

114TH CONGRESS }
1st Session

HOUSE OF REPRESENTATIVES

{ REPORT
114-293

**RESTORING AMERICANS' HEALTHCARE
FREEDOM RECONCILIATION ACT OF 2015**

—
R E P O R T

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3762

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SEC-
TION 2002 OF THE CONCURRENT RESOLUTION ON THE BUDGET
FOR FISCAL YEAR 2016

together with

ADDITIONAL AND MINORITY VIEWS



OCTOBER 16, 2015.—Committed to the Committee of the Whole House
on the State of the Union and ordered to be printed

—
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WASHINGTON : 2015

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CONTENTS

	Page
Introduction by the Committee on the Budget	3
Reconciliation and the Budget Resolution	9
Title I—Committee on Education and the Workforce	14
Title II—Committee on Energy and Commerce	67
Title III—Committee on Ways and Means	69
Subtitle A—Revenue Provisions	73
Subtitle B—Repeal of the Independent Payment Advisory Board	141
Committee on the Budget:	
Votes of the Committee on the Budget	189
Other House Report Requirements	193
Views of Committee Members	199
H.R. 3762, Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015	205

114TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } 114-293

**RESTORING AMERICANS' HEALTHCARE FREEDOM
RECONCILIATION ACT OF 2015**

PROVIDING FOR RECONCILIATION PURSUANT TO SECTION 2002 OF THE
CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2016

OCTOBER 16, 2015.—Committed to the Committee of the Whole House on the State
of the Union and ordered to be printed

Mr. TOM PRICE of Georgia, from the Committee on the Budget,
submitted the following

R E P O R T

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany H.R. 3762]

The Committee on the Budget, to whom reconciliation recommendations were submitted pursuant to section 2002 of S. Con. Res. 11, the concurrent resolution on the budget for fiscal year 2016, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

INTRODUCTION BY THE COMMITTEE ON THE BUDGET

Clearing the Way for Real Health Care Reform

The essential failing of Obamacare runs deeper than its distortions of health care delivery and financing, its clumsy rollout, or the President's numerous unilateral changes in the law *after* its enactment. Beneath all these, the fundamental flaw of Obamacare is the conceit that Washington could somehow centrally manage a vast and complex medical sector serving nearly 320 million diverse individuals. That notion has proved a failure. It requires suffocating mandates and regulations. It stifles health care delivery, making it less responsive and more costly. Above all, it necessarily imposes government dictates on highly personal medical decisions, effectively placing a government agent in every examining room and alongside every hospital bed.

That is why Obamacare must be dismantled. The aim is not only to reject this illegitimately conceived government expansion, which still—more than 5 years after its enactment—lacks the support of even a simple majority of the American public. It is not just to replace one national health program with another. The point is to discard the entire pretense of nationalized medicine, and recognize that health care works best when it promotes the most important and basic relationship in medicine—the one between the patient and the doctor. Everything else in the \$3 trillion health care network—hospitals, nurses, technicians, medical device makers, pharmaceutical companies, researchers, health insurers, and many more—revolves around that fundamental partnership.

Obamacare must be repealed to clear the way for genuine, compassionate, patient-centered health care reform. That is the broader aim of this legislation: the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015.

Like so much of Washington's health care policy, this massive program—formally called the Affordable Care Act¹—was designed to satisfy the ivory tower aspirations of academics and protect the fortresses of government bureaucracies. Instead of responding to the medical needs of real people in the real world, it adds layers of rules and directives to further systematize health care as a government-run service. It seeks to control costs from the top down—which can only lead to rationing health services—rather than trust-

¹ Because the House and Senate could not agree on a single plan, they had to pass two bills, one modifying the other, to create the Affordable Care Act. The two measures were the Patient Protection and Affordable Care Act (H.R. 3590, Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (H.R. 4872, Public Law 111-152).

ing prices to emerge naturally from the free choices of millions of individuals.

True health care reform can only arise from a different way of thinking about it. There is no one strategy for making health care more effective and efficient; there is no unified approach, especially not by government. True reform can only emerge from the flexibility and innovation of all the participants, always seeking creative ways to advance better and less costly health care. As spelled out in the fiscal year 2016 budget resolution, which led to this legislation, policymakers should apply the guiding principles below to develop real health care reform.²

Affordability. Real reform should ensure that all Americans, no matter their age, income, or health status, can afford health coverage. The health care delivery structure should be improved, and individuals should not be priced out of the insurance market due to pre-existing conditions. Nationalized health care not only fails to accomplish these aims, but in fact undermines them. Individuals should be allowed to join together voluntarily to pool risk through mechanisms such as Individual Membership Associations and Small Employer Membership Associations.

Accessibility. Instead of Washington dictating to Americans how they may or may not use their health insurance, reforms should make health coverage more portable. Individuals should be able to own their insurance and have it follow them in and out of jobs throughout their careers. Small business owners should be permitted to band together across State lines through their membership in bona fide trade or professional associations to purchase health coverage for their families and employees at a low cost. This will increase small businesses' bargaining power, volume discounts, and administrative efficiencies while giving them freedom from State-mandated benefit packages. Also, insurers licensed to sell policies in one State should be permitted to offer them to residents in any other State; consumers should be permitted to shop for health insurance across State lines, as they are with other insurance products online, by mail, by telephone, or in consultation with an insurance agent.

Quality. Incentives for providers to deliver high-quality, responsive, and coordinated care will promote better patient outcomes and drive down health care costs. Likewise, reforms should work to restore the patient-physician relationship by reducing administrative burdens and allowing physicians to do what they do best: care for patients.

Choices. Genuine reform should free individuals and families to secure the health coverage that best meets their needs, rather than instituting one-size-fits-all directives from Federal bureaucracies such as the Internal Revenue Service, the Department of Health and Human Services, and the Independent Payment Advisory Board.

²See section 6205 of the Conference Report accompanying the Concurrent Resolution on the Budget for Fiscal Year 2016 (S. Con. Res. 11).

Innovation. Instead of stifling innovation in health care technologies, treatments, medications, and therapies with Federal mandates, taxes, and price controls, a reformed health care system should encourage research, development, and innovation.

Responsiveness. Reform should vigorously apply the spirit of federalism, returning authority to States wherever possible, to make health care more responsive to patients and their needs. Instead of tying States' hands with Federal requirements for their Medicaid programs, the Federal Government should return control of this program to the States. The current Medicaid Program only drives up Federal debt and threatens to bankrupt State budgets. States are better positioned to provide quality, affordable care to those eligible for the program and to track down and weed out waste, fraud, and abuse. Beneficiary choices in the State Children's Health Insurance Program [SCHIP] and Medicaid should be improved. States should make available the purchase of private insurance as an option to their Medicaid and SCHIP populations (though they should not require enrollment).

Legal Reforms. Policymakers should develop reforms that prevent lawsuit abuse and curb the practice of defensive medicine, which are significant drivers increasing health care costs. The burden of proof in medical malpractice cases should be based on compliance with best practice guidelines and States should be free to implement those policies to best suit their needs.

The Role of the Committee on the Budget

As required by the conference agreement accompanying the Concurrent Resolution on the Budget for Fiscal Year 2016 (S. Con. Res. 11), this reconciliation legislation comprises provisions from three committees of the House of Representatives with jurisdiction related to the Affordable Care Act: the Committee on Education and the Workforce, the Committee on Energy and Commerce, and the Committee on Ways and Means. Each committee met its instruction to achieve at least \$1 billion in deficit reduction over 10 years, submitting targeted provisions aimed at deconstructing the foundation of the Affordable Care Act.

At this stage of the process, the role of the Committee on the Budget is to determine whether the bill complies with the deficit reduction targets in the budget resolution. It then binds together the submissions of the three committees into a single bill. The Committee on the Budget subsequently reports the combined bill to the House with the recommendation that it be passed by the entire House. The Congressional Budget Act of 1974 precludes the Committee on the Budget from making any substantive change in the bill during the course of its markup. If a change in the reported bill is necessary, section 310(d)(5) of the Act prescribes the following procedure: "The Committee on Rules of the House of Representatives may make in order amendments to achieve changes specified by reconciliation directives contained in a concurrent resolution on the budget if a committee or committees of the House fail to submit recommended changes to its Committee on the Budget pursuant to its instruction."

During markup, the Committee on the Budget adopted a motion granting the Chairman, at his discretion, the authority to request the Committee on Rules to report a rule for consideration of this measure that would make in order an amendment to the bill.

It is not unusual for amendments to budget reconciliation legislation to be made in order at the Rules Committee for reasons other than one or more committees failing to meet reconciliation instructions. Amendments often are needed to make technical and conforming changes in complex legislation. At other times, changes are needed to address any of the many House and Senate budget rules. On occasion, amendments are needed to resolve the inevitable interactions among multiple committees' submissions or to address unresolved policy issues.

The Committees' Submissions

The submissions from the three reporting committees detail and explain their specific provisions and outline how they fulfill their instructions and provide the required amount of deficit reduction over the next 10 years. A summary of the provisions is as follows:

TITLE I: COMMITTEE ON EDUCATION AND THE WORKFORCE

Section 101: Repeal of Automatic Enrollment Requirement. Repeals Section 18A of the Fair Labor Standards Act (29 U.S.C. 218a), as added by section 1511 of the Affordable Care Act. Section 1511 requires employers with more than 200 employees to automatically enroll new full-time equivalents into a qualifying health plan if offered by that employer, and to automatically continue enrollment of current employees.

Net Change in Deficit, 2016–2025: –\$7.9 billion.

TITLE II: COMMITTEE ON ENERGY AND COMMERCE

Section 201: Repeal Prevention and Public Health Fund. Repeals the Prevention and Public Health Fund [PPHF] and rescinds unobligated balances. The PPHF allows the Secretary of Health and Human Services to transfer amounts from the fund to Department of Health and Human Services accounts to increase funding for Public Health Service Act-authorized prevention, wellness, and public health activities, including prevention research and health screenings.

Section 202: Federal Payment to States. Prohibits Medicaid reimbursement for 1 year for a defined entity, which includes its affiliates, subsidiaries, successors, and clinics.

Section 203: Funding for Community Health Center Program. Increases funding to the Community Health Center Fund by \$235 million in each of fiscal years 2016 and 2017, as extended by the Medicare Access and CHIP Reauthorization Act (H.R. 2).

Net Change in Deficit, 2016–2025: –\$12.4 billion.

TITLE III: COMMITTEE ON WAYS AND MEANS

Subtitle A—Revenue Provisions

Section 301: Repeal Individual Mandate Tax. Repeals the penalty on individuals who do not obtain qualified health insurance, effective after 1 December 2014.

Section 302. Repeal of Employer Mandate. Repeals the penalty on employers who do not offer their employees qualified health insurance, effective after 1 December 2014.

Section 303: Repeal Medical Device Tax. Repeals the 2.3-percent excise tax, effective 31 December 2012, on the sale of any taxable medical device by a manufacturer, producer, or importer of such device.

Section 304: Repeal of the Excise Tax on Employee Health Insurance Premiums and Health Benefits and Related Reporting Requirements (i.e. the Cadillac Tax). Repeals the 40-percent excise tax on high-value health plans.

Subtitle B—Repeal of the Independent Payment Advisory Board

Section 311: Repeal Medicare Independent Payment Advisory Board [IPAB]. Repeals IPAB, which would have been required under certain circumstances to modify the Medicare Program to achieve specified savings in the Medicare Program. See also H.R. 1190, which passed the House on 23 June 2015.

Net Change in Deficit, 2016–2025: –\$37.1 billion.

Due to interactions between the provisions submitted by the House committees, an additional net change in the deficit of –\$19.4 billion for fiscal years 2016–2025 was determined by the Congressional Budget Office. The reconciliation bill's total net change in the deficit for all reported provisions is –\$78.9 billion for fiscal years 2016–2025.

RECONCILIATION AND THE BUDGET RESOLUTION

Budget resolutions and reconciliation bills have a special relationship in the congressional budget process. The adoption of a budget resolution—formally designated a concurrent resolution on the budget—establishes the reconciliation process for a fiscal year in addition to providing rules that assist in guiding a reconciliation bill through the congressional legislative procedure. Conversely, a reconciliation bill may be essential to fulfilling the aims of a given budget resolution.

The Reconciliation Process

The term “reconciliation” refers to both a form of legislation and a specific legislative procedure. Only by adopting a concurrent resolution on the budget that includes reconciliation instructions can Congress initiate the reconciliation process,³ ideally culminating in the enactment of reconciliation legislation. Such a measure is termed a “reconciliation bill” because it is designed to amend existing law to reflect the assumptions underlying the budget resolution from which it has commenced; that is, it reconciles current law to the budget resolution framework.

S. Con. Res. 11, the conference report accompanying the Concurrent Resolution on the Budget for Fiscal Year 2016,⁴ agreed to on May 5, 2015, included reconciliation instructions requiring three House committees and two Senate committees to amend laws in their jurisdictions such that each committee reduces the deficit by \$1 billion over 10 years.⁵ Under the procedure, these legislative amendments were then to be submitted to the Committees on the Budget of the House and Senate by July 24, 2015.

In the House, the Committee on the Budget accepted submissions from the three reconciled committees—the Committees on Education and the Workforce, Energy and Commerce, and Ways and Means—on October 2, 2015. The submissions included legislative text, short summaries, Congressional Budget Office estimates, and other material to assist the Committee on the Budget in preparing this explanatory report.

The basic elements of a reconciliation bill are set forth in the Congressional Budget Act of 1974 [Budget Act]. Additional guidelines over content and procedures governing consideration may be included in budget resolutions.

³Section 310 of the Congressional Budget Act of 1974 (2 U.S.C. § 641).

⁴H. Rept. 114-096.

⁵Sections 2001(a) and 2002(a) of S. Con. Res. 11 (114th Congress).

Reconciliation in the House of Representatives

Reconciliation is defined as a privileged measure in the House and hence takes precedence over certain other matters that may be considered on the floor. When a bill is reported by the Committee on the Budget, comprising the submissions transmitted to it, under House Rules such a bill is “originated” rather than “introduced”. Only certain measures become legislation in this fashion: resolutions providing for consideration of bills on the floor, appropriation bills, and budget resolutions are examples. Therefore, a reconciliation bill neither receives an “H.R.” number nor is considered a legislative matter until the Committee on the Budget votes to report the bill and formally files it with the Clerk of the House.

Budget Resolution Adjustment and House Rules. Under normal circumstances, all points of order and other procedural budget-related requirements apply to House reconciliation bills. For the measure reported by the Committee on the Budget on October 9, 2015, this is not the case. S. Con. Res. 11 specifically provided for the consideration of this bill and took into account its budgetary effects. Therefore, Budget Act points of order, the Cut-As-You-Go point of order,⁶ and the long-term direct spending point of order contained in the fiscal year 2016 budget resolution⁷ do not apply to this House reconciliation bill.

The budget resolution also affirmed and clarified the authority of the Chairman of the Committee on the Budget to determine the cost estimates of legislative measures.⁸ In particular, if the Congressional Budget Office makes adjustments to its baseline subsequent to its official publication, the Chairman is authorized to make decisions as to how to treat those updates. The intent of the provision is to affirm the Chairman’s ability to take into account unforeseeable events that may occur and diverge from the assumptions underlying the budget resolution. This has important implications in how the budgetary effects of reconciliation bills are determined.

Reconciliation and Health Care Legislation. An additional House component of the budget resolution entails providing guidance to the committees receiving reconciliation instructions. They are asked to “note the policies discussed in the fiscal year 2016 budget resolution that repeal the Affordable Care Act and the health care related provisions of the Health Care and Education Reconciliation Act of 2010”.

Reconciliation in the Senate

The two committees in the Senate that received reconciliation instructions are the Committee on Finance and the Committee on Health, Education, Labor, and Pensions. These Senate committees generally have commensurate jurisdiction as those in the House, and each was required to reduce the deficit by \$1 billion over the same 10-year period.

⁶ Clause 10 of rule XXI of the Rules of the House of Representatives.

⁷ Section 3101(b)(2) of S. Con. Res. 11 (114th Congress).

⁸ Section 2002(b)(1)(A) of S. Con. Res. 11 (114th Congress).

Reconciliation and the Deficit Point of Order. The budget resolution amended Senate legislative procedures by repealing the point of order against a reconciliation bill increasing the deficit over 5 or 10 fiscal years.⁹ This prohibition was originally adopted in the 110th Congress and was intended to prevent such bills from reducing taxes. The reconciliation bill considered and reported by the Committee on the Budget of the House does not increase the deficit in either of the periods set forth in the Senate point of order repealed by the budget resolution.

