

VETERAN ACT

JUNE 2, 2017.—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

together with

DISSENTING VIEWS

[To accompany H.R. 2372]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2372) to amend the Internal Revenue Code of 1986 to clarify the rules relating to veteran health insurance and eligibility for the premium tax credit, 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 “Veterans Equal Treatment Ensures Relief and Access Now Act” or the “VETERAN Act”.

SEC. 2. CLARIFICATION RELATING TO VETERAN HEALTH INSURANCE AND ELIGIBILITY FOR PREMIUM TAX CREDIT.

(a) **AMENDMENT OF PRE-2020 CREDIT.—**

(1) **IN GENERAL.**—Section 36B(c)(2)(B)(i) of the Internal Revenue Code of 1986, prior to any amendment by section 214 of the American Health Care Act of 2017, is amended by adding at the end the following: “For purposes of the preceding sentence, an individual shall not be treated as eligible for coverage described in section 5000A(f)(1)(A)(v) unless such individual is enrolled in such coverage.”

(2) **EFFECTIVE DATE.**—The amendment made by this subsection shall apply to taxable years ending after December 31, 2013.

(b) **AMENDMENT OF POST-2019 CREDIT.—**

(1) **IN GENERAL.**—Section 36B(d) of such Code, as amended by section 214 of the American Health Care Act of 2017 and in effect for months beginning after December 31, 2019, is amended by adding at the end the following: “For purposes of paragraph (2)(B), an individual shall not be treated as eligible for coverage described in section 5000A(f)(1)(A)(v) unless such individual is enrolled in such coverage.”

(2) **EFFECTIVE DATE.**—The amendment made by this subsection is contingent upon the enactment of the American Health Care Act of 2017 and shall apply (if at all) to months beginning after December 31, 2019, in taxable years ending after such date.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 2372, as reported by the Committee on Ways and Means, codifies a Treasury regulation, under which, for purposes of eligibility for the premium tax credit under section 36B of the Internal Revenue Code (“Code”),¹ an individual is not considered eligible for certain health care programs of the United States Department of Veterans Affairs (“VA health program”) unless enrolled in the program. In addition, H.R. 2372, as reported by the Committee on Ways and Means, amends H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017, to provide a similar rule with respect to a new credit for the purchase of health insurance (effective for months beginning after December 31, 2019, in taxable years ending after that date).

B. BACKGROUND AND NEED FOR LEGISLATION

Under present law and under the American Health Care Act of 2017, an individual generally may not receive the premium assistance credit if the individual is eligible for certain types of health

¹All section references herein are to the Internal Revenue Code of 1986, as amended, unless otherwise stated.

coverage from a source other than the individual insurance market, including coverage under certain VA health programs. However, under Treasury regulations, an individual is not considered eligible for coverage under certain VA health programs (and, therefore, not precluded from receiving the premium assistance credit) unless enrolled in the program. The bill amends the Code and the American Health Care Act of 2017 to include the rule from the regulations, thus assuring its continued application.

On March 8, 2017, in fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee marked up Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy. This submission included a special rule codifying the Treasury regulations. However, that language was later removed at the Committee on Rules in order to comply with Senate guidance regarding the Reconciliation process.

C. LEGISLATIVE HISTORY

Background

H.R. 2372 was introduced on May 4, 2017, and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up H.R. 2372, the Veterans Equal Treatment Ensures Relief and Access Now Act (the VETERAN Act), on May 24, 2017, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

Since the 112th Congress, the Committee on Ways and Means and its subcommittees have held a number of hearings on health reform that explored various parts of the health system and informed policy contained in the American Health Care Act. These hearings include:

- March 5, 2013—Hearing on Tax-Related Provisions in the President’s Health Care Law
- December 4, 2013—Hearing on the Challenges of the Affordable Care Act
- March 14, 2016—Hearing on the Tax Treatment of Health Care
- May 17, 2016—Member Day Hearing on Tax-Related Proposals to Improve Health Care

II. EXPLANATION OF THE BILL

A. CLARIFICATION RELATING TO VETERAN HEALTH INSURANCE AND ELIGIBILITY FOR PREMIUM TAX CREDIT

PRESENT LAW

A refundable tax credit (“premium assistance credit”) is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an American Health Benefit Ex-

change (“Exchange”), referred to as “qualified health plans.”² In general, advance payments with respect to the premium assistance credit are made during the year directly to the insurer.³ However, eligible individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

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.⁴ 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,⁵ (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.⁶ To be eligible for the premium assistance credit, individuals who are married must file a joint return. Individuals who are listed as dependents on a return are not eligible for the premium assistance credit.

