

THE “INCREASING ACCESS TO LOWER PREMIUM PLANS
ACT OF 2018”

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

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

R E P O R T

[To accompany H.R. 6311]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6311) to amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to modify the definition of qualified health plan for purposes of the health insurance premium tax credit and to allow individuals purchasing health insurance in the individual market to purchase a lower premium copay plan, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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Mr. BRADY of Texas, from the Committee on Ways and Means,
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together with

DISSENTING VIEWS

[To accompany H.R. 6311]

The Committee on Ways and Means, to whom was referred the bill (H.R. 6311) to amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to modify the definition of qualified health plan for purposes of the health insurance premium tax credit and to allow individuals purchasing health insurance in the individual market to purchase a lower premium copay plan, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Increasing Access to Lower Premium Plans Act of 2018”.

SEC. 2. MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended—

(1) by inserting “(determined without regard to subparagraphs (A), (C)(ii), and (C)(iv) of paragraph (1) thereof and without regard to whether the plan is offered on an Exchange)” after “1301(a) of the Patient Protection and Affordable Care Act”, and

(2) by striking “shall not include” and all that follows and inserting “shall not include any health plan that—

 “(i) is a grandfathered health plan or a grandmothers health plan,
or

 “(ii) includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).”.

(b) DEFINITION OF GRANDMOTHERED HEALTH PLAN.—Section 36B(c)(3) of such Code is amended by adding at the end the following new subparagraph:

 “(C) GRANDMOTHERED HEALTH PLAN.—

 “(i) IN GENERAL.—The term ‘grandmothered health plan’ means health insurance coverage which is offered in the individual health insurance market as of October 1, 2013, and is permitted to be offered in such market after January 1, 2014, as a result of CCIIO guidance.

 “(ii) CCIIO GUIDANCE DEFINED.—The term ‘CCIIO guidance’ means the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified (including by a communication entitled ‘Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through 2019’ issued on April 9, 2018, by the Director of the Center for Consumer Information and Insurance Oversight of such Centers).

 “(iii) INDIVIDUAL HEALTH INSURANCE MARKET.—The term ‘individual health insurance market’ means the market for health insurance coverage (as defined in section 9832(b)) offered to individuals other than in connection with a group health plan (within the meaning of section 5000(b)(1)).”.

(c) CONFORMING AMENDMENT RELATED TO ABORTION COVERAGE.—Section 36B(c)(3) of such Code, as amended by subsection (b), is amended by adding at the end the following new subparagraph:

 “(D) CERTAIN RULES RELATED TO ABORTION.—

 “(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

 “(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of

any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

“(iii) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).”.

(d) CONFORMING AMENDMENTS RELATED TO OFF-EXCHANGE COVERAGE.—

(1) ADVANCE PAYMENT NOT APPLICABLE.—Section 1412 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

“(f) EXCLUSION OF OFF-EXCHANGE COVERAGE.—Advance payments under this section, and advance determinations under section 1411, with respect to any credit allowed under section 36B shall not be made with respect to any health plan which is not enrolled in through an Exchange.”.

(2) REPORTING.—Section 6055(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(3) INFORMATION RELATING TO OFF-EXCHANGE PREMIUM TAX CREDIT ELIGIBLE COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of a qualified health plan (as defined in section 36B(c)(3)) which is not enrolled in through an Exchange established under title I of the Patient Protection and Affordable Care Act, a return described in this subsection shall include—

“(A) a statement that such plan is a qualified health plan (as defined in section 36B(c)(3)),

“(B) the premiums paid with respect to such coverage,

“(C) the months during the calendar year for which such coverage is provided to the individual,

“(D) the adjusted monthly premium for the applicable second lowest cost silver plan (as defined in section 36B(b)(3)) for each such month with respect to such individual, and

“(E) such other information as the Secretary may prescribe.”.

(3) OTHER CONFORMING AMENDMENTS.—

(A) Section 36B(b)(2)(A) of such Code is amended by striking “and which were enrolled” and all that follows and inserting “, or”.

(B) Section 36B(b)(3)(B)(i) of such Code is amended by striking “the same Exchange” and all that follows and inserting “the Exchange through which such taxpayer is permitted to obtain coverage, and”.

(C) Section 36B(c)(2)(A)(i) of such Code is amended by striking “that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act”.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 2018.

(2) ADVANCE PAYMENT NOT APPLICABLE TO OFF-EXCHANGE COVERAGE.—The amendment made by subsection (d)(1) shall take effect on January 1, 2019.

(3) REPORTING.—The amendment made by subsection (d)(2) shall apply to coverage provided for months beginning after December 31, 2018.

SEC. 3. ALLOWING ALL INDIVIDUALS PURCHASING HEALTH INSURANCE IN THE INDIVIDUAL MARKET THE OPTION TO PURCHASE A LOWER PREMIUM COPPER PLAN.

(a) IN GENERAL.—Section 1302(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(e)) is amended—

(1) in paragraph (1)—

(A) by redesignating clauses (i) and (ii) of subparagraph (B) as subparagraphs (A) and (B), respectively, and adjusting the margins accordingly;

(B) by striking “plan year if—” and all that follows through “the plan provides—” and inserting “plan year if the plan provides—”; and

(C) in subparagraph (A), as redesignated by subparagraph (A), by striking “clause (ii)” and inserting “subparagraph (B)”;

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) RISK POOLS.—Section 1312(c)(1) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(c)(1)) is amended by inserting “and enrollees in catastrophic plans described in section 1302(e)” after “Exchange”.