Debt Limit Prohibition. Under the Congressional Budget Act of 1974, reconciliation bills are specifically allowed to include changes in the public debt limit.¹⁰ Section 2001(b)(1) of S. Con. Res. 11, though, overturns that authority and instead establishes a point of order against including a debt limit increase. The Senate may not consider a reconciliation bill, joint resolution, conference report, or an amendment, if it would increase the public debt limit in any year during the period of fiscal years 2016 through 2025.¹¹

This point of order may be waived, but only if two-thirds of the Senate (67 Senators) votes to do so. This supermajority is atypical in that most budget-related points of order may be waived by a three-fifths vote (60 Senators).

Conclusion

The relationship between the concurrent resolution on the budget for a fiscal year, and a reconciliation bill that may result from the adoption of such a measure, is a significant element of the congressional budget process. Budget resolutions not only initiate the reconciliation procedure, but can set key parameters and guidelines by which a reconciliation bill ultimately navigates the sometimes complex legislative process of the U.S. Congress. Conversely, the provisions of a reconciliation bill may be necessary for achieving the budget resolution's goals. Thus, this reconciliation measure represents an important step toward fulfilling the aims of S. Con. Res. 11, the Concurrent Resolution on the Budget for Fiscal Year 2016.

⁹Section 3204 of S. Con. Res. 11 (114th Congress).

¹⁰Section 310(a)(3) of the Congressional Budget Act of 1974 authorizes a reconciliation measure to "specify the amounts by which the statutory limit on the public debt is to be changed and direct the committee having jurisdiction to recommend such change."

¹¹The statutory debt limit is set in 31 U.S.C. § 3101.

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October 2, 2015

The Honorable Tom Price, M.D.
Chairman, Committee on the Budget
U.S. House of Representatives
207 Cannon HOB
Washington, DC 20515

Dear Chairman Price:

The House Education and the Workforce Committee has met its instruction to achieve net savings of \$1 billion as part of the budget reconciliation process, while generating savings on behalf of taxpayers.

This submission is in order to comply with the reconciliation directives included in S. Con. Res. 11, the Fiscal Year 2016 budget resolution and is consistent with section 310 of the *Congressional Budget and Impoundment Control Act of 1974*. I am pleased to transmit the Committee's recommendation to eliminate the *Patient Protection and Affordable Care Act* (PPACA) mandate for certain large employers to enroll full-time employees in one of their health care plans initially and continue enrollment subsequently. This recommendation was considered in a Full Committee markup on September 30, 2015, and approved by a vote of 22-15.

A copy of the legislation and Committee Report (including the Committee Views, Summary, Section by Section Analysis, Congressional Budget Office estimate, and Ramseyer and Minority Views) are enclosed. I hope these proposals will be of assistance to your committee in meeting the budget reconciliation targets. If you have questions or comments, please do not hesitate to call me.

Sincerely,


JOHN KLINE
Chairman

[COMMITTEE PRINT]

**[Budget Reconciliation Legislative Recommendations Relating to Repeal of
Automatic Enrollment Requirement]**

**TITLE I—COMMITTEE ON EDUCATION
AND THE WORKFORCE**

SEC. 01. REPEAL OF AUTOMATIC ENROLLMENT REQUIREMENT.

The Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.) is amended by repealing section 18A (as added by section 1511 of the Patient Protection and Affordable Care Act (P.L. 111–148)).

**COMMITTEE ON EDUCATION AND THE WORKFORCE
RECONCILIATION COMMITTEE PRINT
COMMITTEE REPORT**

PURPOSE

The Committee Print on legislation regarding the Committee’s instruction pursuant to section 2002 (a)(1) of S.Con.Res 11(Reconciliation Committee Print) eliminates the *Patient Protection and Affordable Care Act* (PPACA) mandate for certain large employers to enroll full-time employees in one of their health care plans initially and continue enrollment subsequently. Eliminating this requirement will reduce the federal deficit by \$7.9 billion over ten years (2016-2025), thus satisfying the instructions given to the Committee by S. Con. Res. 11.

COMMITTEE ACTION

112th CONGRESS

Full Committee Hearing Examining the State of the American Workforce

On January 26, 2011, the Committee on Education and the Workforce (Committee) held a hearing entitled “State of the American Workforce” to review the economic uncertainty felt by businesses, including concerns resulting from enactment of PPACA. The witnesses before the committee were the Honorable Robert F. McDonnell, Governor, Commonwealth of Virginia, Richmond, Virginia; Mr. Douglas Holtz-Eakin, President, American Action Forum, Washington, D.C.; Mr. Dyke Messinger, President, Power Curbers, Inc., Salisbury, North Carolina; and Ms. Heather Boushey, Senior Economist, Center for American Progress, Washington, D.C.

Full Committee Hearing Examining the Impact of the Health Care Law on the Economy, Employers, and the Workforce

On February 9, 2011, the Committee held a hearing entitled “The Impact of the Health Care Law on the Economy, Employers, and the Workforce.” The witnesses before the Committee were Dr. Paul Howard, Senior Fellow, Manhattan Institute, New York, New York; Ms. Gail Johnson, President & CEO, Rainbow Station, Inc., Glenn Allen, Virginia; Dr. Paul Van de Water, Senior Fellow, Center on Budget and Policy Priorities, Washington, D.C.; and Mr. Neil Trautwein, Vice President & Employee Benefits Policy Counsel, National Retail Federation, Washington, D.C.

Subcommittee Hearing Examining the Pressures of Rising Costs on Employer Provided Health Care

On March 10, 2011, the Subcommittee on Health, Employment, Labor, and Pensions (HELP) held a hearing entitled “The Pressures of Rising Costs on Employer Provided Health Care” to examine how increased health care costs are creating uncertainty for employers, including an examination of the impact of PPACA on employer coverage. The witnesses were Mr. Tom Miller, Resident Fellow, American Enterprise Institute, Washington, D.C.; Mr. Brett Parker, Vice Chairman and Chief Financial Officer, Bowlmor Lanes, New York, New York; Mr.

John Houser, Owner, Hawthorne Auto, Portland, Oregon; and Mr. J. Michael Brewer, President, Lockton Benefit Group, Lockton Companies, LLC, Kansas City, Missouri.

Full Committee Hearing Examining the Policies and Priorities of the U.S. Department of Health and Human Services

On May 5, 2011, the Committee held a hearing entitled “Policies and Priorities of the U.S. Department of Health and Human Services,” which examined the failures of the department to properly implement the recently enacted health care law. The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services (HHS), Washington, D.C., was the only witness.

Subcommittee Hearing Examining the Effects of the Recent Health Care Law on Indiana Families and Workers

On June 7, 2011, the HELP Subcommittee held a field hearing in Evansville, Indiana, entitled “The Recent Health Care Law: Consequences for Indiana Families and Workers” to review the negative effects of the health care law on employers and employees in the community. The witnesses were the Honorable Mark Messmer, Indiana House of Representatives, Messmer Mechanical, Jasper, Indiana; Ms. Robyn Crosson, Company Compliance Services, State of Indiana Department of Insurance, Indianapolis, Indiana; Ms. Sherry Lang, H.R. Director, Womack Restaurants, Terre Haute, Indiana; Mr. Denis Johnson, Vice President of Operations, Boston Scientific, Spencer, Indiana; Dr. David J. Carlson, M.D., General Surgeon, Deaconess Hospital, Evansville, Indiana; and Mr. Glen Graber, President, Graber Post Buildings, Inc., Odon, Indiana.

Subcommittee Hearing Examining the Regulations, Costs, and Uncertainty in Employer Provided Health Care

On October 13, 2011, the HELP Subcommittee held a hearing entitled “Regulations, Costs, and Uncertainty in Employer Provided Health Care” to examine the extent to which PPACA negatively impacted employer health care coverage. The witnesses were Ms. Grace-Marie Turner, President, Galen Institute, Alexandria, Virginia; Mr. Dennis M. Donahue, Managing Director, Wells Fargo Insurance Services USA, Inc., Chicago, Illinois; Mr. Ron Pollack, Executive Director, Families USA, Washington, D.C.; and Ms. Robyn Piper, President, Piper Jordan, San Diego, California.

Full Committee Hearing Examining Expanding Opportunities for Job Creation

On February 1, 2012, the Committee held a hearing entitled “Expanding Opportunities for Job Creation” to examine the adverse impact of growing health care costs on job creation, and the increasing economic uncertainty caused by PPACA. The witnesses were the Honorable Rick Snyder, Governor, State of Michigan, Lansing, Michigan; the Honorable Daniel “Dan” Malloy, Governor, State of Connecticut, Hartford, Connecticut; Ms. Kellie Johnson, President, ACE Clearwater Industries, Torrance, California; Dr. Jared Bernstein, Senior Fellow, Center on Budget and Policy Priorities, Washington, D.C.; and Dr. Matthew Mitchell, Senior Research Fellow for Economics, The Mercatus Center at George Mason University, Arlington, Virginia.

Subcommittee Hearing Examining the Health Care Challenges Facing Pennsylvania's Workers and Job Creators

On February 22, 2012, the HELP Subcommittee held a field hearing in Butler, Pennsylvania, entitled "Health Care Challenges Facing Pennsylvania's Workers and Job Creators" to review the harmful impact of the health care law on employers in the community. The witnesses were the Honorable Donald C. White, Senator PA-41, Pennsylvania State Senate, Harrisburg, Pennsylvania; Ms. Kathleen Bishop, President and CEO, Meadville-Western Crawford, County Chamber of Commerce, Meadville, Pennsylvania; Ms. Georgeanne Koehler, retired SEIU member, Pittsburgh, Pennsylvania; Ms. Lori Joint, Director of Government Affairs, Manufacturer & Business Association, Erie, Pennsylvania; Ms. Patti-Ann Kanterman, CFO, Associated Ceramics & Technology, Inc., Sarver, Pennsylvania; Mr. Paul T. Nelson, Owner and CEO, Waldameer Park, Inc., Erie, Pennsylvania; Mr. Ralph Vitt, Owner, Vitt Insure, Pittsburgh, Pennsylvania; and Mr. Will Knecht, President, Wendell August Forge, Grove City, Pennsylvania.

Full Committee Hearing Reviewing the President's Fiscal Year 2013 Budget Proposal for the U.S. Department of Labor

On March 21, 2012, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2013 Budget Proposal for the U.S. Department of Labor," which included an examination of the Department of Labor's (DOL) failure to properly oversee the implementation of the health care law. The Honorable Hilda L. Solis, Secretary, U.S. Department of Labor, Washington, D.C., was the only witness.

Full Committee Hearing Reviewing the President's Fiscal Year 2013 Budget Proposal for the U.S. Department of Health and Human Services

On March 28, 2012, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2013 Budget Proposal for the U.S. Department of Health and Human Services" to examine the adverse effects of rising health care costs on employers and the department's role in implementing the health care law. The Honorable Kathleen G. Sebelius, Secretary, U.S. Department of Health and Human Services, Washington, D.C., was the only witness.

Subcommittee Hearing Examining Barriers to Lower Health Care Costs for Workers and Employers

On May 31, 2012, the HELP Subcommittee held a hearing entitled "Barriers to Lower Health Care Costs for Workers and Employers" to examine rising health care costs facing employers and employees, including the destructive impact of PPACA. The witnesses were Mr. Ed Fensholt, Senior Vice President, Lockton Companies, LLC, Kansas City, Missouri; Mr. Roy Ramthun, President, HAS Consulting Services, Washington, D.C.; Ms. Jody Hall, Founder & Owner, Cupcake Royale, Seattle, Washington; and Mr. Bill Streitberger, Vice President of Human Resources, Red Robin, Greenwood Village, Colorado.

113th CONGRESS

H.R. 1245, the Auto Enroll Repeal Act, Introduced

On March 19, 2013, Committee member Rep. Richard Hudson (R-NC) introduced H.R. 1245, the *Auto Enroll Repeal Act*. The legislation repealed section 18A of the *Fair Labor Standards Act* (FLSA) as added by section 1511 of PPACA. The FLSA provision requires employers with 200 or more full-time employees that offer health plans to automatically enroll new full-time employees (and continue enrollment of current employees) in a health plan. This mandate does not apply if the full-time employee chooses to opt-out within the applicable waiting period. H.R. 1245 was substantively identical to a bill, H.R. 2206, introduced in the 112th Congress by Rep. Frank Guinta (R-NH), who was not a member of the Committee.

Subcommittee Hearing Examining Health Care Challenges Facing North Carolina's Workers and Job Creators

On April 30, 2013, the HELP Subcommittee held a field hearing entitled "Health Care Challenges Facing North Carolina's Workers and Job Creators" to review the negative impact of PPACA on North Carolina employers and their workers. Witnesses before the subcommittee were Mr. Chuck Horne, President, Homwood Inc., Lilesville, North Carolina; Ms. Tina Haynes, Chief Human Resource Officer, Rowan-Cabarrus Community College, Salisbury, North Carolina; Mr. Adam Searing, Director, Health Access Coalition, Raleigh, North Carolina; Mr. Ken Conrad, Chairman, Libby Hill Seafood Restaurants, Greensboro, North Carolina; Mr. Dave Bass, Vice President, Compensation and Associate Wellness, Delhaize America, Concord, North Carolina; Mr. Ed Tubel, Founder and CEO, Tricor Inc., Charlotte, North Carolina; Dr. Olson Huff, Pediatrician, Asheville, North Carolina; and Mr. Bruce Silver, President and CEO, Racing Electronics, Concord, North Carolina.

Full Committee Hearing Reviewing the President's Fiscal Year 2014 Budget Proposal for the U.S. Department of Health and Human Services

On June 4, 2013, the Committee held a hearing entitled "Reviewing the President's Fiscal Year 2014 Budget Proposal for the U.S. Department of Health and Human Services." Testimony included discussion about implementation of PPACA. The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, Washington, D.C., was the only witness.

Subcommittee Hearing Regarding the Employer Mandate: Examining the Delay and Its Effect on Workplaces

On July 23, 2013, the HELP Subcommittee and the Workforce Protections Subcommittee jointly held a hearing entitled "The Employer Mandate: Examining the Delay and Its Effect on Workplaces" to review the costly impact of the administration's recent decision to delay the employer mandate. Witnesses before the subcommittees were Ms. Grace-Marie Turner, President, Galen Institute, Alexandria, Virginia; Mr. Jamie T. Richardson, Vice President, White Castle System, Inc., Columbus, Ohio; Mr. Ron Pollack, Executive Director, Families USA, Washington, D.C.; and Dr. Douglas Holtz-Eakin, President, American Action Forum, Washington, D.C.

Subcommittee Hearing Regarding Health Care Challenges Facing Kentucky's Workers and Job Creators

On August 27, 2013, the HELP Subcommittee held a field hearing entitled "Health Care Challenges Facing Kentucky's Workers and Job Creators," which included an examination of the harmful impact of PPACA on Kentucky's employers and their employees. Witnesses before the subcommittee were Mr. Tim Kanaly, Owner and President, Gary Force Honda, Bowling Green, Kentucky; Mr. Joe Bologna, Owner, Joes Bologna's – Italian Pizzeria & Restaurant, Lexington, Kentucky; Ms. Carrie Banahan, Executive Director, Office of the Kentucky Health Benefit Exchange, Frankfort, Kentucky; Mr. John Humkey, President, Employee Benefit Associates, Inc., Lexington, Kentucky; Ms. Janey Moores, President and CEO, BJM & Associates, Inc., Lexington, Kentucky; Mr. Donnie Meadows, Vice President of Human Resources, K-VA-T Food Stores, Inc., Abingdon, VA; Ms. Debbie Basham, Southwest Breast Cancer Awareness Group, Louisville, Kentucky; and Mr. John McPhearson, CEO, Lectrodryer, Richmond, Kentucky.

Full Committee Hearing Examining The Effects of the Patient Protection And Affordable Care Act on Schools, Colleges, and Universities

On November 14, 2013, the Committee held a hearing entitled "The Effects of the Patient Protection And Affordable Care Act on Schools, Colleges, and Universities" to examine the destructive effects of PPACA's employer mandate on elementary, secondary, and higher education employers and their workers. Witnesses before the Committee were Gregory L. Needles, Partner, Morgan, Lewis & Bockius, Washington, D.C.; Dr. Thomas Jandris, Dean, College of Graduate and Innovative Programs, Concordia University Chicago, River Forest, Illinois; Maria Maisto, President, New Faculty Majority, Akron, Ohio; and Dr. Mark D. Benigni, Superintendent, Meriden Public Schools, Meriden, Connecticut.