An individual who is eligible for certain types of health coverage (“minimum essential coverage”) from a source other than the individual insurance market generally may not receive the premium assistance credit.⁷ Coverage under certain government-sponsored health programs constitutes minimum essential coverage, including coverage under certain comprehensive health care programs administered by the United States Department of Veterans Affairs (“designated Veterans Affairs health programs”).⁸ Although mere eligibility for minimum essential coverage from a source other than the individual insurance market generally precludes an individual from receiving the premium assistance credit, Treasury regulations provide that, in the case of one of the designated Veterans Affairs health programs, an individual is not considered eligible for coverage under such a program (and precluded from receiving the premium assistance credit) unless enrolled in the program.⁹ Thus, an individual who may be eligible for a designated Veterans Affairs

²Sec. 36B, effective for taxable years ending after December 31, 2013. Under the Affordable Care Act, an American Health Benefit Exchange is a source through which individuals can purchase health insurance coverage. As used herein, the Affordable Care Act (or “ACA”) refers to the combination of the Patient Protection and Affordable Care Act (“PPACA”), Pub. L. No. 111–148, and the Healthcare and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111–152. Qualified health plan is defined in PPACA section 1301.

³PPACA sections 411–412 provide rules relating to eligibility for and receipt of advance payments.

⁴Federal poverty level refers to the most recently published poverty guidelines determined by the Secretary of Health and Human Services. Levels for 2017 and previous years are available at <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>.

⁵Sec. 911.

⁶Under section 86, only a portion of an individual’s social security benefits are included in gross income.

⁷Minimum essential coverage is defined in section 5000A(f).

⁸Under section 5000A(f)(1)(A)(v), certain health care programs available to veterans and family members may constitute minimum essential coverage, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of the Treasury and the Secretary of Health and Human Services. Regulations designate certain comprehensive health care programs administered by the Department of Veterans Affairs as minimum essential coverage. Treas. Reg. sec. 1.5000A–2(b)(v).

⁹Treas. Reg. sec. 1.36B–2(c)(2)(iii).

health program, but is not actually enrolled in the program, may receive the premium assistance credit.

THE AMERICAN HEALTH CARE ACT OF 2017

The American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017 (the “AHCA”), amends various health-related provisions of the Code.¹⁰ Effective for months beginning after December 31, 2019, in taxable years ending after that date, the AHCA replaces the present-law premium assistance credit with a new credit and provides a new definition of “qualified health plan” to which the new credit applies.¹¹ Similar to the present-law credit, under the AHCA, an individual eligible for health coverage from other sources, including coverage under a designated Veterans Affairs health program, generally may not receive the new premium assistance credit.

REASONS FOR CHANGE

The Committee agrees with the interpretation contained in the Treasury regulations with respect to eligibility for designated Veterans Affairs health programs. The Committee wishes to codify this interpretation, thus ensuring its continued application under present law and under the AHCA.

EXPLANATION OF PROVISION

The provision amends the statutory provisions relating to eligibility for the present-law premium assistance credit to codify the rule under which an individual is not considered eligible for coverage under a designated Veterans Affairs health program unless enrolled in the program. In addition, the provision amends the provision of the AHCA relating to eligibility for the new premium assistance credit to specify that an individual is not considered eligible for coverage under a designated Veterans Affairs health program unless enrolled in the program.

EFFECTIVE DATE

The provision relating to the present-law premium assistance credit is effective for taxable years ending after December 31, 2013. The provision relating to the new premium assistance credit under the AHCA is contingent on enactment of the AHCA and will apply (if at all) to months beginning after December 31, 2019, in taxable years ending after that date.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 2372, the “Veterans Equal Treatment Ensures Relief and Access Now Act” (the “VETERAN Act”), on May 24, 2017.

¹⁰ H.R. 1628, as passed by the House of Representatives on May 4, 2017.

¹¹ AHCA section 214. AHCA sections 201 and 202 amend the present-law premium assistance credit for periods before the new credit becomes effective.

Mr. Tiberi's motion to table Mr. Doggett's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson				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			
Ms. Jenkins	X			Mr. Pascrell		X	
Mr. Paulsen	X			Mr. Crowley		X	
Mr. Marchant	X			Mr. Davis		X	
Ms. Black	X			Ms. Sanchez		X	
Mr. Reed	X			Mr. Higgins		X	
Mr. Kelly	X			Ms. Sewell		X	
Mr. Renacci	X			Ms. DelBene		X	
Mr. Meehan	X			Ms. Chu		X	
Ms. Noem	X						
Mr. Holding	X						
Mr. Smith (MO)	X						
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						

Mr. Tiberi's motion to table Mr. Thompson's appeal of the ruling of the Chair was agreed to by a roll call vote of 23 yeas and 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson				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	X			Ms. Sanchez		X	
Mr. Reed	X			Mr. Higgins		X	
Mr. Kelly	X			Ms. Sewell		X	
Mr. Renacci	X			Ms. DelBene			
Mr. Meehan	X			Ms. Chu		X	
Ms. Noem	X						
Mr. Holding	X						
Mr. Smith (MO)	X						
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						