(c) CONFORMING AMENDMENT.—Section 1312(d)(3)(C) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032(d)(3)(C)) is amended by striking “, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2)”.

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

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill H.R. 6311, as reported by the Committee on Ways and Means, provides an off-ramp from Obamacare’s rising premiums and limited choices by allowing the premium tax credit to be used for qualified plans offered outside of the law’s exchanges and Healthcare.gov. In addition, it expands access to the lowest-premium plans available (“catastrophic” plans) for all individuals purchasing coverage in the individual market and allows the premium tax credit to be used to offset the cost of such plans.

B. BACKGROUND AND NEED FOR LEGISLATION

Obamacare’s flawed policies have increased the cost of coverage in the individual market by 105 percent over 2013–2017 on average. As Republicans continue their efforts to reverse Obamacare’s damage, policies such as those included in this bill will help to lower premiums and increase choices for Americans.

Obamacare’s tax credits are only available to offset the cost of bronze, silver, gold, and platinum health care plans that are sold on the law’s government-run health insurance exchanges. Catastrophic plans are not eligible for the premium tax credit. In addition, catastrophic plans are only available to those under age 30 or those over age 30 that qualify for a hardship exemption.

C. LEGISLATIVE HISTORY

Background

H.R. 6311 was introduced on July 6, 2018 and was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

Committee action

The Committee on Ways and Means marked up H.R. 6311, the “Increasing Access to Lower Premium Plans Act of 2018,” on July 12, 2018, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

The policy issues associated with tax pertaining to health care and the ACA were discussed at the following Ways and Means hearings during the 114th and 115th Congresses:

- Full Committee Hearing on the Tax Treatment of Health Care (April 14, 2016)
- Subcommittee on Health Member Day Hearing on Tax-Related Proposals to Improve Health Care (May 17, 2016)
- Subcommittee on Health Hearing on Rising Health Insurance Premiums Under the Affordable Care Act (July 12, 2016)

- Subcommittee on Health Hearing on Lowering Costs and Expanding Access to Health Care through Consumer-Directed Health Plans (June 6, 2018)

II. EXPLANATION OF THE BILL

A. MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN

PRESENT LAW

In general

A refundable tax credit (the “premium assistance credit”) is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an American Health Benefit Exchange (“Exchange”), referred to as “qualified health plans.”¹ The premium assistance credit is generally payable in advance directly to the insurer, as discussed below. However, eligible individuals may choose to pay their total health insurance premiums out-of-pocket and claim the credit at the end of the taxable year.

Qualified health plans generally must meet certain requirements.² Special rules apply to certain qualified health plans, referred to as “catastrophic-only” qualified health plans, which are available only to individuals who are under age 30 or meet other specified requirements.³ The premium assistance credit is not available with respect to catastrophic-only qualified health plans.⁴ In addition, in the case of a qualified health plan that provides coverage for abortions for which Federal funds may not be used, no part of the premium assistance credit may be used for the portion of premiums attributable to that coverage.⁵

The premium assistance credit is generally available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level (“FPL”) for the family size involved. Household income is defined as the sum of: (1) the individual’s modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining the individual’s family size (but only if the other individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,⁶ (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the individual’s social security benefits not included in gross income.⁷ To be eligible for the premium assistance credit, individuals who are married must file a joint return. Individuals who are listed as

¹Sec. 36B. Section 36B was enacted as part of the Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111–148, and modified by the Healthcare and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111–152. PPACA and HCERA are referred to collectively as the Affordable Care Act (“ACA”).

²Secs. 1301 and 1302 of PPACA.

³Sec. 1302(e) of PPACA.

⁴Under the Public Health Service Act (“PHSA”) as amended by the ACA, health insurance must meet certain requirements. Section 1251 of PPACA excepts certain health plans sold at the time of enactment of PPACA from some of the PHSA requirements (“grandfathered” plans). The premium assistance credit is not available with respect to a grandfathered plan or plans that receive similar treatment under administrative guidance.

⁵Sec. 1303(b)(2) of PPACA.

⁶Sec. 911.

⁷Under section 86, only a portion of an individual’s social security benefits are included in gross income.

dependents on a return are not eligible for the premium assistance credit.

An individual who is eligible for minimum essential coverage from a source other than the individual insurance market generally is not eligible for the premium assistance credit.⁸ However, an individual who is offered minimum essential coverage under an employer-sponsored health plan may be eligible for the premium assistance credit if an employee's share of the premium for self-only coverage exceeds 9.56 percent (for 2018) of the employee's household income, or the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent of such costs (called "minimum value"), and the individual declines the employer-offered coverage. An individual who enrolls in an employer-sponsored health plan generally is ineligible for the premium assistance credit, even if the coverage is considered unaffordable or does not provide minimum value.

