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.

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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