The vote on the amendment by Mr. Davis to the amendment in the nature of a substitute to H.R. 2372, which would adjust the tax credit for certain veteran taxpayers, was not agreed to by a roll call vote of 23 nays to 16 yeas (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady		X		Mr. Neal	X		
Mr. Johnson				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		X		Ms. Sanchez	X		
Mr. Reed		X		Mr. Higgins	X		
Mr. Kelly		X		Ms. Sewell	X		
Mr. Renacci		X		Ms. DelBene	X		
Mr. Meehan		X		Ms. Chu	X		
Ms. Noem		X					
Mr. Holding		X					
Mr. Smith (MO)		X					
Mr. Rice		X					
Mr. Schweikert		X					
Ms. Walorski		X					
Mr. Curbelo		X					
Mr. Bishop		X					

Mr. Nunes's motion to table Ms. DelBene's appeal of the ruling of the Chair was agreed to by a roll call vote of 22 yeas and 16 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson				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. Sanchez		X	
Mr. Reed	X			Mr. Higgins		X	
Mr. Kelly	X			Ms. Sewell		X	
Mr. Renacci	X			Ms. DelBene		X	
Mr. Meehan	X			Ms. Chu		X	
Ms. Noem	X						
Mr. Holding	X						
Mr. Smith (MO)	X						
Mr. Rice	X						
Mr. Schweikert	X						
Ms. Walorski	X						
Mr. Curbelo	X						
Mr. Bishop	X						

Mr. Nunes's motion to table Ms. Sanchez's appeal of the ruling of the Chair was agreed to by a roll call vote of 22 yeas and 15 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X			Mr. Neal		X	
Mr. Johnson				Mr. Levin		X	
Mr. Nunes	X			Mr. Lewis		X	
Mr. Tiberi	X			Mr. Doggett		X	

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	.....	.....
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. Sanchez .....	.....	X	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Nunes's motion to table Ms. Sewell's appeal of the ruling of the Chair was agreed to by a roll call vote of 22 yeas and 13 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson .....	.....	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	.....	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	.....	.....
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. Sanchez .....	.....	.....	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Nunes's motion to table Ms. Chu's appeal of the ruling of the Chair was agreed to by a roll call vote of 22 yeas and 12 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson .....	.....	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	.....	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	.....	.....
Mr. Smith (NE)	X	.....	.....	Mr. Kind .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Ms. Jenkins	X	.....	.....	Mr. Pascrell .....	.....	X	.....
Mr. Paulsen	X	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black .....	.....	.....	.....	Ms. Sanchez .....	.....	.....	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	.....	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

Mr. Nunes's motion to table Mr. Pascrell's appeal of the ruling of the Chair was agreed to by a roll call vote of 22 yeas and 12 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson .....	.....	.....	.....	Mr. Levin .....	.....	X	.....
Mr. Nunes	X	.....	.....	Mr. Lewis .....	.....	.....	.....
Mr. Tiberi	X	.....	.....	Mr. Doggett .....	.....	X	.....
Mr. Reichert	X	.....	.....	Mr. Thompson .....	.....	X	.....
Mr. Roskam	X	.....	.....	Mr. Larson .....	.....	X	.....
Mr. Buchanan	X	.....	.....	Mr. Blumenauer .....	.....	.....	.....
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. Sanchez .....	.....	.....	.....
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	.....	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	X	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	X	.....	.....		

The legislation was ordered favorably transmitted to the House of Representatives as amended by a roll call vote of 22 yeas and 14 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Brady	X	.....	.....	Mr. Neal .....	.....	X	.....
Mr. Johnson .....	.....	.....	.....	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 .....	.....	.....	.....	Mr. Crowley .....	.....	X	.....
Mr. Marchant	X	.....	.....	Mr. Davis .....	.....	X	.....
Ms. Black .....	.....	.....	.....	Ms. Sanchez .....	.....	X	.....

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Reed	X	.....	.....	Mr. Higgins .....	.....	X	.....
Mr. Kelly	X	.....	.....	Ms. Sewell .....	.....	X	.....
Mr. Renacci	X	.....	.....	Ms. DelBene .....	.....	.....	.....
Mr. Meehan	X	.....	.....	Ms. Chu .....	.....	X	.....
Ms. Noem	X	.....	.....		
Mr. Holding	X	.....	.....		
Mr. Smith (MO)	X	.....	.....		
Mr. Rice	X	.....	.....		
Mr. Schweikert	X	.....	.....		
Ms. Walorski	X	.....	.....		
Mr. Curbelo	X	.....	.....		
Mr. Bishop	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. 2372, as reported.