As part of the process of enrollment in a qualified health plan through an Exchange, an individual may apply and be approved in advance for a premium assistance credit.⁹ The individual must provide information on income, family size, changes in marital or family status or income, and citizenship or lawful presence status.¹⁰ Initial eligibility for the premium assistance credit is generally based on the individual's income for the tax year ending two years prior to the enrollment period. The Exchange process includes a system through which information provided by the individual is verified with the Internal Revenue Service ("IRS"), the Social Security Administration ("SSA") and the Department of Homeland Security ("DHS").¹¹ If an individual is approved for advance premium assistance payments, the Treasury pays the advance amount directly to the issuer of the health plan in which the individual is enrolled. The individual then pays to the issuer of the plan the difference between the advance payment amount and the total premium charged for the plan.

REASONS FOR CHANGE

The Committee believes that tax credits provided to offset the cost of health plans provided on government exchanges should also be available to offset the cost of similar health plans offered outside the government exchanges. This would expand the choices available to individuals and families and empower them to make decisions based on their specific needs and budgets.

⁸ Minimum essential coverage is defined in section 5000A(f).

⁹ Secs. 1411–1412 of PPACA. Under section 1402 of PPACA, certain individuals eligible for advance premium assistance payments are eligible also for a reduction in their share of medical costs, such as deductibles and copays, under the plan, referred to as reduced cost-sharing. Eligibility for reduced cost-sharing is also determined as part of the Exchange enrollment process. The Department of Health and Human Services ("HHS") is responsible for rules relating to Exchanges and the eligibility determination process.

¹⁰ Under section 1312(f)(3) of PPACA, an individual may not enroll in a qualified health plan through an Exchange if the individual is not a citizen or national of United States or an alien lawfully present in the United States. Thus, such an individual is not eligible for the premium assistance credit.

¹¹ Under section 6103, except as provided in the Code, returns and return information are confidential and may not be disclosed by the IRS, other Federal employees, State employees, and certain others having access to such information. Under section 6103(1)(21), upon written request of the Secretary of HHS, the IRS is permitted to disclose certain return information in connection with a determination through the Exchange process of an individual's eligibility for advance premium assistance payments, reduced cost-sharing, or certain other government-sponsored health programs.

Furthermore, the Committee believes that Federal assistance in the form of premium tax credits should not be available for health plans that cover elective abortion. This would allow individuals to avoid directly, unwittingly, and unwillingly subsidizing abortion.

EXPLANATION OF PROVISION

Application of credit to additional coverage

Qualified health plans generally must meet certain requirements.¹² Under the proposal, the premium assistance credit is available with respect to catastrophic plans¹³ that meet the requirements relating to qualified health plans. Under the proposal, the premium assistance credit is also available with respect to health plans that meet the requirements relating to qualified health plans except that they are not offered through an Exchange. Thus, an individual who purchases a qualified health plan in the individual market, but not through an Exchange, may be eligible for the premium assistance credit if the requirements for eligibility are otherwise met. However, advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange. An individual who purchases such a plan must claim the premium assistance credit on his or her income tax return.

Under present law, any person that provides minimum essential coverage to an individual during a calendar year must report certain information to the IRS.¹⁴ The proposal requires additional information reporting for minimum essential coverage provided to an individual that is not enrolled through an Exchange.

As under present law, the credit is not available with respect to grandfathered plans or plans that receive similar treatment under administrative guidance. In addition, the proposal specifies that the credit is not available with respect to grandmothers plans. Under the proposal, a grandmothers health plan is defined to be health insurance coverage which is offered in the individual health insurance market as of October 1, 2013, and is permitted to be offered in such market after January 1, 2014, as a result of CCIIO guidance.¹⁵

Ineligibility of qualified health plans covering abortion

Under the proposal, the premium assistance credit is not available with respect to a qualified health plan that provides coverage for abortions for which Federal funds may not be used.¹⁶ However,

¹²Section 2 of the proposal amends section 1302(e) of PPACA to allow all individuals purchasing health insurance in the individual market the option to purchase a lower premium plan that does not offer a bronze, silver, gold, or platinum level of coverage.

¹³As described in sec. 1302(e) of PPACA.

¹⁴Sec. 6055(b).

¹⁵CCIIO guidance refers to the letters issued by the Centers for Medicare and Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified. Subsequent modifications include a communication entitled, "Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through Calendar Year 2017," issued on February 29, 2016 by the Director of the Center for Consumer Information and Insurance Oversight of such Centers.

¹⁶This includes coverage for abortions other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest. The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of determining eligibility for the premium assistance credit.

nothing in the proposal prohibits an individual from purchasing, or a health insurance issuer from offering separate coverage for abortions, or a health plan that includes abortions, as long as no premium assistance credit is allowed with respect to the premiums for such coverage and premiums are not paid for with any amount attributable to the premium assistance credit (or the amount of any advance payment of the credit).

EFFECTIVE DATE

The modifications to the premium assistance credit are generally effective for taxable years beginning after December 31, 2018. The proposal specifying that advance premium assistance payments are not available with respect to a qualified health plan that is not purchased through an Exchange is effective on January 1, 2019. The proposal amending the present-law reporting requirements under section 6055 is effective for coverage provided for months beginning after December 31, 2018.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 6311, the “Increasing Access to Lower Premium Plans Act of 2018,” on July 12, 2018.

The vote on Mr. Reichert’s motion to table Mr. Neal’s appeal of the ruling of the Chair that Mr. Thompson’s amendment was non-germane, was agreed to by a roll call vote of 21 yeas to 15 nays. The vote was as follows:

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

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of

H.R. 6311, the “Increasing Access to Lower Premium Plans Act of 2018,” on July 12, 2018.

