr. CRIST, Mr. LAWSON of Florida, and Mr. RICHMOND.

H.R. 305: Mr. AMASH.

H.R. 402: Mr. VISCLOSKY.

H.R. 489: Mr. EVANS.

H.R. 502: Mr. GOTTHEIMER, Mr. KIHUEN, Mr. CAPUANO, Ms. SINEMA, Ms. BORDALLO, and Mrs. TORRES.

H.R. 579: Mr. MEEKS.

H.R. 580: Mr. RUSH, Mr. LOEBSACK, Ms. NORTON, Ms. LEE, Mrs. DINGELL, Ms. JACKSON LEE, Mr. KILDEE, and Ms. WILSON of Florida.

H.R. 749: Mr. SCHNEIDER.

H.R. 786: Mr. ELLISON.

H.R. 804: Mr. COURTNEY.

H.R. 825: Mrs. LOVE.

H.R. 828: Mr. LONG.

H.R. 846: Mrs. BEATTY, Ms. KAPTUR, Mr. SMUCKER, Ms. LOFGREN, Mr. COSTELLO of Pennsylvania, Mrs. HARTZLER, Mr. DEFAZIO, Mr. LARSEN of Washington, Mr. ROGERS of Alabama, Mr. SMITH of Texas, and Ms. KUSTER of New Hampshire.

H.R. 849: Mr. COOK and Mrs. WALORSKI.

H.R. 873: Mr. O'ROURKE and Mr. MCGOVERN.

H.R. 896: Mr. PETERSON.

H.R. 909: Ms. BARRAGÁN.

H.R. 918: Mr. LOEBSACK.

H.R. 1002: Mr. UPTON.

H.R. 1017: Mr. HECK.

H.R. 1057: Mr. STIVERS, Mr. BISHOP of Georgia, Mrs. BLACK, Mr. CÁRDENAS, and Mr. BUTTERFIELD.

H.R. 1090: Mr. STIVERS and Mr. HIGGINS of New York.

H.R. 1098: Mr. LONG.

H.R. 1111: Mrs. CAROLYN B. MALONEY of New York.

H.R. 1154: Mr. YOUNG of Alaska, Mr. ROKITA, and Mr. WITTMAN.

H.R. 1155: Mr. BLUMENAUER.

H.R. 1159: Mr. LIPINSKI, Mr. POSEY, and Mr. ROKITA.

H.R. 1168: Mr. RASKIN.

H.R. 1169: Ms. GABBARD.

H.R. 1223: Mr. FORTENBERRY and Mr. HUFFMAN.

H.R. 1239: Mr. KIND.

H.R. 1279: Mr. JONES.

H.R. 1299: Mr. BEYER.

H.R. 1317: Mr. OLSON.

H.R. 1318: Mr. BISHOP of Georgia, Ms. SPEIER, and Mr. BLUMENAUER.

H.R. 1334: Mr. COLLINS of Georgia and Mr. SESSIONS.

H.R. 1370: Mr. FITZPATRICK.

H.R. 1405: Mr. PETERS, Mr. POCAN, and Mr. EVANS.

H.R. 1407: Mrs. HARTZLER.

H.R. 1421: Mr. KENNEDY and Mr. PETERSON.

H.R. 1438: Mr. SIRES.

H.R. 1452: Mr. EVANS.

H.R. 1465: Mr. WESTERMAN.

H.R. 1481: Mrs. COMSTOCK.

H.R. 1511: Mrs. BEATTY.

H.R. 1513: Mr. PASCRELL.

H.R. 1552: Mr. ABRAHAM, Mr. HARPER, Mr. FRANKS of Arizona, Mr. BROOKS of Alabama, Mr. GROTHMAN, and Mr. CALVERT.

H.R. 1562: Ms. SHEA-PORTER.

H.R. 1569: Mr. MCGOVERN.

H.R. 1596: Mr. WELCH and Mr. CAPUANO.

H.R. 1600: Mr. BISHOP of Georgia.

H.R. 1614: Ms. LEE and Mr. GRIJALVA.

H.R. 1626: Mr. WESTERMAN, Mr. OLSON, and Mr. BISHOP of Georgia.

H.R. 1661: Mr. YOUNG of Alaska, Mr. MARCHANT, and Ms. BROWNLEY of California.

H.R. 1676: Mr. KINZINGER.

H.R. 1697: Mr. GOTTHEIMER and Mr. BRADY of Pennsylvania.

H.J. Res. 74: Mr. YARMUTH.

H. Con. Res. 8: Mr. ARRINGTON.

H. Con. Res. 40: Mr. ABRAHAM.

H. Res. 15: Mr. RENACCI, Miss RICE of New York, Mr. NADLER, Mr. VEASEY, Mr. AMODEI, Mr. TED LIEU of California, Mr. CAPUANO, and Ms. KUSTER of New Hampshire.

H. Res. 90: Ms. CLARKE of New York.

H. Res. 92: Mr. Mr. PERRY, Mr. FERGUSON, Mr. SCHIFF, and Mr. PETERS.

H. Res. 128: Mr. BRADY of Pennsylvania, Mrs. BEATTY, Ms. LEE, Mr. BEYER, Ms. NORTON, Mr. WOODALL, Ms. JUDY CHU of California, and Mr. MCGOVERN.

H. Res. 178: Mr. MCGOVERN.

H. Res. 184: Mr. KIHUEN, Mr. SEAN PATRICK MALONEY of New York, Mr. RYAN of Ohio, Mr. KHANNA, Mr. CUMMINGS, Mr. VEASEY, Ms. TSONGAS, Mr. RUPPERSBERGER, Mr. NADLER, and Mr. MCEACHIN.

H. Res. 202: Mr. BARR and Mr. PERLMUTTER.

H. Res. 206: Mr. BYRNE, Mr. KENNEDY, Ms. STEFANIK, and Mr. JOHNSON of Georgia.

H. Res. 219: Mr. NOLAN.

H. Res. 220: Mr. CROWLEY.