The bill, as reported, is estimated to have no effect on Federal fiscal year budget receipts for fiscal years 2017–2027.

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 provisions of the bill do not increase or decrease tax expenditures.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the CBO, the following statement by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 1, 2017.

Hon KEVIN BRADY,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2372, the Veterans Equal Treatment Ensures Relief and Access Now Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Mark Booth.

Sincerely,

KEITH HALL.

Enclosure.

H.R. 2372—Veterans Equal Treatment Ensures Relief and Access Now Act

H.R. 2372 would amend the Internal Revenue Code to codify certain health-related regulations affecting veterans. Specifically, the bill would codify regulations that allow veterans who are eligible for, but do not elect to be covered by, certain Veterans Affairs health programs to qualify for premium assistance tax credits. Under current law, people can purchase health insurance through marketplaces and receive such credits to cover part or all of the premiums if, among other criteria, they have income below certain amounts and are not eligible for certain types of health coverage. H.R. 2372 also contains a contingency under which the provisions would apply upon enactment of the American Health Care Act of 2017, which would provide new credits and eligibility requirements.

Because H.R. 2372 would in part codify existing regulations and in part be contingent upon enactment of subsequent legislation, the staff of the Joint Committee on Taxation estimates that the bill would have no effect on revenues or direct spending relative to current law; therefore pay-as-you-go procedures do not apply. However, if the American Health Care Act of 2017 was enacted prior to this legislation, then relative to such new law the enactment of this bill could affect revenues or direct spending and, as a result, subsequent estimates of the effects of this legislation could change.

CBO and JCT estimate that enacting the bill would not increase on-budget deficits or net direct spending by more than \$5 billion in any of the four 10-year periods beginning in 2028.

JCT has determined that the bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

The CBO staff contact for this estimate is Mark Booth. The estimate was approved by John McClelland, Assistant Director for Tax Analysis.

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 gen-

eral 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. 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):

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 (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

* * * * *

【The following shows current law section 36B of the Internal Revenue Code of 1986:】

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

(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 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 cal-

endar 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

(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 pro-

gram 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). *For purposes of the preceding sentence, an individual shall not be treated as eligible for coverage described in section 5000A(f)(1)(A)(v) unless such individual is enrolled in such coverage.*

(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 provided 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, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(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.

(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 reimburse-

ment 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 during 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 1992” in subparagraph (B) 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.

【The following shows proposed changes to section 36B of the Internal Revenue Code of 1986 as such section is proposed to read after amendment by section 214 of the American Health Care Act of 2017 (H.R. 1628, as engrossed in the House):】

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

(a) ALLOWANCE OF PREMIUM TAX CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this subtitle for the taxable year the sum of the monthly credit amounts with respect to such taxpayer for calendar months during such taxable year which are eligible coverage months appropriately taken into account under subsection (b)(2) with respect to the taxpayer or any qualifying family member of the taxpayer.

(b) MONTHLY CREDIT AMOUNTS.—

(1) IN GENERAL.—The monthly credit amount with respect to any taxpayer for any calendar month is the lesser of—

(A) the sum of the monthly limitation amounts determined under subsection (c) with respect to the taxpayer and the taxpayer's qualifying family members for such month, or

(B) the amount paid for a qualified health plan for the taxpayer and the taxpayer's qualifying family members for such month.

(2) ELIGIBLE COVERAGE MONTH REQUIREMENT.—No amount shall be taken into account under subparagraph (A) or (B) of paragraph (1) with respect to any individual for any month unless such month is an eligible coverage month with respect to such individual.

(c) MONTHLY LIMITATION AMOUNTS.—

(1) IN GENERAL.—The monthly limitation amount with respect to any individual for any eligible coverage month during any taxable year is $\frac{1}{12}$ of—

(A) \$2,000 in the case of an individual who has not attained age 30 as of the beginning of such taxable year,

(B) \$2,500 in the case of an individual who has attained age 30 but who has not attained age 40 as of such time,

(C) \$3,000 in the case of an individual who has attained age 40 but who has not attained age 50 as of such time,

(D) \$3,500 in the case of an individual who has attained age 50 but who has not attained age 60 as of such time, and

(E) \$4,000 in the case of an individual who has attained age 60 as of such time.

(2) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—The credit allowed under subsection (a) with respect to any taxpayer for any taxable year shall be reduced (but not below zero) by 10 percent of the excess (if any) of—

(A) the taxpayer's modified adjusted gross income (as defined in section 36B(d)(2)(B), as in effect for taxable years beginning before January 1, 2020) for such taxable year, over

(B) \$75,000 (twice such amount in the case of a joint return).

(3) OTHER LIMITATIONS.—

(A) AGGREGATE DOLLAR LIMITATION.—The sum of the monthly limitation amounts taken into account under this section with respect to any taxpayer for any taxable year shall not exceed \$14,000.