The vote on the amendment offered by Ms. DelBene to the amendment in the nature of a substitute offered by Chairman Brady to H.R. 6311, which would strike sec 2(a)(2) and subsection (c) of section 2”, was not agreed to by a rollcall vote of 15 yeas to 22 nays. The vote was as follows:

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

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 6311, the “Increasing Access to Lower Premium Plans Act of 2018,” on July 12, 2018.

The vote on the amendment offered by Ms. Sánchez to the amendment in the nature of a substitute offered by Chairman Brady to H.R. 6311, which would make plans that are otherwise eligible for section 2 in the underlying bill contingent on if that plan issuer does not discriminate or raise premiums on the basis of gender for any plan, was not agreed to by a rollcall vote of 16 yeas to 23 nays. The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X		Mr. Neal	X		
Mr. Johnson		X		Mr. Levin	X		
Mr. Nunes		X		Mr. Lewis	X		
Mr. Tiberi		X		Mr. Doggett	X		
Mr. Reichert		X		Mr. Thompson	X		
Mr. Roskam		X		Mr. Larson	X		
Mr. Buchanan		X		Mr. Blumenauer	X		
Mr. Smith (NE)		X		Mr. Kind	X		
Ms. Jenkins		X		Mr. Pascrell	X		
Mr. Paulsen		X		Mr. Crowley	X		
Mr. Marchant		X		Mr. Davis	X		
Ms. Black				Ms. Sánchez	X		
Mr. Reed		X		Mr. Higgins	X		
Mr. Kelly		X		Ms. Sewell	X		
Mr. Renacci		X		Ms. DelBene	X		

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Ms. Noem		X	.....	Ms. Chu	X	.....	.....
Mr. Holding		X	.....			
Mr. Smith (MO)		X	.....			
Mr. Rice		X	.....			
Mr. Schweikert		X	.....			
Ms. Walorski		X	.....			
Mr. Curbelo		X	.....			
Mr. Bishop		X	.....			
Mr. Wenstrup		X	.....			

In compliance with the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means during the markup consideration of H.R. 6311, the “Increasing Access to Lower Premium Plans Act of 2018,” on July 12, 2018.

H.R. 6311 was ordered favorably reported to the House of Representatives as amended by an amendment in the nature of a substitute offered by Chairman Brady by a rollcall vote of 23 yeas to 16 nays. The vote was as follows:

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

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 6311, as reported.

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

Item	FISCAL YEARS (Millions of Dollars)											
	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-23	2019-28
Modification of Definition of Qualified Health Plan ^{1,2}	-388	-1,288	-1,252	-1,258	-1,295	-1,284	-1,206	-1,265	-1,284	-1,304	-5,481	-11,823
Allow All Individuals Purchasing Health Insurance in the Individual Market the Option to Purchase a Lower Premium Copper Plan ^{1,2}	51	76	85	94	98	99	101	103	106	110	404	923
Total	-337	-1,212	-1,167	-1,164	-1,197	-1,185	-1,104	-1,162	-1,178	-1,194	-5,077	-10,901
<p>NOTE: Details may not add to totals due to rounding. ¹ Estimate provided by the staff of the Joint Committee on Taxation and the Congressional Budget Office. ² Estimate includes the following outlay effects:</p>												
Modification of Definition of Qualified Health Plan	168	902	848	823	833	810	727	758	738	738	3,574	7,346
Allow All Individuals Purchasing Health Insurance in the Individual Market the Option to Purchase a Lower Premium Copper Plan	-50	-74	-82	-91	-95	-96	-98	-99	-101	-105	-391	-890

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

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES BUDGET AUTHORITY

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee further states that the revenue-reducing tax provision involves a new tax expenditure. See Part IV.A., above.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 6138, as reported. As of the filing of this report, the Committee had not received an estimate prepared by the Congressional Budget Office (CBO).

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

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated into the description portions of this report.

B. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

With respect to clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee advises that the bill contains no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizes funding is required.

C. INFORMATION RELATING TO UNFUNDED MANDATES

This information is provided in accordance with section 423 of the Unfunded Mandates Reform Act of 1995 (Pub. L. No. 104-4).

The Committee has determined that the bill does not contain Federal mandates on the private sector. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. APPLICABILITY OF HOUSE RULE XXI 5(b)

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

E. TAX COMPLEXITY ANALYSIS

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

Pursuant to clause 3(h)(1) of rule XIII of the Rules of the House of Representatives, the staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Internal Revenue Code of 1986 and that have “widespread applicability” to individuals or small businesses, within the meaning of the rule.

F. CONGRESSIONAL EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

With respect to clause 9 of rule XXI of the Rules of the House of Representatives, the Committee has carefully reviewed the provisions of the bill and states that the provisions of the bill do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

G. DUPLICATION OF FEDERAL PROGRAMS

In compliance with Sec. 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111†139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to section 6104 of title 31, United States Code.