Subcommittee Hearing Regarding Providing Access to Affordable, Flexible Health Plans through Self-Insurance

On February 26, 2014, the HELP Subcommittee held a hearing entitled "Providing Access to Affordable, Flexible Health Plans through Self-Insurance" to examine the adverse impact of PPACA on self-insured plans. Witnesses before the subcommittee were Mr. Michael Ferguson, President and CEO, Self-Insurance Institute of America, Simpsonville, South Carolina; Mr. Wes Kelley, Executive Director, Columbia Power and Water Systems, Columbia, Tennessee; Ms. Maura Calsyn, Director of Health Policy, Center for American Progress, Washington, D.C.; and Mr. Robert Melillo, National Vice President of Risk Financing Solutions, USI Insurance, Glastonbury, Connecticut.

Subcommittee Hearing Regarding The Effects of the President's Health Care Law on Indiana's Classrooms and Workplaces

On September 4, 2014, the HELP Subcommittee held a hearing entitled "The Effects of the President's Health Care Law on Indiana's Classrooms and Workplaces," which included an examination of the damaging impact of the law on employer-sponsored coverage, especially in Indiana. Witnesses before the subcommittee were Mr. Mike Shafer, Chief Financial Officer, Zionsville Community Schools, Zionsville, Indiana; Mr. Tom Snyder, President, Ivy Tech

Community College, Indianapolis, Indiana; Mr. Danny Tanoos, Superintendent, Vigo County School Corporation, Terre Haute, Indiana; Mr. Tom Forkner, President, Anderson Federation of Teachers, AFT Local 519, Anderson, Indiana; Mr. Mark DeFabis, President and CEO, Integrated Distribution Services, Plainfield, Indiana; Mr. Nate LaMar, International Regional Manager, Draper, Inc., Spiceland, Indiana; Mr. Dan Wolfe, Owner, Wolfe's Auto Auction, Terre Haute, Indiana; and Dr. Robert Stone, Director of Palliative Care, IU Health Bloomington Hospital, Bloomington, Indiana.

114th CONGRESS

Subcommittee Hearing on Five Years of Broken Promises: How the President's Health Care Law is Affecting America's Workplaces

On April 14, 2015, the HELP Subcommittee held a hearing entitled "Five Years of Broken Promises: How the President's Health Care Law is Affecting America's Workplaces," which examined the continuing negative impact of PPACA on employer-sponsored health coverage. Witnesses before the subcommittee were the Honorable Tevi Troy, Ph.D., President, American Health Policy Institute, Washington, D.C.; Mr. Rutland Paal, Jr., President, Rutland Beard Floral Group, Scotch Plains, New Jersey; Michael Brev, President, Brev Corp. t/a Hobby Works®, WingTOTE Manufacturing, LLC, Laurel, Maryland; and Ms. Sally Roberts, Human Resources Director, Morris Communications Company, LLC, Augusta, Georgia.

H.R. 3112, the Better Enrollment Options Protect Employee Needs Act (BE OPEN Act), Introduced

On July 16, 2015, Rep. Elise Stefanik (R-NY) introduced the *Better Enrollment Options Protect Employee Needs Act* (BE OPEN Act), with two cosponsors. This legislation was substantively identical to H.R. 2206, as introduced in the 112th Congress, and to the Reconciliation Committee Print.

Full Committee Hearing Reviewing the Policies and Priorities of the U.S. Department of Health and Human Services

On July 28, 2015, the Committee held a hearing entitled "Reviewing the Policies and Priorities of the U.S. Department of Health and Human Services" to examine the adverse impact of automatic enrollment on employees and employers. The Honorable Sylvia Burwell, Secretary, U.S. Department of Health and Human Services, Washington, D.C., was the only witness.

Full Committee Markup of the Committee Print on Legislation Regarding the Committee's Reconciliation Instruction

The U.S. House of Representatives and U.S. Senate passed S. Con. Res. 11, the concurrent resolution on the budget for fiscal year 2016, respectively on April 30, 2015, and May 5, 2015. This budget agreement instructed the committees with jurisdiction over PPACA – the House Ways and Means, House Energy and Commerce, House Education and the Workforce, Senate Finance, and Senate Health, Education, Labor and Pensions Committees – to report legislation that would achieve at least \$1 billion in savings per committee.

On September 30, 2015, the Committee marked up the Reconciliation Committee Print legislation to achieve those savings in accordance with the instructions for deficit reduction. Rep. Elise Stefanik (R-NY) offered an amendment in the nature of a substitute, making technical drafting corrections to the Reconciliation Committee Print. The Committee voted to adopt the amendment in the nature of a substitute by voice vote. The Committee then voted favorably by a recorded vote of 22-15 to transmit the amended Reconciliation Committee Print to the House Committee on the Budget. According to the Congressional Budget Office and Joint Committee on Taxation, this legislation will reduce the federal deficit by \$7.9 billion (2016-2025).¹

OTHER CONGRESSIONAL AND REGULATORY ACTION

Enactment of Automatic Enrollment for Health Care

In March 2010, Congress passed and the President signed PPACA (P.L. 111-148) and the *Health and Education Reconciliation Act of 2010* (P.L. 111-152). Section 1511 of PPACA amended the FLSA, over which the Committee has jurisdiction.

Prior to consideration of the bill that would become PPACA, the House considered H.R. 3200, *America's Affordable Health Choices Act of 2009*. The Committee marked up relevant portions of H.R. 3200 on July 15-17, 2009. H.R. 3200 contained an "Automatic Enrollment for Employer Sponsored Health Benefits" provision requiring employers to automatically enroll an employee into individual coverage under the employer's health benefits plan with the lowest premium contribution.² The provision gave employees a 30 day window to opt out or be automatically enrolled in the employers' coverage, and it explicitly outlined employer notice requirements.

Subsequently, the House passed H.R. 3962, the *Affordable Health Care for America Act*, on November 7, 2009, by a vote of 220-215.³ H.R. 3962 contained the same "Automatic Enrollment for Employer Sponsored Health Benefits" provision included in H.R. 3200.⁴

On October 19, 2009, the Senate Committee on Finance considered S. 1796, the *America's Healthy Future Act of 2009*, which amended Title XXII of the *Social Security Act* by adding section 2244, "Application of Certain Rules to Plans in Group Markets." Section 2244 included an auto enrollment provision that required large employers with more than 200 employees offering health coverage to automatically enroll new full-time employees in one of the employer's plans, and to continue enrollment of current employees. The section also required notice to employees of automatic enrollment and the opportunity for employees to opt out of coverage.

On December 24, 2009, the Senate passed H.R. 3590, PPACA, using the bill number of a tax bill previously passed by the House.⁵ The amended bill included section 1511, "Automatic

¹ Congressional Budget Office, cost estimate for Reconciliation Recommendations of the House Committee on Education and the Workforce, (Oct. 2, 2015).

² H.R. 3200, Section 312(c), 111th Cong. (2009).

³ The measure went straight to the Rules Committee and then the House Floor without any Committee consideration. It was primarily referred to the House Energy and Commerce Committee, with seven committees receiving secondary referrals, including this Committee.

⁴ H.R. 3962, Section 412(c), 111th Cong. (2009).

Enrollment for Employees of Large Employers,” which mandated employers with 200 or more full-time employees enroll new full-time employees in their lowest cost plan, unless the employee declines the coverage or chooses another plan offered by the employer subject to certain conditions. The House passed the bill on March 21, 2010, by a vote of 219-212. PPACA was signed into law by President Obama on March 23, 2010.

Delay of Implementation

DOL is responsible for the implementation of section 1511 of PPACA. In December 2010, DOL, in conjunction with the Department of the Treasury and HHS, delayed implementation of PPACA’s automatic enrollment provision in “FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation.”⁶ The subregulatory guidance stated, “it is the view of the Department of Labor that, until such regulations are issued, employers are not required to comply with section 18A.”⁷ The guidance also indicated DOL intended to complete this rulemaking by 2014.⁸ In April 2011, DOL hosted a public hearing regarding this provision.⁹ Subsequently, the departments issued additional subregulatory guidance reiterating that implementation of the provision had been delayed until DOL issues such regulations and that they intended to complete this by 2014.¹⁰ To date, DOL has not implemented the provision.

SUMMARY

The Reconciliation Committee Print repeals section 1511 of PPACA. Section 1511 mandates certain large employers enroll full-time employees in one of the employer’s health care plans initially and continue enrollment subsequently. The mandate applies to employers with 200 or more full-time employees that offer employees enrollment in one or more health plans. The requirement does not apply if an employee chooses to opt-out within 90 days. Eliminating this requirement will reduce the federal deficit by \$7.9 billion over ten years (2016-2025), thus satisfying the instructions given to the Committee by S. Con. Res. 11.

COMMITTEE VIEWS

Consequences of Automatic Enrollment for Employees and Employers

Employers have voluntarily offered insurance for decades as an effective means of attracting and retaining employees. Now, PPACA has changed this voluntary, employer-sponsored system into one with government mandates on employers and employees. Mandating

⁵ H.R. 3590, the *Service Members Home Ownership Tax Act of 2009*, passed the House on Oct. 8, 2009. The Senate took up the bill and replaced the text with that of PPACA on Nov. 19, 2009.

⁶ PPACA section 1511 does not contain an effective date.

⁷ U.S. Dept. of Lab., Emp. Benefits and Security Administration, *Frequently Asked Questions About Affordable Care Act Implementation Part V and Mental Health Parity Implementation*, (Dec. 22, 2010), <http://www.dol.gov/ebsa/pdf/faq-aca5.pdf>.

⁸ *Id.*

⁹ U.S. Dept. of Lab., Emp. Benefits and Sec. Admin., *Automatic Enrollment in Large Employer Health Plans*, Public Forum, Apr. 8, 2011. <http://www.dol.gov/ebsa/regs/autoenrollforumtranscript.html>.

¹⁰ U.S. Dept. of Lab., Emp. Benefits Sec. Admin., *Technical Release 2012-01: Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods*, (Feb. 9, 2012), <http://www.dol.gov/ebsa/newsroom/tr12-01.html>.

automatic enrollment of employees in health care coverage reduces employees' flexibility and choice, places undue financial burdens on employees, and unnecessarily drives up coverage and administrative costs for employers.

Auto Enroll Reduces Employees' Flexibility and Choice

Automatically enrolling employees in health care coverage restricts employees' ability to select a plan that best meets their coverage needs. This requirement could result in employees being enrolled in coverage that is unaffordable for them and may lead to unanticipated reductions in their take home pay to cover new premiums. These sums could even exceed their paychecks.

In a recent Committee hearing, Rep. Elise Stefanik (R-NY) explained these concerns, saying "[t]his mandate takes away the ability for employees to choose coverage that best meets their needs, and it could result in a loss of take home pay to cover possibly more expensive health insurance than they would have otherwise chosen."¹¹

Employers have expressed concern about the impact automatic enrollment will have on the morale of their workforce and financially on their employees. In testimony before the HELP Subcommittee on April 30, 2013, Rep. Richard Hudson (R-NC) asked Chuck Horne, President, Hornwood, Inc., about the benefits he offers to his employees and the impact of the law. Mr. Horne responded:

*... we think there is going to be a morale issue here. We have some young employees who choose not to take our health insurance. It may not be the best decision, but we have that, and, of course, we are going to have to automatically enroll them. They have no choice in that. And I feel like the response is going to be angry at us about that as opposed to the law, and it is going to be difficult to explain that.*¹²

Testifying at the same hearing, Ken Conrad, Chairman, Libby Hill Seafood Restaurants, agreed:

*The auto enrollment [requirement] is going to create ill will for those people who really didn't want health insurance and all of a sudden they get that check on the 91st day and it has them enrolled in health insurance, and they didn't sign up for [it]. All of a sudden, you have another problem with morale of your employees.*¹³

Donnie Meadows, Vice President of Human Resources, K-VA-T Food Stores, Inc. echoed these concerns as part of another HELP Subcommittee hearing on August 27, 2013, stating:

We are also concerned that the Affordable Care Act's mandatory, auto-enrollment provision will increase administrative costs and cause confusion

¹¹ *Reviewing the Policies and Priorities of the U.S. Department of Health and Human Services: Hearing Before H. Comm. on Educ. and the Workforce 114th Cong. (2015).* (Statement of Rep. Stefanik).

¹² *Health Care Challenges Facing North Carolina's Workers and Job Creators: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. and the Workforce, 113th Cong. (2013).* (Statement of Chuck Horne).

¹³ *Health Care Challenges Facing North Carolina's Workers and Job Creators: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. and the Workforce, 113th Cong. (2013).* (Statement of Ken Conrad).

between employers and employees. We anticipate scenarios where our company offers coverage to a qualified, full-time employee who ignores the offer due to already receiving health benefits from a parent, spouse, or other retiree program. Under this ACA provision, the employer is required to deduct a premium from the associates' paycheck. As a result, an employee is being charged a premium (and the employer is paying an even higher percentage) for coverage the employee does not want or need.¹⁴

Auto Enrollment Places Undue Financial Burdens on Employees

Employer-sponsored coverage may not be the only source of health insurance for employees. PPACA offers employees choices about how to comply with the law's individual mandate. For example, young adults, seniors, and veterans can be enrolled in a parent's or spouse's plan, Tricare, or Medicare, instead of choosing to accept an employer's offer of coverage. If automatically enrolled in employer coverage, employees could find themselves double-enrolled in coverage, paying multiple health insurance premiums at the same time, and facing penalties if they terminate coverage. During a HELP Subcommittee field hearing on April 30, 2013, Dave Bass, Vice President of Compensation and Associate Wellness, Delhaize America, discussed how the mandatory nature of automatic enrollment under PPACA could be a burden to employees, including duplicate coverage. He stated:

Allowing for automatic enrollment of associates who have previously chosen to receive coverage saves associates time and ensures continued coverage. Whereas, the Affordable Care Act's mandatory associate enrollment under Section 1511 could inadvertently cost associates' wages and create duplicative coverage if a parent or spouse already covers the associate. When associates who do not want employer coverage fail to opt-out of the auto-enrollment process, the employer is required to deduct a premium from the associates' paycheck.¹⁵

During a subsequent joint hearing of the HELP Subcommittee and the Workforce Protection Subcommittee on July 23, 2013, Jamie Richardson, Vice President, White Castle System, Inc. agreed that double-enrollment due to automatic enrollment is redundant and burdensome for employees. He explained that almost half of their team members could be already enrolled in their parents' insurance under PPACA, and the financial impact automatic enrollment redundancy could cause for these employees. He stated:

We support repeal of the auto enrollment [requirement] because it hurts our team members and the way we look at it is 43 percent of White Castle team members are under the age of 26, so with auto enrollment, on that 91st day, they are

¹⁴ *Health Care Challenges Facing Kentucky's Workers and Job Creators: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. and the Workforce*, Field Hearing in Lexington, Kentucky, 113th Cong. (2013). (Written statement of Donnie Meadows).

¹⁵ *Health Care Challenges Facing North Carolina's Workers and Job Creators: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. and the Workforce*, 113th Cong. (2013). (Written statement of Dave Bass).

*automatically enrolled in the plan and their check gets smaller and it just creates an unnecessary burden. It is redundant ...*¹⁶

Proponents often point to the success of automatic enrollment in defined contribution 401(k) retirement plans as proof automatic enrollment in health care will increase health care coverage. However, an employee's 401(k) contributions are based on a percentage of wages earned, belong to the employee, and may increase in value over time. By contrast, health insurance premium contributions are fixed and are immediately expended once coverage is in effect, even if the employee was unaware of the coverage. During a hearing of the HELP Subcommittee on April 30, 2013, Ken Conrad explained this distinction. He stated:

*Some compare automatically enrolling employees in health benefit plans to automatically enrolling them in a 401(k) plan, but this isn't a good parallel. The financial contribution associated with health benefits can be much larger, for example: 9.5 percent of household income toward the cost of the premium for employees of large employers versus an average of 3 percent automatic 401(k) contribution. The financial burden on employees of automatic enrollment in health benefit plans would be much greater than that of 401(k) plans. Additionally, 401(k) rules allow employees to access their contributions when they opt-out of automatic enrollment; however health benefit premium contributions cannot be retrieved Restaurateurs will educate their employees about how this provision impacts them, but if an employee misses the 90-day opt-out deadline, a premium contribution is a significant amount of money, which can be a financial burden.*¹⁷

Auto Enrollment Unnecessarily Drives Up Costs

PPACA's automatic enrollment requirement would increase the cost of coverage and administrative costs for employers. Many employees are already offered the opportunity to enroll in employer-sponsored insurance but decline enrollment because other coverage options are available. However, under this automatic enrollment requirement, employers pay premiums for unwanted coverage if employees do not opt-out in time. Employers must bear the cost of insuring these employees, even though employees may not want or will not use the coverage. In testimony before the HELP Subcommittee on March 10, 2011, Brett Parker, Vice Chairman and Chief Financial Officer, Bowlmor Lanes, on behalf of the U.S. Chamber of Commerce, discussed his experience that some employees do not want employer coverage and the impact it would have on his business. He stated:

This [automatic enrollment provision] would be a disaster for a company like Bowlmor, with a somewhat transient workforce, high turnover, and a large number of low wage employees. These employees do not want to purchase benefits, and automatically enrolling them would be contrary to both their

¹⁶ *The Employer Mandate: Examining the Delay and Its Effect on Workplaces: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions Jointly with the Subcomm. on Workforce Protections of the H. Comm. on Educ. and the Workforce*, 113th Cong. (2013). (Statement of Jamie Richardson).