(B) MAXIMUM NUMBER OF INDIVIDUALS TAKEN INTO ACCOUNT.—With respect to any taxpayer for any month, monthly limitation amounts shall be taken into account under this section only with respect to the 5 oldest individuals with respect to whom monthly limitation amounts could (without regard to this subparagraph) otherwise be so taken into account.

(d) ELIGIBLE COVERAGE MONTH.—For purposes of this section, the term “eligible coverage month” means, with respect to any individual, any month if, as of the first day of such month, the individual meets the following requirements:

(1) The individual is covered by a health insurance coverage which is certified by the State in which such insurance is offered as coverage that meets the requirements for qualified health plans under subsection (f).

(2) The individual is not eligible for—

(A) coverage under a group health plan (within the meaning of section 5000(b)(1)) other than coverage under a plan substantially all of the coverage of which is of excepted benefits described in section 9832(c), or

(B) coverage described in section 5000A(f)(1)(A).

(3) The individual is either—

(A) a citizen or national of the United States, or

(B) a qualified alien (within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641)).

(4) The individual is not incarcerated, other than incarceration pending the disposition of charges.
For purposes of paragraph (2)(B), an individual shall not be treated as eligible for coverage described in section 5000A(f)(1)(A)(v) unless such individual is enrolled in such coverage.

(e) **QUALIFYING FAMILY MEMBER.**—For purposes of this section, the term “qualifying family member” means—

- (1) in the case of a joint return, the taxpayer’s spouse,
- (2) any dependent of the taxpayer, and
- (3) with respect to any eligible coverage month, any child (as defined in section 152(f)(1)) of the taxpayer who as of the end of the taxable year has not attained age 27 if such child is covered for such month under a qualified health plan which also covers the taxpayer (in the case of a joint return, either spouse).

(f) **QUALIFIED HEALTH PLAN.**—For purposes of this section, the term “qualified health plan” means any health insurance coverage (as defined in section 9832(b)) if—

- (1) such coverage is offered in the individual health insurance market within a State (within the meaning of section 5000A(f)(1)(C)),
- (2) substantially all of such coverage is not of excepted benefits described in section 9832(c),
- (3) such coverage does not consist of short-term limited duration insurance (within the meaning of section 2791(b)(5) of the Public Health Service Act),
- (4) such coverage is not a grandfathered health plan (as defined in section 1251 of the Patient Protection and Affordable Care Act) or a grandmothers health plan (as defined in section 36B(c)(3)(C) as in effect for taxable years beginning before January 1, 2020), and
- (5) such coverage does not include coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).

(g) **SPECIAL RULES.**—

(1) **MARRIED COUPLES MUST FILE JOINT RETURN.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), if the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, no credit shall be allowed under this section to such taxpayer unless such taxpayer and the taxpayer’s spouse file a joint return for such taxable year.

(B) **EXCEPTION FOR CERTAIN TAXPAYERS.**—Subparagraph

(A) shall not apply to any married taxpayer who—

- (i) is living apart from the taxpayer’s spouse at the time the taxpayer files the tax return,
- (ii) is unable to file a joint return because such taxpayer is a victim of domestic abuse or spousal abandonment,
- (iii) certifies on the tax return that such taxpayer meets the requirements of clauses (i) and (ii), and
- (iv) has not met the requirements of clauses (i), (ii), and (iii) for each of the 3 preceding taxable years.

(2) **DENIAL OF CREDIT TO DEPENDENTS.**—

(A) IN GENERAL.—No credit shall be allowed under this section to any individual who is a dependent with respect to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

(B) COORDINATION WITH RULE FOR OLDER CHILDREN.—In the case of any individual who is a qualifying family member described in subsection (e)(3) with respect to another taxpayer for any month, in determining the amount of any credit allowable to such individual under this section for any taxable year of such individual which includes such month, the monthly limitation amount with respect to such individual for such month shall be zero and no amount paid for any qualified health plan with respect to such individual for such month shall be taken into account.

(3) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—Amounts described in subsection (b)(1)(B) with respect to any month shall not be taken into account in determining the deduction allowed under section 213 except to the extent that such amounts exceed the amount described in subsection (b)(1)(A) with respect to such month.

(4) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year—

(A) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 1412 of the Patient Protection and Affordable Care Act for months beginning in such taxable year, and

(B) the tax imposed by section 1 for such taxable year shall be increased by the excess (if any) of—

(i) the aggregate amount paid on behalf of such taxpayer under such section 1412 for months beginning in such taxable year, over

(ii) the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a).