H. DISCLOSURE OF DIRECTED RULE MAKINGS

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

VI. CORRESPONDENCE

**A. EXCHANGE OF LETTERS BETWEEN WAYS AND MEANS AND ENERGY
AND COMMERCE**

COMMITTEE ON WAYS AND MEANS

**U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515**

July 13, 2018

The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Walden,

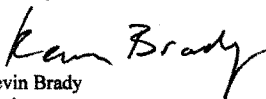
I write to you regarding H.R. 6311, to amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to modify the definition of the qualified health plan for purposes of the health insurance premium tax credit and to allow individuals purchasing health insurance in the individual market to purchase a lower premium copper plan.

The Committee on Ways and Means ordered favorably reported this bill which was also referred to the Committee on Energy and Commerce. I ask that the Committee on Energy and Commerce waive formal consideration of the bill so that it may proceed expeditiously to the House Floor.

I acknowledge that by waiving formal consideration of the bill, the Committee on Energy and Commerce is in no way waiving its jurisdiction over the subject matter contained in those provisions of the bills that fall within your Rule X jurisdiction. I would support your effort to seek appointment of an appropriate number of conferees on any House-Senate conference involving this legislation.

I will include a copy of our letters in the *Congressional Record* during consideration of this legislation on the House floor.

Sincerely,


Kevin Brady
Chairman

cc: The Honorable Paul Ryan, Speaker
The Honorable Richard E. Neal
The Honorable Frank Pallone
Thomas J. Wickham, Jr., Parliamentarian

GREG WALDEN, OREGON
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

July 16, 2018

The Honorable Kevin Brady
Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515


Dear Chairman Brady:

Thank you for your letters regarding H.R. 4952, the "Improving Seniors Access to Quality Benefits Act," H.R. 6138, the "Ambulatory Surgical Center (ACS) Payment Transparency Act of 2018," and H.R. 6311, the "To amend the Internal Revenue Code of 1986 and the Patient Protection and Affordable Care Act to modify the definition of qualified health plan for purposes of the health insurance premium tax credit and to allow individuals purchasing health insurance in the individual market to purchase a lower premium copper plan."

The Committee on Energy and Commerce will forgo consideration of both bills so that they may proceed expeditiously to the House Floor.

I appreciate your assurance that by forgoing action on these bills, the Committee is in no way waiving its jurisdiction over the subject matter contained in the bills. I also appreciate your offer of support for the appointment of conferees from the Committee to any House-Senate conference involving this legislation.

Sincerely,



Greg Walden
Chairman

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

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

In compliance with clause 3(e)(1)(B) of rule XIII of the Rules of the House of Representatives, changes in existing law proposed by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

* * * * *

Subtitle A—Income Taxes

* * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

Subchapter A—Determination of Tax Liability

* * * * *

PART IV—CREDITS AGAINST TAX

* * * * *

Subpart C—Refundable Credits

* * * * *

SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) **IN GENERAL.**—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

(b) **PREMIUM ASSISTANCE CREDIT AMOUNT.**—For purposes of this section—

- (1) **IN GENERAL.**—The term “premium assistance credit amount” means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer’s spouse, or any dependent (as defined in section 152) of the taxpayer [and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or], or

(B) the excess (if any) of—

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to $\frac{1}{12}$ of the product of the applicable percentage and the taxpayer’s household income for the taxable year.

(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

(A) APPLICABLE PERCENTAGE.—

(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

In the case of household income (expressed as a percent of poverty line) within the following income tier.	The initial premium percentage is--	The final premium percentage is--
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

(ii) INDEXING.—

(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth

estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

(III) FAILSAFE.—Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

(i) is offered through [the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and] *the Exchange through which such taxpayer is permitted to obtain coverage, and*

(ii) provides—

(I) self-only coverage in the case of an applicable taxpayer—

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall

be determined without regard to any premium discount or rebate under such project.

(D) ADDITIONAL BENEFITS.—If—

(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—

For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii) (I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

(1) APPLICABLE TAXPAYER.—

(A) IN GENERAL.—The term “applicable taxpayer” means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and

the taxpayer's spouse file a joint return for the taxable year.

(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(2) COVERAGE MONTH.—For purposes of this subsection—

(A) IN GENERAL.—The term “coverage month” means, with respect to an applicable taxpayer, any month if—

(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) [that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act], and

(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

(i) IN GENERAL.—The term “coverage month” shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

(ii) MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” has the meaning given such term by section 5000A(f).

(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits pro-

vided under the plan is less than 60 percent of such costs.

(iii) **EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.**—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) **INDEXING.**—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) **DEFINITIONS AND OTHER RULES.**—

(A) **QUALIFIED HEALTH PLAN.**—The term “qualified health plan” has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act (*determined without regard to subparagraphs (A), (C)(ii), and (C)(iv) of paragraph (1) thereof and without regard to whether the plan is offered on an Exchange*), except that such term [shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.] *shall not include any health plan that—*

(i) *is a grandfathered health plan or a grandmothered health plan, or*

(ii) *includes coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).*

(B) **GRANDFATHERED HEALTH PLAN.**—The term “grandfathered health plan” has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(C) **GRANDMOTHERED HEALTH PLAN.**—

(i) **IN GENERAL.**—*The term “grandmothered health plan” means health insurance coverage which is offered in the individual health insurance market as of October 1, 2013, and is permitted to be offered in such market after January 1, 2014, as a result of CCIIO guidance.*

(ii) **CCIIO GUIDANCE DEFINED.**—*The term “CCIIO guidance” means the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified (including by a communication entitled “Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through 2019” issued on April 9, 2018, by the Director of the Center for Consumer Information and Insurance Oversight of such Centers).*

(iii) **INDIVIDUAL HEALTH INSURANCE MARKET.**—*The term “individual health insurance market” means the market for health insurance coverage (as defined in*

section 9832(b)) offered to individuals other than in connection with a group health plan (within the meaning of section 5000(b)(1)).