¹⁷ *Health Care Challenges Facing North Carolina's Workers and Job Creators: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. and the Workforce*, 113th Cong. (2013). (Written statement of Ken Conrad).

*financial interests and their wishes – not to mention an administrative nightmare.*¹⁸

Employee benefits experts predict cost increases to employer coverage and administrative costs as a result of this requirement. In testimony before the HELP Subcommittee on May 31, 2012, Edward Fensholt, J.D., Senior Vice President, Director, Compliance Services and Health Reform Advisory Practice, Lockton Benefit Group, warned:

*Our actuaries tell us that, across all industry segments other than retail and hospitality, our clients can expect to experience a 4.4 percent cost increase attributable to the automatic enrollment requirement In modeling the effect of the automatic enrollment provision, our actuaries assumed that 75 percent of employees who are newly eligible for coverage but have not affirmatively enrolled, and who are automatically enrolled by the employer, will [subsequently] opt out of coverage.*¹⁹

CONCLUSION

The testimony before the Committee illustrates the duplicative and burdensome nature of PPACA's automatic enrollment provision for employees and employers. If left intact, the auto enrollment mandate will restrict employees' ability to select the coverage that best meets their own needs and the needs of their family and could place undue financial burdens on employees. It will also impose costly burdens on employers, thereby impeding employer's ability to grow their businesses and create new jobs. Finally, repealing this provision will reduce the federal deficit by \$7.9 billion over ten years.

SECTION-BY-SECTION ANALYSIS

The following is a section-by-section analysis of the Amendment in the Nature of a Substitute offered by Rep. Elise Stefanik (R-NY) and reported favorably by the Committee.

Section 1. Amends the *Fair Labor Standards Act* to repeal Section 18A.

EXPLANATION OF AMENDMENTS

The amendments, including the amendment in the nature of a substitute, are explained in the body of this report.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) of Public Law 104-1 requires a description of the application of this bill to the legislative branch. The Committee Print on legislation regarding the Committee's instruction pursuant to section 2002 (a)(1) of S. Con. Res 11 eliminates the *Patient Protection*

¹⁸ *The Pressures of Rising Costs on Employer Provided Health Care: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. and the Workforce, 112th Cong. (2011).* (Statement of Brett Parker).

¹⁹ *Barriers to Lower Health Care Costs for Workers and Employers: Hearing Before the Subcomm. on Health, Employment, Labor, and Pensions of the H. Comm. on Educ. and the Workforce, 112th Cong. (2012).* (Written statement of Edward Fensholt, J.D.).

and Affordable Care Act (PPACA) mandate for certain large employers to enroll full-time employees in one of their health care plans initially and continue enrollment subsequently.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act (as amended by Section 101(a)(2) of the Unfunded Mandates Reform Act, P.L. 104-4) requires a statement of whether the provisions of the reported bill include unfunded mandates. This issue is addressed in the CBO letter.

EARMARK STATEMENT

The Reconciliation Committee Print does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of House Rule XXI.

ROLL CALL VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee Report to include for each record vote on a motion to report the measure or matter and on any amendments offered to the measure or matter the total number of votes for and against and the names of the Members voting for and against.

Date: September 30, 2015

COMMITTEE ON EDUCATION AND THE WORKFORCE RECORD OF COMMITTEE VOTE

Roll Call: 1 Bill: Committee Print Amendment Number: _____

Disposition: Ordered favorably transmitted to the House Budget Committee by a vote of 22-15.

Sponsor/Amendment: Mr. Roe - Motion to transmit the Committee Print, as amended, to the Committee on Budget.

Name & State	Aye	No	Not Voting	Name & State	Aye	No	Not Voting
Mr. KLINE (MN) (Chairman)	X			Mr. SCOTT (VA) (Ranking)		X	
Mr. WILSON (SC)	X			Mr. HINOJOSA (TX)		X	
Mrs. FOXX (NC)	X			Mrs. DAVIS (CA)		X	
Mr. HUNTER (CA)	X			Mr. GRIJALVA (AZ)		X	
Mr. ROE (TN)	X			Mr. COURTNEY (CT)		X	
Mr. THOMPSON (PA)	X			Ms. FUDGE (OH)		X	
Mr. WALBERG (MI)	X			Mr. POLIS (CO)		X	
Mr. SALMON (AZ)	X			Mr. SABLAN (MP)			X
Mr. GUTHRIE (KY)	X			Ms. WILSON (FL)		X	
Mr. ROKITA (IN)	X			Ms. BONAMICI (OR)		X	
Mr. BARLETTA (PA)	X			Mr. POCAN (WI)		X	
Mr. HECK (NV)	X			Mr. TAKANO (CA)		X	
Mr. MESSER (IN)	X			Mr. JEFFRIES (NY)		X	
Mr. BYRNE (AL)	X			Ms. CLARK (MA)		X	
Mr. BRAT (VA)	X			Ms. ADAMS (NC)		X	
Mr. CARTER (GA)	X			Mr. DeSAULNIER (CA)			
Mr. BISHOP (MI)	X						
Mr. GROTHMAN (WI)	X						
Mr. RUSSELL (OK)	X						
Mr. CURBELO (FL)	X						
Ms. STEFANIK (NY)	X						
Mr. ALLEN (GA)	X						

TOTALS: Aye: 22 No: 15 Not Voting: 1

Total: 38 / Quorum: 13 / Report: 20

(22 R - 16 D)

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause (3)(c) of House Rule XIII, the goals of the Reconciliation Committee Print are to satisfy the instructions given to the Committee by S. Con. Res. 11.

DUPLICATION OF FEDERAL PROGRAMS

No provision of the Reconciliation Committee Print establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111-139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The committee estimates that enacting the Reconciliation Committee Print does not specifically direct the completion of any specific rule makings within the meaning of 5 U.S.C. 551.

**STATEMENT OF OVERSIGHT FINDINGS AND
RECOMMENDATIONS OF THE COMMITTEE**

In compliance with clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the committee's oversight findings and recommendations are reflected in the body of this report.

NEW BUDGET AUTHORITY AND CBO COST ESTIMATE

With respect to the requirements of clause 3(c)(2) of rule XIII of the Rules of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 3(c)(3) of rule XIII of the Rules of the House of Representatives and section 402 of the Congressional Budget Act of 1974, the committee has received the following estimate for the Reconciliation Committee Print from the Director of the Congressional Budget Office:



October 2, 2015

Honorable John Kline
Chairman
Committee on Education
and the Workforce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the Reconciliation Recommendations of the House Committee on Education and the Workforce.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sarah Masi, who can be reached at 226-9010.

Sincerely,



Keith Hall

Enclosure

cc: Honorable Robert C. "Bobby" Scott
Ranking Member



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

October 2, 2015

**Reconciliation Recommendations of the House Committee
on Education and the Workforce**

*As ordered reported by the House Committee on Education and the Workforce
on September 30, 2015*

SUMMARY

S. Con. Res. 11, the Concurrent Resolution on the Budget for fiscal year 2016, instructed several committees of the House of Representatives to recommend legislative changes that would reduce deficits by at least \$1 billion over the 2016-2025 period. As part of that reconciliation process, the House Committee on Education and the Workforce has approved legislation on September 30, 2015, that would reduce deficits.

The legislation would repeal the requirement that certain large employers automatically enroll new employees in health insurance plans and continue the enrollment of current employees in a health insurance plan. CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would reduce federal deficits by \$7.9 billion over the 2016-2025 period. The 2016-2025 total consists of \$2.5 billion in on-budget savings and \$5.4 billion in off-budget savings.

CBO and JCT estimate that enacting the legislation would not increase on-budget deficits in any of the four consecutive 10-year periods beginning in 2026; however, the agencies estimate that enacting the legislation would increase net direct spending by at least \$5 billion in one or more of the four 10-year periods beginning in 2026.

The legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of the legislation is shown in the following table. The costs of this legislation fall within budget function 550 (health). For this estimate, CBO and JCT assume that the legislation will be enacted at the end of calendar year 2015.

	By Fiscal Year, in Billions of Dollars											2016-	2016-	
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020	2025		
CHANGES IN DIRECT SPENDING														
Estimated Budget Authority	0.0	0.1	0.2	0.4	0.5	0.5	0.5	0.6	0.6	0.7	1.3	4.3		
Estimated Outlays	0.0	0.1	0.2	0.4	0.5	0.5	0.5	0.6	0.6	0.7	1.3	4.3		
CHANGES IN REVENUES														
Estimated Revenues	0.0	0.2	0.8	1.4	0.8	1.1	1.7	1.9	2.1	2.2	3.3	12.2		
On-Budget	0.0	0.1	0.4	0.8	0.6	0.5	0.9	1.1	1.2	1.2	1.9	6.8		
Off-Budget	0.0	0.2	0.4	0.6	0.2	0.5	0.8	0.8	0.9	1.0	1.4	5.4		
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES														
Impact on Deficit	0.0	-0.2	-0.6	-0.9	-0.2	-0.5	-1.1	-1.3	-1.4	-1.5	-2.0	-7.9		
On-Budget	0.0	*	-0.2	-0.3	-0.1	*	-0.3	-0.5	-0.5	-0.5	-0.6	-2.5		
Off-Budget ^a	0.0	-0.2	-0.4	-0.6	-0.2	-0.5	-0.8	-0.8	-0.9	-1.0	-1.4	-5.4		

Sources: Congressional Budget Office; Staff of the Joint Committee on Taxation.

Notes: Numbers may not sum to totals because of rounding; * = costs or savings of less than \$500 million.

a. All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as "off-budget.")

BASIS OF ESTIMATE

Under current law, employers with more than 200 full-time employees that offer health insurance coverage to at least one employee must automatically enroll new full-time employees in one of the health insurance plans offered by the employer. Additionally, such employers must automatically continue enrollment of current employees in a health insurance plan offered by the employer. Employees retain the right to opt out of health insurance offered by their employer, and CBO and JCT anticipate that some individuals who gain health insurance coverage through automatic enrollment will do so. The agencies project that about 750,000 people will be enrolled in employment-based health insurance in most years after 2018 because of the automatic enrollment requirements.

Although the requirement was originally scheduled to take effect in 2014, it is not currently being enforced. The Department of Labor announced in 2012 that employers would not be required to comply with requirements to automatically enroll employees until it issues implementing regulations.¹ To date, those regulations have not been issued and CBO and

1. Department of Labor, Employee Benefits Security Administration, "Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods" (February 9, 2012), <http://www.dol.gov/ebsa/newsroom/tr12-01.html>.

JCT expect that the requirements will not be enforced during 2016. CBO expects that in future years the requirements will be enforced and will increase the number of people enrolled in health insurance through their employer.

The legislation would repeal the auto-enrollment requirement. CBO and JCT estimate that the legislation would reduce the number of people enrolled in employment-based health insurance coverage by about 750,000 people in most years after 2018, with smaller effects in 2017 and 2018 and no effect in 2016. Of those people who would not be enrolled in employment-based coverage as a result of this legislation, CBO and JCT estimate that about 90 percent would be uninsured because they would not take action to enroll in insurance in the absence of the automatic enrollment requirements for their employer. The remainder would enroll in Medicaid or, to a lesser extent, in nongroup coverage offered through an exchange established under the Affordable Care Act (ACA). Although most people with an offer of health insurance from their employer are not eligible to receive subsidies to purchase insurance through an exchange, people with an unaffordable offer from their employer (as defined by the ACA) are eligible to receive subsidies.

CBO and JCT estimate that the legislation would result in net budgetary savings to the federal government of \$7.9 billion over the 2016-2025 period. That projected decrease in federal deficits over the 10-year period consists of a \$12.2 billion increase in revenues, partially offset by a \$4.3 billion increase in direct spending.

The projected increase in revenues over the 2016-2025 period primarily stems from lower projected enrollment in employment-based insurance, as discussed above. Relative to current law, that change in coverage would result in a smaller share of total compensation taking the form of non-taxable health benefits, increasing the share taking the form of taxable wages and salaries. A small portion of the estimated increase in revenues comes from higher projected penalty payments paid by people who would become uninsured under the bill. The projected increase in direct spending over the 2016-2025 period primarily reflects higher projected enrollment in insurance obtained through Medicaid and exchanges.

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICIT

CBO and JCT estimate that enacting the legislation would not increase on-budget deficits by \$5 billion or more in any of the four 10-year periods beginning in 2026. On the basis of the growth in direct spending over the 2016-2025 period, the agencies estimate that enacting the legislation would increase net direct spending by at least \$5 billion in one or more of the those periods because the agencies expect the estimated increase in direct spending to continue to grow.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

The legislation contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

ESTIMATE PREPARED BY:

Federal Costs: Kate Fritzsche, Sarah Masi, and Staff of the Joint Committee on Taxation
Impact on State, Local, and Tribal Governments: J'nell Blanco Suchy
Impact on the Private Sector: Amy Petz

ESTIMATE APPROVED BY:

Holly Harvey
Deputy Assistant Director for Budget Analysis

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 and existing law in which no change is proposed is shown in roman):

**SECTION 18A OF THE FAIR LABOR STANDARDS ACT OF
1938****[SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.**

[In accordance with regulations promulgated by the Secretary, an employer to which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plans shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee to opt out of any coverage the individual or employee were automatically enrolled in. Nothing in this section shall be construed to supersede any State law which establishes, implements, or continues in effect any standard or requirement relating to employers in connection with payroll except to the extent that such standard or requirement prevents an employer from instituting the automatic enrollment program under this section.]

MINORITY VIEWS
Committee Print on Legislation Regarding the Committee's Instruction Pursuant to
Section 2002 (a)(1) of S.Con.Res. 11.
114th Congress, 1st. Session
October 2, 2015

Introduction

Committee Democrats unanimously oppose the Committee Print on legislation regarding the Committee's instruction pursuant to section 2002 (a)(1) of S.Con.Res. 11.

Committee Democrats voted unanimously against the Committee's recommendation to the Budget Committee during consideration of the bill on September 30, 2015. And we continue to stand opposed to both the Committee Print and the forthcoming reconciliation package that will undermine the Affordable Care Act (ACA) and put access to women's health care at risk. The budget conference agreement passed by the Majority in May of 2015 included reconciliation instructions to the Committee on Education and the Workforce to identify \$1 billion worth of budgetary savings. However, the bill considered by the Committee on September 30, 2015 was not a serious effort at deficit reduction. It was simply another attempt to dismantle the Affordable Care Act. Nor was the proposal a serious effort to strengthen a provision of the ACA that requires certain large employers to automatically enroll new full-time employees in one of the employer's health plans. The Committee Print repeals this automatic enrollment employer requirement which applies to large employers. This provision has yet to be implemented and many of the hypothetical concerns with the provision's implementation could likely be addressed through either the regulatory process or a deliberative legislative process.

To the contrary, this reconciliation process was undertaken solely for the purposes of political theater and to perpetuate the ongoing assault on the ACA. The budget conference agreement that included the reconciliation instructions made that very clear. It states that each reporting Committee should "determine the most effective methods by which the... [ACA] shall be repealed..."¹

Republicans have repeatedly tried to undermine the successes of the ACA. Specifically, they have now lost two Supreme Court challenges and voted 60 times in the House to repeal or undermine the ACA, despite the fact that the President would most certainly veto any repeal legislation. This reconciliation package is just another worn-out attempt at this same futile goal.