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

(A) IN GENERAL.—If the taxpayer or any qualifying family member of the taxpayer is provided a qualified small employer health reimbursement arrangement for an eligible coverage month, the sum determined under subsection (b)(1)(A) with respect to the taxpayer shall be reduced (but not below zero) by $\frac{1}{12}$ of the permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement for each such month such arrangement is provided to such taxpayer.

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

- (C) COVERAGE FOR LESS THAN ENTIRE YEAR.—In the case of an employee who is provided a qualified small employer health reimbursement arrangement for less than an entire year, subparagraph (A) shall be applied by substituting “the number of months during the year for which such arrangement was provided” for “12”.
- (6) CERTAIN RULES RELATED TO NONQUALIFIED HEALTH PLANS.—The rules of section 36B(c)(3)(D), as in effect for taxable years beginning before January 1, 2020, shall apply with respect to subsection (f)(5).
- (7) INFLATION ADJUSTMENT.—
- (A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2020, each dollar amount in subsection (c)(1), the \$75,000 amount in subsection (c)(2)(B), and the dollar amount in subsection (c)(3)(A), shall be increased by an amount equal to—
- (i) such dollar amount, multiplied by
 - (ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined—
- (I) by substituting “calendar year 2019” for “calendar year 1992” in subparagraph (B) thereof, and
 - (II) by substituting for the CPI referred to section 1(f)(3)(A) the amount that such CPI would have been if the annual percentage increase in CPI with respect to each year after 2019 had been one percentage point greater.
- (B) TERMS RELATED TO CPI.—
- (i) ANNUAL PERCENTAGE INCREASE.—For purposes of subparagraph (A)(ii)(II), the term “annual percentage increase” means the percentage (if any) by which CPI for any year exceeds CPI for the prior year.
 - (ii) OTHER TERMS.—Terms used in this paragraph which are also used in section 1(f)(3) shall have the same meanings as when used in such section.
- (C) ROUNDING.—Any increase determined under subparagraph (A) shall be rounded to the nearest multiple of \$50.
- (8) RULES RELATED TO STATE CERTIFICATION OF QUALIFIED HEALTH PLANS.—A certification shall not be taken into account under subsection (d)(1) unless such certification is made available to the public and meets such other requirements as the Secretary may provide.
- (9) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section and section 1412 of the Patient Protection and Affordable Care Act.

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VII. DISSENTING VIEWS

H.R. 2372 (Johnson, R-TX) would allow veterans who are not enrolled in military-related coverage to access tax credits (as modified by the American Health Care Act (AHCA), H.R. 1628) for the purchase of health insurance in the individual market. This legislation amends the AHCA, which, while passed out of the House, is not yet law.

This legislation is only necessary because of gimmickry in the underlying AHCA. Section 2 of H.R. 2372 was originally part of the AHCA legislation, but it was removed in the Manager's Amendment in the Ways and Means Committee. It would have triggered a budget process (Byrd Rule), which would have required the Republicans to submit the AHCA to the Veteran's Affairs Committee. H.R. 2372 would reinsert the provision.

As passed by the House in early May, the AHCA would prohibit any veteran eligible for government healthcare (such as VA and TRICARE) from receiving a tax credit even if the veteran has a non-group health plan. The important word is "eligible"—this could affect veterans who have never used the VA system and are not enrolled.

Veterans decline VA or TRICARE health care services for a wide variety of reasons, including enrollment requirements (i.e., length of consecutive service and time period of service, tiered prioritization of enrollment eligibility, and separation from service conditions), access issues (e.g., living far from VA services), and availability of other coverage options (e.g., employer-sponsored insurance).

Veterans are already protected under current law; this is a Republican attempt to repeal current law health coverage and protections that has caused the issue. Under current law, veterans are protected both if they are eligible for 15949 military-related coverage and do not enroll, or if they enroll in partial benefits, military-related coverage that does not meet the essential health benefits test. The purpose of Mr. Johnson's bill is to ensure that the House-passed AHCA legislation is consistent with current law in its treatment of veterans.

However, it is not clear that H.R. 2372 would protect veterans who are enrolled in military-related coverage for limited benefits or services, as is provided by current regulations. The Republican AHCA does not have a minimum standard for coverage and allows states to waive essential health benefits; therefore, veterans enrolled for treatment of service-connected disability could be prohibited from receiving tax credits to help them secure coverage for other health care needs.

H.R. 2372 masquerades as help for veterans, but fails to address underlying flaws in the Republican health care bill that harm veterans. H.R. 2372 does not fix any of the problems for veterans

caused by the AHCA bill, including loss of health insurance coverage, higher out-of-pocket costs, loss of essential benefits and treatments, or caps or limits on annual or lifetime coverage.

According to estimates by the independent, nonpartisan Congressional Budget Office (CBO), the AHCA would result in 23 million Americans losing health insurance coverage. This stems from a combination of inadequate out-of-pocket assistance, significant reductions in Medicaid enrollment and a change in rating practices that would allow insurers to charge significantly more for individuals with pre-existing conditions.