(D) CERTAIN RULES RELATED TO ABORTION.—

(i) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in subparagraph (A) shall restrict any health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section (or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act).

(iii) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).

(4) SPECIAL RULES FOR QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—

(A) IN GENERAL.—The term “coverage month” shall not include any month with respect to an employee (or any spouse or dependent of such employee) if for such month the employee is provided a qualified small employer health reimbursement arrangement which constitutes affordable coverage.

(B) DENIAL OF DOUBLE BENEFIT.—In the case of any employee who is provided a qualified small employer health reimbursement arrangement for any coverage month (determined without regard to subparagraph (A)), the credit otherwise allowable under subsection (a) to the taxpayer for such month shall be reduced (but not below zero) by the amount described in subparagraph (C)(i)(II) for such month.

(C) AFFORDABLE COVERAGE.—For purposes of subparagraph (A), a qualified small employer health reimbursement arrangement shall be treated as constituting affordable coverage for a month if—

(i) the excess of—

(I) the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market, over

(II) $\frac{1}{12}$ of the employee’s permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

(ii) $\frac{1}{12}$ of 9.5 percent of the employee's household income.

(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this paragraph, the term “qualified small employer health reimbursement arrangement” has the meaning given such term by section 9831(d)(2).

(E) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (C)(i)(II) shall be applied by substituting “the number of months during the year for which such arrangement was provided” for “12”.

(F) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent amount under subparagraph (C)(ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) HOUSEHOLD INCOME.—

(A) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(B) MODIFIED ADJUSTED GROSS INCOME.—The term “modified adjusted gross income” means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911,

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and

(iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

(3) POVERTY LINE.—

(A) IN GENERAL.—The term “poverty line” has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage dur-

ing a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) EXCESS ADVANCE PAYMENTS.—

(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) LIMITATION ON INCREASE.—

(i) IN GENERAL.—In the case of a taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed the applicable dollar amount determined in accordance with the following table (one-half of such amount in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year):

If the household income (expressed as a percent of poverty line) is:	The applicable dollar amount is:
Less than 200%	\$600
At least 200% but less than 300%	\$1,500
At least 300% but less than 400%	\$2,500

(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts in the table contained under clause (i) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2013” for “calendar year 2016” in subparagraph (A)(ii) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(3) INFORMATION REQUIREMENT.—Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

(F) Information necessary to determine whether a taxpayer has received excess advance payments.

(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subpart D—Information Regarding Health Insurance Coverage

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SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

(b) FORM AND MANNER OF RETURN.—

(1) IN GENERAL.—A return is described in this subsection if such return—

(A) is in such form as the Secretary may prescribe, and

(B) contains—

(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy,

(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,

(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—

(I) whether or not the coverage is a qualified health plan offered through an Exchange established under section 1311 of the Patient Protection and Affordable Care Act, and

(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

(iv) such other information as the Secretary may require.

(2) INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

(A) the name, address, and employer identification number of the employer maintaining the plan,

(B) the portion of the premium (if any) required to be paid by the employer, and

(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).

(3) INFORMATION RELATING TO OFF-EXCHANGE PREMIUM TAX CREDIT ELIGIBLE COVERAGE.—*If minimum essential coverage provided to an individual under subsection (a) consists of a qualified health plan (as defined in section 36B(c)(3)) which is not enrolled in through an Exchange established under title I of the Patient Protection and Affordable Care Act, a return described in this subsection shall include—*

(A) a statement that such plan is a qualified health plan (as defined in section 36B(c)(3)),

(B) the premiums paid with respect to such coverage,

(C) the months during the calendar year for which such coverage is provided to the individual,

(D) the adjusted monthly premium for the applicable second lowest cost silver plan (as defined in section 36B(b)(3)) for each such month with respect to such individual, and

(E) such other information as the Secretary may prescribe.

(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

(B) the information required to be shown on the return with respect to such individual.

(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

(e) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section, the term “minimum essential coverage” has the meaning given such term by section 5000A(f).

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

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TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

* * * * *

Subtitle D—Available Coverage Choices for All Americans

PART 1—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

* * * * *

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits package” means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such ben-

efits shall include at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.—

(1) ANNUAL LIMITATION ON COST-SHARING.—

(A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.

(B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(3) COST-SHARING.—In this title—

(A) IN GENERAL.—The term “cost-sharing” includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(d) LEVELS OF COVERAGE.—

(1) LEVELS OF COVERAGE DEFINED.—The levels of coverage described in this subsection are as follows:

(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that

are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—

(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

(B) EMPLOYER CONTRIBUTIONS.—The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

(C) APPLICATION.—In determining under this title, the Public Health Service Act, or the Internal Revenue Code of 1986 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

(3) ALLOWABLE VARIANCE.—The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

(4) PLAN REFERENCE.—In this title, any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

(e) CATASTROPHIC PLAN.—

(1) IN GENERAL.—A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

[(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

[(B) the plan provides—] *plan year if the plan provides—*

[(i) (A) except as provided in [clause (ii)] subparagraph (B), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713); and

[(ii) (B) coverage for at least three primary care visits.