But the fact of the matter is the Affordable Care Act is working for millions of Americans, and support for this proposal would only move our country backwards. In 2010, when Congress passed and President Obama signed the Affordable Care Act, we improved a system that left many without any protections. If you lost your job and had a preexisting condition, you would lose your health coverage and likely be unable to find affordable coverage elsewhere. If you were a woman, you could be charged more for your insurance plan than a man. The Affordable

¹ S. Con. Res 11 Section 2002, *The Budget Conference Agreement*, available at: <https://www.congress.gov/bills/114th-congress/senate-concurrent-resolution/11/text>

Care Act addressed these inequities, and other systemic flaws, to give millions of Americans access to quality, affordable health care coverage.

Benefits of the Affordable Care Act

The Affordable Care Act has worked to give millions of Americans access to affordable, quality health insurance. To date, the law has reduced the number of uninsured by 18 million. And as of June 2015, 9.9 million Americans were enrolled in coverage through either the federal health insurance marketplace or one of the state-based marketplaces.² The passage of the Affordable Care Act has given millions of Americans access to health insurance coverage, many for the first time in their lives.

The law has also benefited workers and has improved employer-sponsored coverage. Under the ACA, most health insurance plans now provide recommended preventative health care services without cost-sharing for individuals – including blood pressure screening, vision screening for children, and tobacco cessation information – and an estimated 137 million Americans have insurance coverage that includes these services without cost sharing.³ In addition, before the ACA, nearly one in six workers lacked the protection of an annual out-of-pocket limit. Today, thanks to the ACA, just 2 percent of workers in single coverage lack this kind of out-of-pocket limit.⁴

There have also been noted improvements for workers and employers who pay premiums. The average premium for employer-based family coverage grew 4.2 percent in 2015, continuing the recent pattern of unusually slow growth. Had premium growth since 2010 matched the average rate recorded over the preceding decade, the average total premium for employer-based family coverage would have been nearly \$2,600 higher in 2015.⁵ Furthermore, the Affordable Care Act has helped slow the growth in health care costs, resulting in the lowest annual increase in health care spending since the government began tracking the statistic in 1960.⁶

Young adults are also enjoying better coverage options. Thanks to the reforms passed in the Affordable Care Act, they have the option of staying on a parent's health insurance policy up

² CMS, *Effected Enrollment Snapshot*, June 30, 2015, available at:

<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html>

³ ASPE, *Data Point: The Affordable Care Act is Improving Access to Preventive Services for Millions of Americans*, May 14, 2015, available at:

<http://aspe.hhs.gov/sites/default/files/pdf/83176/The%20Affordable%20Care%20Act%20is%20Improving%20Access%20to%20Preventive%20Services%20for%20Millions%20of%20Americans.pdf>

⁴ The White House Blog, *New Data Show Slow Health Care Cost Growth is Continuing*, September 22, 2015,

available at: <https://www.whitehouse.gov/blog/2015/09/22/new-data-show-slow-health-care-cost-growth-continuing>

⁵ *ibid*

⁶ The White House Blog, *Historically Slow Growth in Health Spending Continued in 2013, and Data Show Underlying Slow Cost Growth Is Continuing*, December 3, 2014, available at:

<https://www.whitehouse.gov/blog/2014/12/03/historically-slow-growth-health-spending-continued-2013-and-data-show-underlying-slo>

until age 26, providing them with more security as they further their education or career. Over 2 million young adults have benefited from this provision.⁷

The law also protects 129 million Americans with pre-existing health conditions, including 17 million children, who no longer have to worry about being denied coverage or charged higher premiums due to their health status.⁸

Use of Reconciliation to Dismantle the Affordable Care Act

While the law can be strengthened and improved upon, the Majority has always indicated their intention to roll back the progress the ACA has made by repealing the law and gutting the benefits American families now enjoy. Unfortunately, this markup was one in a long series of attempts to dismantle the Affordable Care Act. Specifically, the Majority in the House has orchestrated 60 repeal votes, lawsuits, and countless attacks, all with the same goal of turning the clock backwards on the progress we've made in ensuring health coverage for all.

Two other Committees – the Energy and Commerce Committee and the Ways and Means Committee – have also passed reconciliation recommendations that will be packaged together for consideration by the House. Legislation considered in those Committees will make drastic cuts to the Prevention and Public Health Fund, cut funding for Planned Parenthood, and eliminate the employer and individual responsibility provisions in the Affordable Care Act, among other harmful provisions. These three bills amount to a systematic attack on the underpinnings of the Affordable Care Act and are further motivated by the Majority's insistence on defunding Planned Parenthood and taking away comprehensive health services options for women across the country.

Amendments

No Democratic amendments were offered at the September 30, 2015 markup.

Conclusion

Committee Democrats are open to strengthening the Affordable Care Act and building upon the progress that has been made in providing American families with affordable health coverage. However, this markup and the Committee Print represented yet another attempt to undo this progress. For that reason, the Committee Democrats opposed the Committee Print.

Committee Democrats were disappointed that particularly on the last day of the fiscal year, the Committee Majority held this markup, rather than taking up legislation to reauthorize many of the important programs within this Committee's jurisdiction. It is the hope of the Committee Democrats that the next markup will not involve yet another attack on the Affordable Care Act,

⁷ ASPE, *Health Insurance Coverage and the Affordable Care Act*, September 22, 2015, available at: <http://aspe.hhs.gov/sites/default/files/pdf/111826/ACA%20health%20insurance%20coverage%20brief%2009212015.pdf>

⁸ ASPE, *At Risk: Pre-existing Conditions Could Affect 1 in 2 Americans*, November 1, 2011, available at: <http://aspe.hhs.gov/pdf-report/risk-pre-existing-conditions-could-affect-1-2-americans>

but will focus on many of the important areas where Committee Democrats and Republicans share common ground. Just this week, the progress that this Committee and its Members can achieve was shown through a bipartisan bill to reauthorize the Perkins loan program that recently passed with broad bipartisan support. Democrats hope that the Committee can continue to build upon these successes and can continue to come together to improve the lives of working families.

SIGNATORIES

Robert C. "Bobby" Scott
Rubén Hinojosa
Susan A. Davis
Raúl M. Grijalva
Joe Courtney
Marcia L. Fudge
Jared Polis
Gregorio Kilili Camacho Sablan
Frederica S. Wilson
Suzanne Bonamici
Mark Pocan
Mark Takano
Hakeem S. Jeffries
Katherine M. Clark
Alma S. Adams
Mark DeSaulnier

AMENDMENT IN THE NATURE OF A SUBSTITUTE TO THE COMMITTEE
RECOMMENDATIONS FOR THE COMMITTEE ON THE BUDGET

OFFERED BY MS. STEFANIK OF NEW YORK

Strike all after the instruction and insert the following:

**TITLE I—COMMITTEE ON EDUCATION
AND THE WORKFORCE**

SEC. 01. REPEAL OF AUTOMATIC ENROLLMENT REQUIREMENT.

The Fair Labor Standards Act (29 U.S.C. 201 et seq.) is amended by repealing section 18A (as added by section 1511 of the Patient Protection and Affordable Care Act (P.L. 111-148)).

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH 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

October 5, 2015

The Honorable Tom Price, M.D.
Chairman
Committee on the Budget
U.S. House of Representatives
207 Cannon House Office Building
Washington, DC 20515

Dear Chairman Price,

Pursuant to section 2002(a) of the Concurrent Resolution on the Budget, I hereby transmit these recommendations which have been approved by vote of the Committee on Energy and Commerce, and the appropriate accompanying material including additional, supplemental or dissenting views, to the House Committee on the Budget. This submission is in order to comply with reconciliation directives included in S. Con. Res. 11, the fiscal year 2016 budget resolution and is consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974.

Sincerely,



Fred Upton
Chairman

**RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON
ENERGY AND COMMERCE**

CONTENTS

Purpose and Summary	1
Background and Need for Recommendations	1
Hearings.....	2
Committee Consideration	2
Committee Votes	2
Committee Oversight Findings.....	2
Statement of General Performance Goals and Objectives	2
New Budget Authority, Entitlement Authority, and Tax Expenditures.....	2
Earmark, Limited Tax Benefits, and Limited Tariff Benefits.....	3
Committee Cost Estimate	3
Congressional Budget Office Estimate.....	3
Federal Mandates Statement.....	3
Duplication of Federal Programs.....	3
Disclosure of Directed Rule Makings.....	3
Advisory Committee Statement.....	3
Applicability to Legislative Branch.....	4
Section-by-Section Analysis of these Recommendations.....	4
Constitutional Authority Statement	4
Changes in Existing Law Made by these Recommendations, as Approved and Transmitted.....	4
Minority, Additional, or Dissenting Views	4

PURPOSE AND SUMMARY

The purpose of these recommendations is to comply with the reconciliation directive included in section 2002(a) of the Concurrent Resolution on the Budget for Fiscal Year 2016, S. Con. Res. 11, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974. The Committee’s recommendations would repeal the Prevention and Public Health Fund, which was created by Patient Protection and Affordable Care Act; save taxpayers’ money by prohibiting Federal payments to States for certain prohibited providers for a period of one year; and provide resources for the community health center program.

BACKGROUND AND NEED FOR RECOMMENDATIONS

Section 2002(a) of S. Con. Res. 11 directs the Committee on Energy and Commerce to “submit changes in laws within its jurisdiction to reduce the deficit by not less than \$1,000,000,000 for the period of fiscal years 2016 through 2025.” These recommendations fulfill this directive by reducing the deficit by more than \$1 billion by repealing the Prevention and Public Health Fund, prohibiting Federal payments to

States for certain prohibited providers for a period of one year, and providing resources for the community health center program.

HEARINGS

The Committee on Energy and Commerce has not held hearings on these recommendations.

COMMITTEE CONSIDERATION

On September 29 and September 30, 2015, the full Committee on Energy and Commerce met in open markup session and approved and transmitted the recommendations of the Committee and all appropriate accompanying material, including additional, supplemental or dissenting views, to the House Committee on the Budget, in order to comply with the reconciliation directive included in section 2002(a) of S. Con. Res. 11, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974 by a record vote of 28 yeas and 23 nays.

COMMITTEE VOTES

Clause 3(b) of Rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following reflects the record votes taken during the Committee consideration:

**COMMITTEE ON ENERGY AND COMMERCE -- 114TH CONGRESS
ROLL CALL VOTE # 40**

BILL: Committee Print, Proposed Matters for Inclusion in Reconciliation Recommendations

AMENDMENT: A motion by Mr. Upton to approve and transmit the recommendations of the Energy and Commerce Committee and all appropriate accompanying material, including additional, supplemental or dissenting views, to the House Committee on the Budget, in order to comply with the reconciliation directive included in section 2002(a) of the Concurrent Resolution on the Budget for Fiscal Year 2016, S. Con. Res. 11, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974. (Final Passage)

DISPOSITION: AGREED TO, by a roll call vote of 28 yeas and 23 nays

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Pallone		X	
Mr. Barton	X			Mr. Rush		X	
Mr. Whitfield	X			Ms. Eshoo		X	
Mr. Shimkus	X			Mr. Engel		X	
Mr. Pitts	X			Mr. Green		X	
Mr. Walden	X			Ms. DeGette		X	
Mr. Murphy	X			Ms. Capps		X	
Mr. Burgess	X			Mr. Doyle		X	
Mrs. Blackburn	X			Ms. Schakowsky		X	
Mr. Scalise				Mr. Butterfield		X	
Mr. Latta	X			Ms. Matsui		X	
Mrs. McMorris Rodgers				Ms. Castor		X	
Mr. Harper	X			Mr. Sarbanes		X	
Mr. Lance	X			Mr. McNerney		X	
Mr. Guthrie	X			Mr. Welch		X	
Mr. Olson	X			Mr. Lujan		X	
Mr. McKinley	X			Mr. Tonko		X	
Mr. Pompeo	X			Mr. Yarmuth		X	
Mr. Kinzinger	X			Ms. Clarke		X	
Mr. Griffith	X			Mr. Loeb sack		X	
Mr. Bilirakis	X			Mr. Schrader		X	
Mr. Johnson	X			Mr. Kennedy		X	
Mr. Long	X			Mr. Cardenas		X	
Mrs. Ellmers	X						
Mr. Bucshon	X						
Mr. Flores	X						
Mrs. Brooks	X						
Mr. Mullin	X						
Mr. Hudson							
Mr. Collins	X						
Mr. Cramer	X						

09/30/2015

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of Rule XIII of the Rules of the House of Representatives, the Committee has not held hearings on these recommendations.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal and objective of these recommendations is to fulfill the directive included in section 2002(a) of the S. Con. Res. 11, and consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974 by reducing the deficit by more than \$1 billion by repealing the Prevention and Public Health Fund, prohibiting Federal payments to States for certain prohibited providers for a period of one year, and providing resources for the community health center program.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX
EXPENDITURES

In compliance with clause 3(c)(2) of Rule XIII of the Rules of the House of Representatives, the Committee finds that these recommendations would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

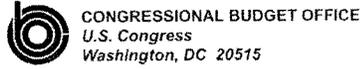
In compliance with clause 9(e), 9(f), and 9(g) of Rule XXI of the Rules of the House of Representatives, the Committee finds that these recommendations contain no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of Rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:



Keith Hall, Director

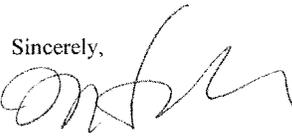
October 2, 2015

Honorable Fred Upton
Chairman
Committee on Energy
and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the Reconciliation Recommendations of the House Committee on Energy and Commerce.

If you wish further details on this estimate, please contact me.

Sincerely,

Keith Hall

Enclosure

cc: Honorable Frank Pallone Jr.
Ranking Member



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

October 2, 2015

**Reconciliation Recommendations of the House Committee
on Energy and Commerce**

*As ordered reported by the House Committee on Energy and Commerce
on September 30, 2015*

SUMMARY

S. Con. Res. 11, the Concurrent Resolution on the Budget for fiscal year 2016, instructed several committees of the House of Representatives to recommend legislative changes that would reduce deficits over the 2016-2025 period. As part of this reconciliation process, the House Committee on Energy and Commerce approved legislation on September 30, 2015, with a number of provisions that would reduce deficits.

The legislation would repeal provisions that established the Prevention and Public Health Fund and rescind any unobligated balances of the fund, which provides grant assistance to entities to carry out prevention, wellness, and public health activities. The legislation also would, for a one-year period following enactment, prohibit federal funds from being made available to certain entities that provide abortions. In addition, the legislation would increase the amount of funding authorized and appropriated to the Community Health Center Fund. That fund provides grants to organizations to improve and expand access to health care services for underserved individuals.

CBO estimates that enacting the legislation would decrease direct spending by \$12.4 billion over the 2016-2025 period. Enacting the legislation would not increase direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2026, CBO estimates.

The legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of the legislation is shown in the following table. The outlay effects of this legislation fall within budget function 550 (health). For this estimate, CBO assumes that the legislation will be enacted near the end of calendar year 2015.

	By Fiscal Year, in Millions of Dollars											2016-	2016-
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020	2025	
CHANGES IN DIRECT SPENDING													
Prevention and Public Health Fund													
Estimated Budget Authority	-1,000	-1,000	-1,250	-1,250	-1,500	-1,500	-2,000	-2,000	-2,000	-2,000	-6,000	-15,500	
Estimated Outlays	-236	-517	-911	-1,130	-1,273	-1,380	-1,582	-1,759	-1,927	-2,001	-4,067	-12,716	
Medicaid													
Estimated Budget Authority	-235	-10	5	5	*	*	*	*	*	0	-235	-235	
Estimated Outlays	-235	-10	5	5	*	*	*	*	*	0	-235	-235	
Community Health Center Program													
Estimated Budget Authority	235	235	0	0	0	0	0	0	0	0	470	470	
Estimated Outlays	88	226	144	12	0	0	0	0	0	0	470	470	
Total													
Estimated Budget Authority	-1,000	-775	-1,245	-1,245	-1,500	-1,500	-2,000	-2,000	-2,000	-2,000	-5,765	-15,265	
Estimated Outlays	-383	-301	-762	-1,113	-1,273	-1,380	-1,582	-1,759	-1,927	-2,001	-3,832	-12,481	

Notes: Components may not add to totals because of rounding; * = between \$0 and \$500,000.

BASIS OF ESTIMATE

In total, CBO estimates that enacting the reconciliation recommendations of the House Committee on Energy and Commerce would reduce direct spending by \$12.4 billion over the 2016-2025 period. CBO estimates that the legislation would not affect federal revenues or spending subject to appropriations.