The Johnson bill does nothing to improve the inadequate tax credits under the MICA, which it amends. Under the AHCA, tax credits to purchase coverage do not account for the differences in the cost of coverage across the country or family incomes—which would make coverage completely unaffordable for countless American families. On top of that, this bill does nothing to eliminate the age tax in the AHCA, meaning older veterans would face significantly higher premiums.

The AHCA would allow pre-existing condition discrimination under its state waivers. Before Affordable Care Act (ACA) market reforms, military service was a condition for underwriting and discrimination.

The AHCA, as amended by the Johnson bill, would slash Medicaid coverage, jeopardizing affordable health coverage for the more than two million veterans who rely on Medicaid for their insurance. Millions more spouses and children of veterans rely on Medicaid; they too would be harmed. The AHCA cuts \$834 billion from Medicaid and the Trump Administration's budget proposes even deeper cuts. More than 40 percent of working-age veterans with Medicaid had no other source of coverage. The AHCA would jeopardize basic living standards and needed care for veterans who are struggling to make ends meet to pay for tax cuts for the rich. Medicaid provides the following that are critical for veterans' health: mental health services; substance abuse and addiction services; physical therapy services; and general wellness care.

Amendments offered during consideration of H.R. 2372. Democrats offered a series of amendments to highlight the shortcomings of H.R. 2372 and the larger MICA, all but one were ruled non-germane by Chairman Kevin Brady (R-TX) and all but two of those ruled non-germane were appealed by Democratic Members. The appeals were then defeated by party-line votes. The one germane amendment offered by Congressman Davis (D-IL) was defeated by a party-line vote.

Congressman Doggett (D-TX) offered an amendment to reinstate the fee on brand pharmaceutical manufacturers, which helps fund Medicare. In repealing this fee, the Republican health legislation would increase Medicare Part B premiums by \$8.7 billion. Striking the pharma fee from the House Republican plan would protect beneficiaries' Medicare premiums. At a time of rising pharmaceutical profits and limited Social Security cost-of-living increases, this amendment would have helped ensure Medicare costs remain reasonable for beneficiaries.

Congressman Thompson (D-CA) offered an amendment to reinstate the tax on high-income earners which directly funds the

Medicare Part A Trust Fund. The Republican health plan would repeal this tax, shortening the life of Medicare while giving a substantial tax break to the richest Americans. This amendment would prevent \$75 billion being taken from the Medicare Trust Fund, which would reduce the solvency of the Medicare Trust Fund by one year.

Congressman Davis (D-IL) offered an amendment to adjust the tax credits in the Republican proposal to protect veterans under 400 percent of the poverty level to ensure that they would not pay more than 10 percent of their annual income toward the cost of health insurance premiums. While the Republican legislation gives billions of dollars in tax breaks to the wealthiest and most financially secure individuals, Mr. Davis' amendment would have provided a small measure of protection for middle-income and working-class veterans. Under current law, tax credits are based on income and premium costs for families earning less than 400 percent of the poverty level. For instance, between 2016 and 2017, under current law, advanced premium tax credits kept premiums paid by individuals flat for 83 percent of Marketplace enrollees (about 10.1 million people) who received them. The Republican health bill would repeal this current law protection, which is embedded in the design of the tax credit.

Congressman Higgins (D-NY) offered an amendment to prevent veterans from being subject to the five-to-one (5:1) age rating established in the AHCA. Under the AHCA, older individuals could be charged 5+ times as much as younger individuals. However, unlike the current tax credits, which adjust to the cost of premiums, the AHCA tax credits are age adjusted well below the 5:1 ratio. This leads to seniors paying much more for health insurance coverage. As CBO noted in an updated score released in the middle of our mark-up, a 64-year-old senior could see his or her net premiums increase by more than \$16,000 under the AHCA due to increased age rating and smaller premium tax credits than are available under current law. Rather than join with Democrats to protect veterans from the age tax, Republican members hid behind parliamentary tricks to avoid voting to support the veterans in their Districts.

Congresswoman DelBene (D-WA) offered an amendment to ensure that the current law protections for individuals with pre-existing conditions remain in place by rescinding the state waiver authority established in the AHCA. This provision of the AHCA would allow states to waive essential health benefits and allow insurance companies to, once again, discriminate against people with pre-existing conditions. As currently drafted, the Republican health bill undermines the guarantee that all health insurance policies cover essential health benefits like prescription drugs, mental health services, opioid addiction treatment, and maternity care. The AHCA threatens to bring back annual and lifetime limits on healthcare as prohibition of these limits only apply to essential health benefits. Therefore, this AHCA provision threatens not only individual market coverage but also employer-sponsored insurance.