[(2) INDIVIDUALS ELIGIBLE FOR ENROLLMENT.—An individual is described in this paragraph for any plan year if the individual—

[(A) has not attained the age of 30 before the beginning of the plan year; or

[(B) has a certification in effect for any plan year under this title that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of—

[(i) section 5000A(e)(1) of such Code (relating to individuals without affordable coverage); or

[(ii) section 5000A(e)(5) of such Code (relating to individuals with hardships).

[(3)] (2) RESTRICTION TO INDIVIDUAL MARKET.—If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.

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PART 2—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

* * * * *

SEC. 1312. CONSUMER CHOICE.

(a) CHOICE.—

(1) QUALIFIED INDIVIDUALS.—A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible.

(2) QUALIFIED EMPLOYERS.—

(A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for coverage of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.

(B) EMPLOYEE MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.

(b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any

applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(c) SINGLE RISK POOL.—

(1) INDIVIDUAL MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange *and enrollees in catastrophic plans described in section 1302(e)*, to be members of a single risk pool.

(2) SMALL GROUP MARKET.—A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(3) MERGER OF MARKETS.—A State may require the individual and small group insurance markets within a State to be merged if the State determines appropriate.

(4) STATE LAW.—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

(d) EMPOWERING CONSUMER CHOICE.—

(1) CONTINUED OPERATION OF MARKET OUTSIDE EXCHANGES.—Nothing in this title shall be construed to prohibit—

(A) a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or qualified employer; and

(B) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to terminate, abridge, or limit the operation of any requirement under State law with respect to any policy or plan that is offered outside of an Exchange to offer benefits.

(3) VOLUNTARY NATURE OF AN EXCHANGE.—

(A) CHOICE TO ENROLL OR NOT TO ENROLL.—Nothing in this title shall be construed to restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(B) PROHIBITION AGAINST COMPELLED ENROLLMENT.—Nothing in this title shall be construed to compel an individual to enroll in a qualified health plan or to participate in an Exchange.

(C) INDIVIDUALS ALLOWED TO ENROLL IN ANY PLAN.—A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in section 1302(e), a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under section 1302(e)(2).

(D) MEMBERS OF CONGRESS IN THE EXCHANGE.—

(i) REQUIREMENT.—Notwithstanding any other provision of law, after the effective date of this subtitle,

the only health plans that the Federal Government may make available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—

(I) created under this Act (or an amendment made by this Act); or

(II) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) DEFINITIONS.—In this section:

(I) MEMBER OF CONGRESS.—The term “Member of Congress” means any member of the House of Representatives or the Senate.

(II) CONGRESSIONAL STAFF.—The term “congressional staff” means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(4) NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—An Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(e) ENROLLMENT THROUGH AGENTS OR BROKERS.—The Secretary shall establish procedures under which a State may allow agents or brokers—

(1) to enroll individuals and employers in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and

(2) to assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

(f) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—

(1) QUALIFIED INDIVIDUALS.—In this title:

(A) IN GENERAL.—The term “qualified individual” means, with respect to an Exchange, an individual who—

(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(ii) resides in the State that established the Exchange.

(B) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) QUALIFIED EMPLOYER.—In this title:

(A) IN GENERAL.—The term “qualified employer” means a small employer that elects to make all full-time employ-

ees of such employer eligible for 1 or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans.

(B) EXTENSION TO LARGE GROUPS.—

(i) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) LARGE EMPLOYERS ELIGIBLE.—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange, the term “qualified employer” shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

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Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

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Subpart B—Eligibility Determinations

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SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

(1) upon request of an Exchange, advance determinations are made under section 1411 with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402;

(2) the Secretary notifies—

(A) the Exchange and the Secretary of the Treasury of the advance determinations; and

(B) the Secretary of the Treasury of the name and employer identification number of each employer with respect

to whom 1 or more employee of the employer were determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing reductions under section 1402 because—

- (i) the employer did not provide minimum essential coverage; or
 - (ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(2)(C) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and
- (3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce the premiums payable by individuals eligible for such credit.
- (b) ADVANCE DETERMINATIONS.—
- (1) IN GENERAL.—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—
 - (A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and
 - (B) on the basis of the individual's household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines information is available.
 - (2) CHANGES IN CIRCUMSTANCES.—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—
 - (A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and
 - (B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.
- (c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—
- (1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.
 - (2) PREMIUM TAX CREDIT.—
 - (A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health

plan on a monthly basis (or such other periodic basis as the Secretary may provide).

(B) ISSUER RESPONSIBILITIES.—An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall—

(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

(ii) notify the Exchange and the Secretary of such reduction;

(iii) include with each billing statement the amount by which the premium for the plan has been reduced by reason of the advance payment; and

(iv) in the case of any nonpayment of premiums by the insured—

(I) notify the Secretary of such nonpayment; and

(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

(3) COST-SHARING REDUCTIONS.—The Secretary shall also notify the Secretary of the Treasury and the Exchange under paragraph (1) if an advance payment of the cost-sharing reductions under section 1402 is to be made to the issuer of any qualified health plan with respect to any individual enrolled in the plan. The Secretary of the Treasury shall make such advance payment at such time and in such amount as the Secretary specifies in the notice.