Direct Spending

Prevention and Public Health Fund. Section 1 of the legislation would repeal the provision that established the Prevention and Public Health Fund and rescind all unobligated balances. The Department of Health and Human Services (HHS) awards grants through the fund to public and private entities to carry out prevention, wellness, and public health activities. The Affordable Care Act provided annual funding for these purposes of \$1.0 billion in 2016, rising to \$2.0 billion in 2022 and each year thereafter. CBO estimates that eliminating that funding would reduce direct spending by \$12.7 billion over the 2016-2025 period.

Medicaid. Section 2 of the legislation would, for a one-year period following enactment, prohibit federal funds from being made available to an entity (defined to include its affiliates, subsidiaries, successors, and clinics) that, as of the date of enactment of this legislation, is:

- A nonprofit organization described in section 501(c)(3) of the Internal Revenue Code and exempt from tax under section 501(a) of the Code;
- An essential community provider that is primarily engaged in providing family planning and reproductive health services and related medical care;
- Provides abortions—other than an abortion if the pregnancy is the result of an act of rape or incest or in the case where a woman’s life is in danger; and
- In fiscal year 2014, had expenditures under the Medicaid program that exceeded \$350 million.

CBO expects that, using the above criteria, only Planned Parenthood Federation of America and its affiliates and clinics would be affected, although some other health care clinics may also be affected. Most federal funds received by such clinics come from payments for services provided to enrollees in states’ Medicaid programs. The budgetary effects of this provision depend mostly on whether the clinics affected by the legislation would decide to continue providing services without Medicaid reimbursement. The extent to which federal funding would be replaced by nonfederal resources during the year in which the prohibition would be in effect is highly uncertain. The amount replaced would depend on actions taken by such clinics and by others, including state and local governments.

If none of the federal funds were replaced, CBO expects that some of the Medicaid beneficiaries who would obtain services from affected clinics under current law would not obtain services at all, leading to lower Medicaid spending. Other people would continue to receive services— from providers that are eligible for Medicaid reimbursement. For those people, CBO estimates that there would be little change in Medicaid spending.

If almost all federal funds were replaced, CBO expects that most Medicaid beneficiaries currently served by affected clinics would continue to obtain services from those clinics, but at no cost to Medicaid. Under that circumstance, there would be little change in the services provided by such clinics and a large reduction in Medicaid spending for those services.

CBO has no clear basis for assessing the extent to which clinics affected by the legislation would be able to replace Medicaid funding. Therefore, for this estimate, CBO assumed that in the one-year period in which federal funds would be not be available to such clinics,

approximately half of the federal funds that such clinics would otherwise receive from Medicaid would be replaced, the center of a wide range of possible outcomes. CBO estimates the combination of the effects described above would reduce direct spending by \$255 million in 2016 and by \$295 million over the 2016-2025 period. Those savings would be partially offset by increased spending for other Medicaid services as discussed below.

To the extent that there would be reductions in access to care under the legislation, they would affect services that help women avert pregnancies. The people most likely to experience reduced access to care would probably reside in areas without access to other health care clinics or medical practitioners who serve low-income populations. However, the extent to which Medicaid beneficiaries served by affected clinics live in such areas is uncertain. On the basis of an analysis of Essential Community Providers that offer family planning services compiled by the Health Resources and Services Administration, CBO estimates that as little as 5 percent or as much as 25 percent of the individuals currently served by affected clinics would face reduced access to care. For this estimate CBO projects that 15 percent of those people would lose access to care, the center of the distribution of possible outcomes.

The government would incur some costs for Medicaid beneficiaries currently served by affected clinics because the costs of about 45 percent of all births are paid for by the Medicaid program. CBO estimates that additional births that would result from enacting the legislation would add to federal spending for Medicaid. In addition, some of those children would themselves qualify for Medicaid and possibly for other federal programs. In the one-year period in which federal funds for the affected clinics would be prohibited under the legislation, CBO estimates the number of births in the Medicaid program would increase by several thousand, increasing direct spending for Medicaid by \$20 million in 2016 and by \$60 million over the 2016-2020 period. Netting those costs against the savings estimated above, CBO estimates that implementing the provision would reduce direct spending by \$235 million over the 2016-2025 period.

Community Health Center Program. Section 3 of the legislation would increase the funds available to the Community Health Center Program (CHC), which provides grant funds to health centers that offer primary and preventive care to patients regardless of their ability to pay. Under current law the program will receive \$3.6 billion in each of the fiscal years 2016 and 2017. The legislation would increase funding for the program by \$235 million in each of the fiscal years 2016 and 2017. CBO estimates that implementing the provision would increase direct spending by \$470 million over the 2016-2025 period.

Although increased funding to CHC could increase access to primary care and preventive services, generally, CBO does not anticipate that the increased funding would have any significant effect on the reduction in access to family planning services estimated in section 2 for two reasons. First, CBO anticipates that HHS would not be able to direct funding towards the provision of such services in time to prevent the disruption in access to services

projected to occur in the first year. In addition, because the legislation would not direct HHS to provide the increased funding for specific types of services or clinics, CBO expects the increased funding would be allocated as under current law, for a wide variety of primary and preventive care services.

Spending Subject to Appropriation

CBO estimates that section 2 of the legislation would not affect spending subject to appropriation because any discretionary grants, such as those made under Title X, that might otherwise have gone to clinics prohibited from receiving federal funds under the legislation would be awarded to other health clinics or medical practitioners. CBO estimates that sections 1 and 3 of the legislation would have no significant effect on spending subject to appropriation.

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO estimates that enacting the legislation would not increase direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2026.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

The legislation contains no intergovernmental or private-sector mandates as defined in UMRA. It would reduce federal Medicaid spending for the one-year period beginning on the date of enactment for certain entities that provide abortion services. The state share of reduced Medicaid spending would total approximately \$90 million over the 2016-2025 period.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

DUPLICATION OF FEDERAL PROGRAMS

No provision of these recommendations establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111-139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The Committee estimates that enacting these recommendations specifically directs to be completed no rule makings within the meaning of 5 U.S.C. 551.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by these recommendations.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that these recommendations do not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THESE RECOMMENDATIONS

Section 201. Repeal of the Prevention and Public Health Fund.

This section would repeal the Prevention and Public Health Fund created in section 4002 of the Patient Protection and Affordable Care Act and would rescind any unobligated balances.

Section 202. Federal Payments to States.

This section would, for a one-year period, prohibit Federal funds to States who are administering Federal programs, for certain prohibited entities.

Section 203. Funding for Community Health Center Program.

This section would increase funding for the community health center program.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 7 of Rule XII of the Rules of the House of Representatives, the following statement is submitted regarding the specific powers granted to Congress in the Constitution to enact the accompanying bill or joint resolution. Congress has the power to enact this legislation pursuant to the following: Article I, Section 8, Clause 1 of the United States Constitution.

CHANGES IN EXISTING LAW MADE BY THE RECOMMENDATIONS, AS
APPROVED AND TRANSMITTED

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 and existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH**Subtitle A—Modernizing Disease Prevention and Public Health Systems**

* * * * *

[SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

[(a)PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the “Fund”), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.

[(b)FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

[(1) for fiscal year 2010, \$500,000,000;

[(2) for each of fiscal years 2012 through 2017, \$1,000,000,000;

[(3) for each of fiscal years 2018 and 2019, \$1,250,000,000;

[(4) for each of fiscal years 2020 and 2021, \$1,500,000,000;

and

[(5) for fiscal year 2022, and each fiscal year thereafter, \$2,000,000,000.

[(c)USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs.

[(d)TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of

Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).】

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MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015

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TITLE II—MEDICARE AND OTHER HEALTH EXTENDERS

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Subtitle B—Other Health Extenders

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SEC. 221. EXTENSION OF FUNDING FOR COMMUNITY HEALTH CENTERS, THE NATIONAL HEALTH SERVICE CORPS, AND TEACHING HEALTH CENTERS.

(a)FUNDING FOR COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS.—

(1)COMMUNITY HEALTH CENTERS.—Section 10503(b)(1)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b-2(b)(1)(E)) is amended *by striking “\$3,600,000,000” and inserting “\$3,835,000,000” and* by striking “for fiscal year 2015” and inserting “for each of fiscal years 2015 through 2017”.

(2)NATIONAL HEALTH SERVICE CORPS.—Section 10503(b)(2)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b-2(b)(2)(E)) is amended by striking “for fiscal year 2015” and inserting “for each of fiscal years 2015 through 2017”.

(b)EXTENSION OF TEACHING HEALTH CENTERS PROGRAM.—Section 340H(g) of the Public Health Service Act (42 U.S.C. 256h(g)) is amended by inserting “and \$60,000,000 for each of fiscal years 2016 and 2017” before the period at the end.

(c)APPLICATION.—Amounts appropriated pursuant to this section for fiscal year 2016 and fiscal year 2017 are subject to the requirements contained in Public Law 113-235 for funds for programs authorized under sections 330 through 340 of the Public Health Service Act (42 U.S.C. 254b-256).

* * * * *

MINORITY VIEWS

Committee Democrats adamantly and unanimously oppose the Committee's Reconciliation recommendations. All Democrats voted in opposition to the Reconciliation recommendations during their consideration in the Committee on September 29 through September 30, 2015. We believe the recommendations will harm the health and limit access to care for millions of Americans. We believe the recommendations would turn back the clock on efforts to transform the U.S. health care system from a system based on the treatment of disease to a system based on disease prevention. The Reconciliation instructions would also harm women's health and place politicians between women and their trusted health care provider by restricting access to the quality health services provided by Planned Parenthood.

SECTION 1 REPEAL OF PREVENTION AND PUBLIC HEALTH FUND
UNDERMINES EFFORTS TO PREVENT DISEASE ONSET

The Reconciliation recommendations would repeal the Prevention and Public Health Fund (Prevention Fund) and rescind the \$15.5 billion in mandatory spending for the period fiscal year 2016 through fiscal year 2025. As a result, that funding would not be available for investment in critical preventive and public health programs such as efforts to reduce tobacco use, increase physical activity, expand mental health and injury prevention, and improve nutrition.

The Prevention Fund is the federal government's only dedicated investment in prevention and the nation's largest single investment in prevention. The Prevention Fund was enacted as part of the Affordable Care Act in response to the overwhelming bipartisan support for prevention efforts and recognition of the lack of targeted and sustained federal initiatives to address chronic and costly illnesses.

Since its creation, most Prevention Fund dollars have gone directly to states, communities, and tribal community organizations to improve the health and wellness of Americans. These funds and the programs and efforts they help finance are targeted at preventing the onset and progression of chronic disease, which account for 7 out of 10 deaths in the U.S. Such programs include the State and Local Public Health Action to Prevent Obesity, Diabetes, and Heart Disease, which support initiatives to reduce the rate of obesity and tobacco use by 3 percent in 3 years, and the Heart Disease and Stroke Prevention program, which funds efforts to improve and enhance heart disease and stroke prevention.

The Prevention Fund also supported the highly successful *Tips from Former Smokers* national campaign. A recent study published in the *Lancet* found that the first three months of the national ad campaign led an estimated 1.6 million smokers to attempt to quit smoking and helped more than 100,000 Americans quit smoking permanently.¹ Another study published in

¹ The Lancet, *Effect of the First Federally Funded US Antismoking National Media Campaign* (Sept. 9, 2013).

the *American Journal of Preventive Medicine* found that the campaign prevented more than 17,000 premature deaths in the U.S.²

Because the Prevention Fund is intended to provide resources to address the perpetual underfunding of prevention activities, its repeal would take vital resources away from these critical efforts. Repeal of the Prevention Fund would leave millions of Americans to suffer the debilitating and potentially life-threatening effects from chronic conditions that could have been prevented with appropriated intervention.

SECTION 1 UNDERMINES EFFORTS TO BEND THE COST CURVE

Investing in prevention efforts to reverse the chronic disease trends in the U.S. not only makes for good health policy, it also makes good financial sense. Chronic diseases such as diabetes, heart disease, and stroke account for \$1.3 trillion in treatment costs and lost productivity every year.³ In fact, the treatment of chronic disease accounts for 86 percent of U.S. health care costs.⁴ When we passed the Affordable Care Act, we knew that we could no longer afford the financial toll of chronic disease. In order to significantly bend the health care cost curve, we needed to focus on the prevention of disease rather than just the treatment of disease. To get the most benefit, we knew that we needed a dedicated, mandatory funding stream, as created through the Prevention Fund, to make the necessary investments in prevention efforts that improve health and save money.

A Trust for America's Health report concluded that investments in proven community-based interventions that increase physical activity, improve nutrition, and prevent smoking generate a return of \$5.60 for every \$1 spent.⁵ An Urban Institute study estimates that proven community-based diabetes program can save as much as \$191 billion over 10 years.⁶ Another Trust for America's Health report found that a reduction in body mass index rates by 5 percent would save over \$158 billion in 10 years and \$612 billion in 20 years.⁷

² American Journal of Preventive Medicine, *A Cost-Effectiveness Analysis of the First Federally Funded Antismoking Campaign* (Dec. 9, 2014).

³ Milken Institute, *An Unhealthy America: The Economic Burden of Chronic Disease – Charting a New Course to Save Lives and Increase Productivity and Economic Growth* (Oct. 1, 2007) (online at <http://www.milkeninstitute.org/publications/view/321>).

⁴ Centers for Disease Control and Prevention, *Chronic Disease Prevention and Health Promotion* (online at www.cdc.gov/chronicdisease) (accessed Sept. 28, 2015).

⁵ Trust for America's Health, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (Feb. 2009) (online at <http://healthyamericans.org/reports/prevention08/Prevention08.pdf>).

⁶ Urban Institute, *How We Can Pay for Health Care Reform* (July 2009) (online at www.urban.org/research/publication/how-we-can-pay-health-reform/view/full_report).

⁷ Trust for America's Health, *Bending the Obesity Cost Curve* (Feb. 2012) (online at <http://healthyamericans.org/report/93/>).

These are the types of successful programs that we are investing in through the use of the Prevention Fund. Failing to continue that commitment will limit our ability to bend the cost curve and save public as well as private payors from the financial burden of paying to treat largely preventable chronic conditions.

SECTION 1 RELIES UPON PATENTLY FALSE AND SPECIOUS CLAIMS THAT THE PREVENTION FUND IS A “SLUSH” FUND

The Prevention Fund is allocated by Congress through the Appropriations process. The Affordable Care Act granted the House and Senate Appropriations Committees transfer authority to determine the distribution of Prevention Funds for prevention, wellness, and public health activities. Beginning in fiscal year 2014, the House and Senate Appropriations Committee have used that authority to direct the funding allocation of the Prevention Fund. The fiscal years 2014 and 2015 Omnibus appropriations bills include bill language to allocate Prevention Fund dollars “to the accounts specified, in the amounts specified, and for activities specified” in a table in the accompanying explanatory statement. Furthermore, the appropriations bills specify that the “Secretary may not further transfer these amounts.” Both the House and Senate fiscal year 2016 Labor, HHS, Education, and Related Agencies funding bills allocate every dollar from the Prevention Fund. Therefore, any suggestion that the Prevention Fund is a “slush fund” for the HHS Secretary is specious and any claim to the same effect is erroneous.

SECTION 2 CUTS FEDERAL PAYMENTS TO STATES FOR PROVIDERS OF LIFESAVING PREVENTIVE HEALTH SERVICES

The Reconciliation Instructions would prohibit federal funding for and restrict federal payments under Medicaid as well as the Children’s Health Insurance Program, Maternal and Child Health Services Block Grant, and Social Services Block Grant to “prohibited entities.” The legislation defines a “prohibited entity” as a §501(c)(3) organization that is an Essential Community Provider (ECP) as defined by the Affordable Care Act that is “primarily engaged in family planning, reproductive health services and related medical care” and provides abortions beyond limited circumstances. A “prohibited entity” is also defined as having a network exceeding \$350 million in Medicaid billing reimbursements. The bill would not allow states to receive or use these federal funds to reimburse certain providers for covered health care services simply because the providers—separate from their participation in federal health care programs—provide abortion services as part of their scope of practice. Federal funds—including in the Medicaid and Children’s Health Insurance Programs—are already withheld from paying for a woman’s abortion, except in the case of rape, incest, or to protect the life of the woman.

This is a punitive policy that clearly targets one specific entity, but would have a chilling effect on all providers who would potentially have to choose, at some point in the future, between providing legal abortion services separately from federal funds as part of their scope of practice, and being a Medicaid provider that cares for low-income women. Moreover, the legislation language extends to ECP’s that are “primarily engaged in family planning, reproductive health and related care.” Such terms like “primarily engaged” and “related care” are vague, unspecified terms that could impact a broad range of ECPs, such as safety-net hospitals, which provide critical health care services to women, including prenatal care,

miscarriage management, and labor and delivery services. For example, as a result of the limit on certain ECPs, it is possible that other ECPs picking up Medicaid revenue could be swept in under this definition of “prohibited entity” and thus, also be prohibited or restricted in some way from receiving Medicaid payments.