In fact, CBO stated that the waiver provision could have particularly detrimental consequences in their latest analysis: "However, the agencies estimate that about one-sixth of the population resides in areas in which the nongroup market would start to become un-

stable beginning in 2020. That instability would result from market responses to decisions by some states to waive two provisions of federal law, as would be permitted under H.R. 1628. One type of waiver would allow states to modify the requirements governing essential health benefits (EHBs), which set minimum standards for the benefits that insurance in the 15943 nongroup and small-group markets must cover. A second type of waiver would allow insurers to set premiums on the basis of an individual's health status if the person had not demonstrated continuous coverage. . . ."

Before the ACA, 43 states and the District of Columbia allowed insurance companies to charge higher premiums to people with pre-existing conditions. As CBO noted, "In addition, premiums would vary significantly according to health status and the types of benefits provided, and less healthy people would face extremely high premiums, despite the additional funding that would be available under H.R. 1628 to help reduce premiums. Over time, it would become more difficult for less healthy people (including people with preexisting medical conditions) in those states to purchase insurance because their premiums would continue to increase rapidly." This provision of the AHCA would have disastrous consequences for the millions of Americans with pre-existing conditions, including veterans.

Congresswoman Sanchez (D-CA) offered an amendment to prevent gender discrimination against female veterans under the AHCA state-waivers, which would once again allow for insurance companies to discriminate against preexisting conditions, including being a woman. CBO, in fact, noted that pregnant women could face thousands of dollars more in out-of-pocket costs under the Republican health bill.

Congresswoman Sewell (D-AL) offered an amendment to prevent states from enforcing future Medicaid work requirements on veterans receiving Medicaid. Research has shown that Medicaid work requirements would cause millions of enrollees with substantial health needs to lose coverage. Veterans have worked tirelessly on behalf of our country and should not be denied services for lack of employment.

Congresswoman Chu (D-CA) offered an amendment that would require qualified health plans purchased with a tax credit under the AHCA include mental health, behavioral health, and substance abuse treatment benefits. This amendment would insure mental health services are not put out of reach for working families because of artificially high premiums or out-of-pocket costs. This need is particularly important for veterans. According to a 2015 survey from the Iraq and Afghanistan Veterans of America, 58 percent of participating veterans reported having a mental health issue as a direct result of their service. A study from JAMA Psychiatry found the rate of post-traumatic stress disorder (PTSD) among veterans to be 15 times higher than civilians. And, according the Department of Veterans Affairs, suicide rates are 41 percent higher than the general population for deployed veterans, and 61 percent higher than the general population for non-deployed veterans. But, instead of addressing the dire need for mental health services for this vulnerable population, the underlying bill that H.R. 2372 amends would allow states to waive current protections and allow insurers

to offer plans without essential health benefits, including mental health benefits. These waivers would permit insurers to charge people with pre-existing conditions—like, for example, PTSD—more for coverage.

Congressman Pascrell (D–NJ) offered an amendment to allow any individual suffering from Traumatic Brain Injury (TBI) to maintain current premium tax credits. TBI is one of the signature injuries of the wars in Iraq and Afghanistan, and many of our veterans are grappling with the consequences of these injuries. The RAND Corporation estimated that nearly 20 percent of the men and women deployed to Iraq and Afghanistan sustained a brain injury while in the line of duty. More than five million Americans are living with a life-long disability as a result of a TBI, and individuals that sustain moderate and severe TBIs require substantial medical care to recover and cope with their injuries. Access to the supports and services that they need to return to school and work and continue with their everyday lives often results in significant out-of-pocket costs even with health coverage. TBI survivors cannot afford to lose their insurance, nor can they afford any additional costs.

Congressman Kind (D–WI) offered an amendment to protect veterans from being charged more for pre-existing conditions under states that allow health status to be used for rating. Under current law, veterans are not allowed to be charged higher insurance premiums because of a pre-existing condition. The AHCA would allow states to apply for a waiver to current law to allow insurance companies charge higher insurance premiums because a person has a pre-existing health condition like heart disease, autism, or traumatic brain injury. Before the ACA, 43 states and the District of Columbia allowed insurance companies to charge higher premiums to people with pre-existing conditions. This provision of the AHCA would have disastrous consequences for the millions of Americans with preexisting conditions, including veterans.

The Republicans rejected all of the Democratic amendments that would have nominally improved the flawed Republican health care bill. The Johnson bill does not fix any of the underlying flaws that would cause veterans to lose coverage or pay higher out-of-pocket costs. There are numerous actions Congress could take to improve health care for veterans. Enacting a technical fix for a bill that isn't even law yet doesn't pass muster as being a legitimate effort to improve care and coverage for America's veterans. For these reasons, we oppose H.R. 2372.

RICHARD E. NEAL,
Ranking Member.