(d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—Nothing in this subtitle or the amendments made by this subtitle allows Federal payments, credits, or cost-sharing reductions for individuals who are not lawfully present in the United States.

(e) STATE FLEXIBILITY.—Nothing in this subtitle or the amendments made by this subtitle shall be construed to prohibit a State from making payments to or on behalf of an individual for coverage under a qualified health plan offered through an Exchange that are in addition to any credits or cost-sharing reductions allowable to the individual under this subtitle and such amendments.

(f) *EXCLUSION OF OFF-EXCHANGE COVERAGE.*—*Advance payments under this section, and advance determinations under section 1411, with respect to any credit allowed under section 36B shall not be made with respect to any health plan which is not enrolled in through an Exchange.*

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DISSENTING VIEWS

H.R. 6311 Increasing Access To Lower Premium Plans Act of 2018

H.R. 6311 (Roskam, R-IL) allows anyone to purchase catastrophic coverage (currently catastrophic plans can only be purchased by those under 30 and people with hardship exemptions), puts all catastrophic plans into the overall risk pool, allows use of Advance Premium Tax Credits (APTCs) to be used for catastrophic plans in the exchange, and allows premium tax credits (but not APTCs) to be used to purchase plans off exchange. The bill explicitly prohibits tax credits for plans that offer comprehensive women's health care.

H.R. 6311 continues Republican efforts to undermine and destabilize the health insurance market increases costs for consumers, and undermines women's health care, while at the same time growing our deficit.

H.R. 6311 would likely reduce choice and competition in the Affordable Care Act (ACA) marketplaces. While the bill would allow people buying individual-market plans outside the ACA marketplaces to receive ACA tax credits, the credits are only be available when individuals file their tax returns the following year (not upfront to help them pay premiums); this disadvantages more moderate-income families that do not have extra disposable income to pay premium costs up front. It also would eliminate the requirement that insurers selling plans eligible for the ACA tax credit must offer at least one "silver" and one "gold" plan through the marketplace—reducing plan choice for patients. If this bill were enacted, an insurer could offer coverage only outside the marketplace (destabilizing the marketplace and undermining marketplace choice) while still giving consumers access to premium tax credits.

H.R. 6311 would likely lead to increased premiums for individuals with preexisting conditions. Reducing the incentives for insurers to offer marketplace coverage could make it easier for insurers to engage in strategies to attract only healthier enrollees, such as offering only bronze or catastrophic plans, which have higher deductibles and other cost-sharing expenses for consumers than silver and gold plans. It also could reduce plan choices for consumers within the marketplaces if insurers shift to off-marketplace business. And it could prompt fewer consumers to comparison shop in the marketplaces—where they can compare premiums and benefits for multiple insurers—thus reducing competitive pressure on insurers to hold down premiums.

Legislation busts the deficit to benefit the wealthy, again. The Joint Committee on Taxation (JCT) estimates the cost of this bill to be \$10.9 billion over 10 years. Altogether the 11 bills this Committee marked up would add another \$92 billion in unoffset tax cuts to the deficit. With this bill, Republicans are adding more tax

cuts and increasing the deficit. Republicans are using the deficit, which they keep making larger with cuts for the wealthy, to justify the deep cuts they plan to make to Medicare and Medicaid. Republicans already are proposing to cut Medicare and Medicaid by nearly a trillion dollars to try to pay for the tax cuts they've already enacted. This bill will only increase Republicans' calls for further cuts to these critical programs.

Democrats offered three amendments to this bill in an attempt to better protect consumers. Representative Thompson (D-CA) offered an amendment to require that plans covered under the underlying bill be offered by an issuer that does not raise premiums in connection with a failure to make risk adjustment payments. This effort to ensure consumers' premiums are not increased due to Republican sabotage of health care was ruled non-germane. The appeal of the ruling of the chair was defeated 21-15.

Representative DelBene (D-WA) offered an amendment to strike language that prohibits premium tax credits from going toward any health plan that includes coverage for abortion services. Washington, Oregon, California, and New York all require health plans to include abortion services in every health plan, and H.R. 6311 would thereby take away premium tax credits for everyone in those four states.

Coalition members of All* Above All, which includes the American Civil Liberties Union and the National Partnership for Women and Families, wrote in opposition to the bill noting, "We oppose HR 6311 which could drastically impact the quality and affordability of insurance coverage available to women. . . . HR 6311 is drafted to achieve anti-abortion politicians' goal of eliminating abortion coverage in the individual insurance marketplace. HR 6311 would deny women the tax credits that make plans affordable merely for choosing comprehensive insurance that includes abortion coverage. These provisions penalize individuals who seek plans that cover abortion and companies that want to provide comprehensive plans to their employees, and disincentivizes plans from covering abortion. Women should not be penalized for seeking comprehensive health coverage that meets their needs." The amendment was defeated on party lines 15-22.

Representative Sánchez (D-CA) offered an amendment to require that plans covered under the underlying bill be offered by an issuer that does not discriminate or raise premiums on the basis of gender. This commonsense amendment was also defeated on party lines, 16-23.

RICHARD E. NEAL,
Ranking Member.