SECTION 2 WOULD LIMIT ACCESS TO HEALTH CARE FOR MILLIONS OF
VULNERABLE WOMEN AND MEN

This bill would immediately disrupt both regular Medicaid programs and the 28 state Medicaid family planning programs that provide contraceptive services and related care to women who would otherwise not be eligible for Medicaid coverage. These family planning programs are critical to reducing unintended pregnancy and are cost-effective, with every dollar spent on family planning services saving more than \$7 in other costs.⁸

If enacted, this legislation would have an immediate and chilling effect on access to care for millions of women nationwide. It should be noted that states that have implemented similar policies have seen significant public health epidemics persist and even worsen. In the state of Indiana, it led to an HIV epidemic,⁹ in Texas it led to tens of thousands of women not getting care with contraceptive claims declining by more than half,¹⁰ and in the state of Tennessee exclusion of vital safety net providers from the Medicaid program resulted in a 93 percent drop in services.¹¹ Currently, the state of Louisiana’s attempts to exclude certain providers led to public acknowledgement by the state in federal district court that just 29 providers would be left to serve more than 5,000 additional patients.¹² Further, the budget reconciliation would redirect \$235 million to other community providers that would almost certainly not have the capacity to meet the need that would be created by suddenly eliminating federal funding for certain women’s health care providers that separately provide abortion services as a comprehensive range of care offered to patients.¹³

⁸ Guttmacher Institute, *Publicly Funded Family Planning Services in the United States* (July 2015) (online at www.guttmacher.org/pubs/fb_contraceptive_serv.html).

⁹ National Public Radio, *Alabama Cuts Funding to Planned Parenthood* (August 8, 2015) (online at www.npr.org/2015/08/08/430633663/alabama-cuts-funding-to-planned-parenthood).

¹⁰ Texas Health and Human Services Commission, *Texas Women’s Health Program: Savings and Performance Reporting* (January 2015) (as required by Rider 44, Senate Bill 1, 83rd Legislature Regular Session, 2013) (online at www.hhsc.state.tx.us/reports/2015/tx-womens-health-program-rider-44-report.pdf).

¹¹ Tara Culp-Ressler, *Defunding Planned Parenthood Caused Women’s Services to Drop by 93 Percent in Tennessee County* (September 2012) (online at <http://thinkprogress.org/health/2012/09/06/807061/defunding-planned-parenthood-caused-womens-services-to-drop-by-93-percent-in-tennessee-county>).

¹² Amended Declaration of Director Ruth Kennedy, *Planned Parenthood Gulf Coast, Inc. v. Kliebert*, 3:15-cv-565, dkt. # 34-2 (M.D. La) (Sept. 8, 2015).

¹³ Sara Rosenbaum, *Planned Parenthood, Community Health Centers, and Women’s Health: Getting the Facts Right* (Sept. 2, 2015)(online at

SECTION 2 UNDERMINES LONGSTANDING STATUTORY PROTECTIONS IN THE MEDICAID PROGRAM

This legislation undermines longstanding statutory protections in the Medicaid program that protect women's access to care from the ideological whims of politicians. Access to family planning services has long held special status in the Medicaid program. In 1972, Congress added family planning to the short list of mandatory benefits states must provide, and, as a further incentive to expand family planning benefits, established a special federal matching rate of 90 percent.¹⁴ Through passage of the Affordable Care Act, Congress again reinforced family planning access when it required coverage of family planning services for the Medicaid expansion population.¹⁵ This means that for family planning, Congress consistently has held high priority for beneficiary access; indeed, the 90 percent rate is a clear incentive for all states to ensure family planning access to eligible beneficiaries.

Under federal law Medicaid beneficiaries may obtain medical services "from any institution, agency, community pharmacy, or person, qualified to perform the service or services required... who undertakes to provide him such services."¹⁶ This provision is often referred to as the "any willing provider" or "free choice of provider" provision. Federal Medicaid funding of abortion services is not permitted under federal law except in extraordinary circumstances (in cases of rape, incest, or when the life of the woman would be in danger). At the same time, Medicaid programs may not exclude qualified health care providers—whether an individual provider, a physician group, an outpatient clinic, or a hospital—from providing services under the program because they separately provide abortion (not funded by federal Medicaid dollars, consistent with the federal prohibition) as part of their scope of practice.¹⁷ This provision is implemented in the Center for Medicare and Medicaid Services' (CMS) "free choice of provider" regulation, which also explicitly states that under no circumstance can the "free choice of provider" protection be compromised with respect to providers of family planning services.¹⁸

This strong patient access protection has remained constant despite significant changes in the flexibility of the Medicaid program through both Democratic and Republican administrations. In short, it is an essential guarantee that state Medicaid programs will provide beneficiaries with the same basic opportunity and rights to choose and receive covered health care services from any qualified provider the same way that any member of the general population seeking health care services.

<http://healthaffairs.org/blog/2015/09/02/planned-parenthood-community-health-centersand-womens-health-getting-the-facts-right>).

¹⁴ Social Security Act, § 1905(a)(4)(C), codified at 42 U.S.C. § 1396a(a)(4)(C).

¹⁵ 42 U.S.C. §§ 1396u-7(b)(7) (as added by ACA § 2303(c)), 1396u-7(b)(5) (as added by ACA § 2001(c)).

¹⁶ Social Security Act, §1902(a)(23)).

¹⁷ *Id.*

¹⁸ Free Choice of Providers, 42 C.F.R. § 431.51(a)(3).

The Medicaid statutory provider choice protections are there for a reason: such language protects against the ideological and political whims of politicians, at the expense of our nation's most vulnerable individuals. This bill would restrict vital access to lifesaving preventative care for millions of women and men and allows the government unprecedented involvement in a woman's own personal health care decisions - right down to who she chooses as her provider, and should be rejected.

SECTION 3
PROVIDING ADDITIONAL FUNDING TO COMMUNITY HEALTH CENTERS WILL NOT
FILL THE VOID IN ACCESS LEFT BY DEFUNDING PLANNED PARENTHOOD

The additional \$235 million in additional funding provided for the Community Health Center Fund (CHC) by the Reconciliation recommendations in each of fiscal years 2016 and 2017 cannot compensate for the reduction in access to care that would be caused by defunding Planned Parenthood for one year. The Congressional Budget Office concluded that all currently federally-funded services received through Planned Parenthood could not be delivered by others providers.¹⁹ Despite this attempt to bolster access by providing additional funding to community health centers, some patients will lose access to the care that they need and that Planned Parenthood can provide.

Neither Community Health Centers nor any other safety net providers are in a position to fill the gaps left by defunding Planned Parenthood. More than half of Planned Parenthood health centers are located in medically underserved areas, health professional shortage areas, or rural areas. That means that there are already a shortage of providers in those communities and that there is not excess provider capacity available to replace the reduction in services that would result if Planned Parenthood were defunded. That means that some of Planned Parenthood's 2.7 million patients would be left without care.

Additionally, it is important to note that Planned Parenthood health centers play a critical role in providing access to contraceptive services. In fact, Planned Parenthood health centers serve a disproportionate number of women served by safety net family planning centers. Planned Parenthood health centers serve more contraceptive clients on average than any other safety net family planning center. While making up 10 percent of the publicly funded safety net family planning centers, Planned Parenthood health centers serve more than one-third of the women who receive services from such centers.²⁰ Additionally, Planned Parenthood health centers serve

¹⁹ See Congressional Budget Office, *Cost Estimate for H.R. 3134 Defund Planned Parenthood Act*, (online at <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3134.pdf>).

²⁰ Health Affairs Blog, *Quantifying Planned Parenthood's Critical Role in Meeting the Need for Publicly Supported Contraceptive Care* (Sept. 8, 2015) (online at <http://healthaffairs.org/blog/2015/09/08/quantifying-planned-parenthoods-critical-role-in-meeting-the-need-for-publicly-supported-contraceptive-care/>)

an average of 2,950 contraceptive clients each year compared to Community Health Centers which serve an average of 330.²¹

²¹ *Id.*

SIGNATORIES

Frank Pallone, Jr., Ranking Member

Bobby L. Rush

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Eliot L. Engel

Gene Green

Diana DeGette

Lois Capps

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Paul Tonko

John Yarmuth

Yvette D. Clarke

David Loebsack

Kurt Schrader

Joseph P. Kennedy, III

Tony Cárdenas

RECOMMENDATIONS APPROVED BY THE COMMITTEE ON ENERGY AND COMMERCE FOR TRANSMITTAL TO THE COMMITTEE ON BUDGET PURSUANT TO SECTION 2002(A)(2) OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2016 (S. CON. RES. 11)

TITLE II—COMMITTEE ON ENERGY AND COMMERCE

SEC. 201. REPEAL OF THE PREVENTION AND PUBLIC HEALTH FUND.

(a) IN GENERAL.—Section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is repealed.

(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the funds made available by such section 4002, the unobligated balance is rescinded.

SEC. 202. FEDERAL PAYMENT TO STATES.

(a) IN GENERAL.—Notwithstanding sections 504(a), 1902(a)(23), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396b(a)(23), 1397a, 1397d(a)(4), 1397bb(a)(2), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the one-year period beginning on the date of the enactment of this Act no Federal funds may be made available to a State for payments to a prohibited entity.

(b) DEFINITION OF PROHIBITED ENTITY.—In this section, the term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinics—

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

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

(B) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations, that is primarily engaged in family planning services, reproductive health, and related medical care; and

(C) provides for elective abortions; and

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

SEC. 203. FUNDING FOR COMMUNITY HEALTH CENTER PROGRAM.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting after “Section 10503(b)(1)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b-2(b)(1)(E)) is amended” the following: “by striking ‘\$3,600,000,000’ and inserting ‘\$3,835,000,000’ and”.

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JANICE MATS,
MINORITY CHIEF COUNSEL

October 2, 2015

The Honorable Tom Price, M.D.
Chairman
Committee on the Budget
U.S. House of Representatives
207 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

Pursuant to section 2002(a) of the Concurrent Resolution on the Budget, I hereby transmit these recommendations which have been approved by vote of the Committee on Ways and Means and the appropriate accompanying material including additional, supplemental or dissenting views, to the House Committee on the Budget. This submission is in order to comply with reconciliation directives included in S. Con. Res. 11, the fiscal year 2016 budget resolution and is consistent with section 310 of the Congressional Budget and Impoundment Control Act of 1974.

Sincerely,


Paul D. Ryan
Chairman



Summaries of Budget Reconciliation Legislative Recommendations

*To be considered by the Committee on Ways and Means on
September 29, 2015*

Taken together, the Joint Committee on Taxation and Congressional Budget Office estimate that the legislative recommendations would reduce the unified deficit by roughly \$37.1 billion over 2016-2025, and would reduce the on-budget deficit (i.e., excluding effects on the Social Security trust funds) by roughly \$12.5 billion over 2016-2025. The Committee's reconciliation instruction in the budget resolution requires the Committee to reduce the on-budget deficit by at least \$1 billion over 2016-2025.

**I. RECOMMENDATIONS RELATING TO REPEAL OF CERTAIN EXCISE TAXES ENACTED
IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

Section __01: Repeal of the Individual Mandate. Beginning in 2014, any individual failing to comply with the Affordable Care Act requirement to purchase qualified coverage under a health plan is subject to an excise tax of a fixed annual amount, or a percentage of income, whichever is greater, pro-rated over months in which such individual lacks qualified coverage. The penalty amount is \$95 or one percent of household income for 2014, \$325 or two percent of household income for 2015, \$695 or 2.5 percent of household income for 2016, and indexed for inflation thereafter. The excise tax exempts certain individuals for reasons including affordability of coverage, income, membership in an Indian tribe, religious reasons, a coverage gap of less than three months, and general hardship. Under the recommendation, the individual mandate excise tax would be repealed. The provision would apply to months beginning after 2014. *Combined with Sec. __02, the provision would reduce the unified deficit by \$147.1 billion, and the on-budget deficit by \$101.7 billion, over 2016-2025.*

Section __02: Repeal of the Employer Mandate. According to statute (i.e., disregarding transitional relief provided by the Obama Administration), beginning in 2014, employers with an average of 50 or more full-time employees during the previous calendar year and that employ one or more employee who receives a premium assistance tax credit or reduced cost-sharing for health insurance, are subject to an excise tax of a fixed amount, pro-rated on a monthly basis. For employers that do not offer insurance coverage, the fixed amount is \$2,000, multiplied by the number of full-time employees in excess of 30. For those that offer coverage that fails to meet the Federal standard for minimum value and affordability, the penalty equals the lesser of (1) \$3,000 per full-time employee who receives subsidized coverage in the exchange or (2) the

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penalty the employer would have to pay if it did not offer health insurance. Full-time employees are defined as those working on average at least 30 hours per week. Under the recommendation, the employer mandate excise tax would be repealed. The provision would apply to months beginning after 2014. *Combined with Sec. __01, the provision would reduce the unified deficit by \$147.1 billion, and the on-budget deficit by \$101.7 billion, over 2016-2025.*

Section __03: Repeal of the Medical Device Excise Tax. Under current law, the manufacturer, producer, or importer of any taxable medical device must pay an excise tax equal to 2.3 percent of the sales price of such device. The excise tax does not apply to eyeglasses, contact lenses, hearing aids, or any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use. Taxpayers are required to pay their excise tax liability on a quarterly basis. Under the recommendation, the medical device excise tax would be repealed. The provision would apply to sales in calendar quarters beginning after the date of enactment. *The provision would reduce revenues by \$23.9 billion over 2016-2025 (on both a unified and an on-budget basis).*

Section __04: Repeal of the Tax on Employee Health Insurance Premiums and Health Plan Benefits and Related Reporting Requirements. Beginning in 2018, the Affordable Care Act is scheduled to impose an excise tax (the “Cadillac tax”) on employers equal to 40 percent multiplied by the excess of the aggregate cost of health insurance coverage for any employee over a fixed threshold amount, pro-rated on a monthly basis. The fixed threshold amount for 2018 is \$10,200 (for self-only coverage) or \$27,500 (for any other coverage) and indexed for inflation. The fixed threshold amount is adjusted if the cost of a standard Federal Employee Health Benefit Plan for 2018 exceeds the cost for 2010. Beginning in 2010, employers were required to report the cost of employer-sponsored health coverage as an item on each employee’s annual Form W-2. Under the recommendation, the Cadillac tax would be repealed, effective for tax years beginning after 2017, and the W-2 reporting requirement for employer-sponsored health coverage would be repealed, effective for calendar years beginning after 2014. *The provision would reduce revenues by \$91.1 billion, and on-budget revenues by \$70.3 billion, over 2016-2025.*

II. RECOMMENDATION RELATING TO REPEAL OF INDEPENDENT PAYMENT ADVISORY BOARD

Section __01: Repeal of the Independent Payment Advisory Board (IPAB). Beginning in 2014, the IPAB is tasked with making recommendations to cut per capita Medicare spending if such spending exceeds certain economic growth targets. The Secretary of Health and Human Services is directed to implement the Board's proposals automatically unless Congress affirmatively acts to alter the Board's proposals or to discontinue the automatic implementation of such proposals. Under the recommendation, the IPAB would be repealed. *The provision would increase direct spending by \$7.1 billion over 2016-2025 (on both a unified and an on-budget basis).*

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COMMITTEE PRINT

Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Excise Taxes Enacted in the Patient Protection and Affordable Care Act

1 **Subtitle A—Revenue Provisions**

2 **SEC. __01. REPEAL OF INDIVIDUAL MANDATE.**

3 (a) IN GENERAL.—Section 5000A of the Internal
4 Revenue Code of 1986 is amended by adding at the end
5 the following:

6 “(h) TERMINATION.—This section shall not apply
7 with respect to any month beginning after December 31,
8 2014.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) Section 5000A(c) of such Code is amend-
11 ed—

12 (A) in paragraph (2)(B) by striking
13 clauses (ii) and (iii),

14 (B) in paragraph (3)(B) by striking
15 “2014” and all that follows and inserting
16 “2014.”, and

17 (C) in paragraph (3) by striking subpara-
18 graph (D).

19 (2) Section 5000A(e)(1) of such Code is amend-
20 ed by striking subparagraph (D).

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1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to months beginning after Decem-
3 ber 31, 2014.

4 **SEC. _02. REPEAL OF EMPLOYER MANDATE.**

5 (a) IN GENERAL.—Section 4980H of the Internal
6 Revenue Code of 1986 is amended by adding at the end
7 the following:

8 “(e) TERMINATION.—This section shall not apply
9 with respect to any month beginning after December 31,
10 2014.”.

11 (b) CONFORMING AMENDMENT.—Section 4980H(e)
12 of such Code is amended by striking paragraph (5).

13 (c) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to months beginning after Decem-
15 ber 31, 2014.

16 **SEC. _03. REPEAL OF MEDICAL DEVICE EXCISE TAX.**

17 (a) IN GENERAL.—Chapter 32 of the Internal Rev-
18 enue Code of 1986 is amended by striking subchapter E.

19 (b) CONFORMING AMENDMENTS.—

20 (1) Subsection (a) of section 4221 of such Code
21 is amended by striking the last sentence.

22 (2) Paragraph (2) of section 6416(b) of such
23 Code is amended by striking the last sentence.

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1 (c) CLERICAL AMENDMENT.—The table of sub-
2 chapters for chapter 32 of such Code is amended by strik-
3 ing the item relating to subchapter E.

4 (d) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to sales in calendar quarters begin-
6 ning after the date of the enactment of this Act.

7 **SEC. 404. REPEAL OF THE TAX ON EMPLOYEE HEALTH IN-**
8 **SURANCE PREMIUMS AND HEALTH PLAN**
9 **BENEFITS AND RELATED REPORTING RE-**
10 **QUIREMENTS.**

11 (a) EXCISE TAX.—Chapter 43 of the Internal Rev-
12 enue Code of 1986 is amended by striking section 4980L.

13 (b) REPORTING REQUIREMENT.—Section 6051(a) of
14 such Code is amended by inserting “and” at the end of
15 paragraph (12), by striking “, and” at the end of para-
16 graph (13) and inserting a period, and by striking para-
17 graph (14).

18 (c) CLERICAL AMENDMENT.—The table of sections
19 for chapter 43 of such Code is amended by striking the
20 item relating to section 4980L.

21 (d) EFFECTIVE DATES.—

22 (1) IN GENERAL.—Except as provided by para-
23 graph (2), the amendments made by this section
24 shall apply to taxable years beginning after Decem-
25 ber 31, 2017.

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1 (2) REPORTING REQUIREMENT.—The amend-
2 ment made by subsection (b) shall apply to calendar
3 years beginning after December 31, 2014.

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CONTENTS

SUBTITLE A - REVENUE PROVISIONS

	<u>Page</u>
SUBTITLE A - REVENUE PROVISIONS	1
I. SUMMARY AND BACKGROUND	1
A. Purpose and Summary	1
B. Background and Need for Legislation	1
C. Legislative History	1
II. EXPLANATION OF PROVISIONS	3
A. Repeal of Individual Mandate (sec. 301 of the committee print and sec. 5000A of the Code)	3
B. Repeal of Employer Mandate (sec. 302 of the committee print and sec. 4980H of the Code)	6
C. Repeal of Medical Device Excise Tax (sec. 303 of the committee print and sec. 4191 of the Code)	9
D. Repeal of the Excise Tax on Employee Health Insurance Premiums and Health Plan Benefits and Related Reporting Requirements (sec. 304 of the committee print and secs. 4980I and 6051(a)(14) of the Code)	11
III. VOTES OF THE COMMITTEE	15
IV. BUDGET EFFECTS OF THE PROVISIONS	16
A. Committee Estimate of Budgetary Effects	16
B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority	16
C. Cost Estimate Prepared by the Congressional Budget Office	16
V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE. 17	
A. Committee Oversight Findings and Recommendations	17
B. Statement of General Performance Goals and Objectives	17
C. Information Relating to Unfunded Mandates	17
D. Applicability of House Rule XXI 5(b)	17
E. Tax Complexity Analysis	17
F. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits	18
G. Duplication of Federal Programs	18
H. Disclosure of Directed Rule Makings	18
VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATION, AS TRANSMITTED	19

A. Text of Existing Law Amended or Repealed by the Budget Reconciliation Legislative
Recommendations, as Transmitted 19

VII. DISSENTING VIEWS 20

SUBTITLE A - REVENUE PROVISIONS

I. SUMMARY AND BACKGROUND

A. Purpose and Summary

In response to the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2016 (S.Con.Res. 11), the Committee on Ways and Means ordered favorably transmitted (with a quorum being present) the Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Excise Taxes Enacted in the Patient Protection and Affordable Care Act. The Committee recommends the repeal of the individual and employer mandate excise taxes, the medical device excise tax, the excise tax on high cost health coverage, and required reporting of employer-provided coverage on Form W-2. The Patient Protection and Affordable Care Act of 2010 ("PPACA"), Pub. L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152 (March 30, 2010),¹ imposes excise taxes on individuals who fail to obtain minimum essential coverage, on certain employers whose employees receive premium assistance credits or cost-sharing reductions, on the sale of medical devices, and on high cost employer-provided health coverage. PPACA also requires employers to report on Forms W-2 issued to employees the cost of employer-provided health coverage. The Committee's recommendations sunset and repeal sections 5000A, 4980H, 4191, 4980I, and 6051(a)(14) of the Internal Revenue Code of 1986, as added and amended by PPACA and HCERA.

B. Background and Need for Legislation

As the Committee continues to actively pursue comprehensive health care reform to relieve unnecessary burdens on the broader economy and on taxpayers in need of access to quality health care, the Committee believes that providing immediate relief from taxes imposing excessive constraints on choices and innovation serves as an important first step toward its broader goals. The Committee believes that repealing the individual mandate, employer mandate, medical device excise tax, excise tax on high cost health coverage, and required reporting of employer-provided coverage on Form W-2 will expand health care choices, decrease health care costs, encourage medical innovation, and eliminate unfair tax burdens.

C. Legislative History

Budget resolution

On April 30, 2015, the House of Representatives approved H. Rept. 114-96, the Conference Report for S. Con. Res. 11, the budget resolution for fiscal year 2016. Pursuant to section 2002(a)(3) of S. Con. Res. 11, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of

¹ PPACA and HCERA are collectively referred to as the Affordable Care Act ("ACA").

the Committee on Ways and Means sufficient to reduce the deficit by \$1,000,000,000 for the period of fiscal years 2016 through 2025.

Committee action

On September 29, 2015, in response to its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative recommendations relating to repeal of certain excise taxes under PPACA and ordered the legislative recommendations, as amended, favorably transmitted (with a quorum being present).

Committee hearings

The Committee on Ways and Means held hearings regarding the President's Fiscal Year 2016 budget submission on February 3, 2015, and June 10, 2015, with Secretary of the Treasury Jacob J. Lew and Secretary of Health and Human Services Sylvia Burwell, respectively, in which the harmful effects of excise taxes in the ACA were discussed.

II. EXPLANATION OF PROVISIONS

A. Repeal of Individual Mandate (sec. 301 of the committee print and sec. 5000A of the Code)

Present Law

Requirement to maintain coverage

Effective as of 2014, individuals must be covered by a health plan that provides at least minimum essential coverage or be subject to a tax for failure to maintain the coverage (commonly referred to as the “individual mandate”).² If an individual is a dependent³ of another taxpayer, the other taxpayer is liable for any tax for failure to maintain the required coverage with respect to the individual. The tax is imposed for any month that an individual does not have minimum essential coverage unless the individual qualifies for an exemption for the month as described below.

Minimum essential coverage

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, plans in the individual market, grandfathered group health plans and grandfathered health insurance coverage, and other coverage as recognized by the Secretary of Health and Human Services (“HHS”) in coordination with the Secretary of the Treasury. Certain individuals present or residing outside of the U.S.⁴ and bona fide residents of territories of the U.S.⁵ are deemed to maintain minimum essential coverage.

Minimum essential coverage does not include coverage that consists of only certain excepted benefits.⁶ Excepted benefits include: (1) coverage only for accident, or disability income insurance; (2) coverage issued as a supplement to liability insurance; (3) liability insurance, including general liability insurance and automobile liability insurance; (4) workers’

² Section 5000A which was added to the Code by section 1501 of PPACA, as amended by section 10106 of PPACA and section 1002 of HCERA. Except where otherwise stated, all references are to the Internal Revenue Code of 1986, as amended.

³ Sec. 152.

⁴ This rule applies to any month that occurs during a period described in section 911(d)(1)(A) or (B) which is applicable to an individual. Such periods include: (1) for a United States citizen, an uninterrupted period which includes an entire taxable year during which the individual is a bona fide resident of a foreign country or countries, and (2) for a United States citizen or resident, a period of 12 consecutive months during which the individual is present in a foreign country at least 330 full days.

⁵ Bona fide residence in a territory is determined under section 937(a). For this purpose, the territories include Puerto Rico, Guam, the Northern Mariana Islands, American Samoa, and United States Virgin Islands.

⁶ Sec. 2791(c)(1)-(4) of PHS (42 U.S.C. sec. 300gg-91(c)(1-4)). A parallel definition of excepted benefits is provided in section 9832(c)(1)-(4).

compensation or similar insurance; (5) automobile medical payment insurance; (6) credit-only insurance; (7) coverage for on-site medical clinics; and (8) other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Other excepted benefits that do not constitute minimum essential coverage if offered under a separate policy, certificate or contract of insurance include long term care, limited scope dental and vision benefits, coverage for a disease or specified illness, hospital indemnity or other fixed indemnity insurance or Medicare supplemental health insurance.

Tax on failure to maintain minimum essential coverage

The tax for failure to maintain minimum essential coverage for any calendar month is one-twelfth of the tax calculated as an annual amount. The annual amount is equal to the greater of the flat dollar amount or the excess income amount. The flat dollar amount is the lesser of the sum of the individual annual dollar amounts for the members of the taxpayer's family and 300 percent of the adult individual dollar amount. The excess income amount is a specified percentage of the excess of the taxpayer's household income for the taxable year over the threshold amount of income for required income tax return filing for that taxpayer.⁷ The total annual household payment may not exceed the national average annual premium for bronze level health plans offered through American Health Benefit Exchanges that year for the applicable family size. The individual adult annual dollar amount is phased in over the first three years as follows: \$95 for 2014; \$325 for 2015; and \$695 in 2016.⁸ For an individual who has not attained age 18, the individual annual dollar amount is one half of the adult amount. The specified percentage of income is phased in as follows: one percent for 2014; two percent in 2015; and 2.5 percent beginning after 2015.

Exemptions

Exemptions from the requirement to maintain minimum essential coverage are provided for the following: (1) an individual for whom coverage is unaffordable because the required contribution exceeds eight percent of household income, (2) an individual with household income below the income tax return filing threshold, (3) a member of an Indian tribe, (4) a member of certain recognized religious sects or a health sharing ministry, (5) an individual with a coverage gap for a continuous period of less than three months, and (6) an individual who is determined by the Secretary of HHS to have suffered a hardship with respect to the capability to obtain coverage.

Reasons for Change

The excise tax for failure to maintain a specific type of minimum essential coverage dictates personal health care choices, interferes in health care markets, and imposes an undue financial burden on families that fail to comply. The Committee believes that individuals should

⁷ Sec. 6012(a).

⁸ For years after 2016, the \$695 amount is indexed to CPI-U, rounded to the next lowest multiple of \$50.

not be required to purchase specific Federally designed and dictated types of health insurance coverage to pay for medical care services.

Explanation of Provision

The provision repeals the individual mandate, so that it does not apply to any month beginning after December 31, 2014.

Effective Date

The provision is effective for months beginning after December 31, 2014.

B. Repeal of Employer Mandate
(sec. 302 of the committee print and sec. 4980H of the Code)

In general

Effective as of 2014, an applicable large employer, as defined below, may be subject to a tax, called an “assessable payment,” for a month if one or more of its full-time employees is certified to the employer as receiving for the month a premium assistance credit for health insurance purchased on an American Health Benefit Exchange or reduced cost-sharing for the employee’s share of expenses covered by such health insurance (commonly referred to as the “employer mandate”).⁹ As discussed below, the amount of the assessable payment depends on whether the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under a group health plan sponsored by the employer and, if it does, whether the coverage offered is affordable and provides minimum value.

Definitions of full-time employee and applicable large employer

For purposes of applying these rules, full-time employee means, with respect to any month, an employee who is employed on average at least 30 hours of service per week. Hours of service are to be determined under regulations, rules, and guidance prescribed by the Secretary of the Treasury, in consultation with the Secretary of Labor, including rules for employees who are not compensated on an hourly basis.

Applicable large employer generally means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.¹⁰ Solely for purposes of determining whether an employer is an applicable large employer (that is, whether the employer has at least 50 full-time employees), besides the number of full-time employees, the employer must include the number of its full-time equivalent employees for a month, determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120. In addition, in determining whether an employer is an applicable large employer, members of the same controlled group, group under common control, and affiliated service group are treated as a

⁹ Sec. 4980H, added to the Code by section 1513 of PPACA and amended by 10106 of PPACA and section 1003 of HCERA. Premium assistance credits for health insurance purchased on an American Health Benefit Exchange are provided under section 36B. Reduced cost-sharing for an individual’s share of expenses covered by such health insurance is provided under section 1402 of PPACA.

Under the ACA, the requirement to offer minimum essential coverage is effective for months beginning after December 31, 2013. However, in Notice 2013-45, 2013-31 I.R.B. 116, Part III, Q&A-2, the Internal Revenue Service (“IRS”) announced that no assessable payments would be assessed for 2014. In addition, on February 10, 2014, the Department of the Treasury and the IRS issued final regulations on the employer shared responsibility requirement and announced that no assessable payments for 2015 will apply to applicable large employers that have fewer than 100 full-time employees and full-time equivalent employees and meet certain other requirements. Section XV.D.6 of the preamble to the final regulations, 79 Fed. Reg. 8544, 8574-8575, February 12, 2014.

¹⁰ Additional rules apply, for example, in the case of an employer that was not in existence for the entire preceding calendar year.

single employer.¹¹ If the group is an applicable large employer under this test, each member of the group is an applicable large employer even if any member by itself would not be an applicable large employer.¹²

Assessable payments

If an applicable large employer does not offer its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is so certified to the employer, the employer may be subject to an assessable payment of \$2,000¹³ (divided by 12 and applied on a monthly basis) multiplied by the number of its full-time employees in excess of 30, regardless of the number of full-time employees so certified. For example, in 2016, Employer A fails to offer minimum essential coverage and has 100 full-time employees, 10 of whom receive premium assistance credits for the entire year. The employer's assessable payment is \$2,000 for each employee over the 30-employee threshold, for a total of \$140,000 (\$2,000 multiplied by 70, that is, 100 minus 30).

Generally an employee who is offered minimum essential coverage under an employer-sponsored plan is not eligible for a premium assistance credit or reduced cost-sharing unless the coverage is unaffordable or fails to provide minimum value.¹⁴ However, if an employer offers its full-time employees and their dependents minimum essential coverage under an employer-sponsored plan and at least one full-time employee is certified as receiving a premium assistance credit or reduced cost-sharing (because the coverage is unaffordable or fails to provide minimum value), the employer may be subject to an assessable payment of \$3,000 (divided by 12 and applied on a monthly basis) multiplied by the number of such full-time employees. However, the assessable payment in this case is capped at the amount that would apply if the employer failed to offer its full-time employees and their dependents minimum essential coverage. For example, in 2016, Employer B offers minimum essential coverage and has 100 full-time employees, 20 of whom receive premium assistance credits for the entire year. The employer's assessable payment before consideration of the cap is \$3,000 for each full-time employee receiving a credit, for a total of \$60,000. The cap on the assessable payment is the

¹¹ The rules for determining controlled group, group under common control, and affiliated service group under section 414(b), (c), (m) and (o) apply for this purpose.

¹² In addition, in determining assessable payments (as discussed herein), only one 30-employee reduction in full-time employees applies to the group and is allocated among the members ratably based on the number of full-time employees employed by each member.

¹³ For calendar years after 2014, the \$2,000 dollar amount, and the \$3,000 dollar amount referenced herein, are increased by 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 of HHS no later than October 1 of the preceding calendar year) exceeds the average per capita premium for 2013 (as determined by the Secretary of HHS), rounded down to the next lowest multiple of \$10.

¹⁴ Under section 36B(c)(2)(C), coverage under an employer-sponsored plan is unaffordable if the employee's share of the premium for self-only coverage exceeds 9.5 percent of household income, and the coverage fails to provide minimum value if the plan's share of total allowed cost of provided benefits is less than 60 percent of such costs.

amount that would have applied if the employer failed to offer coverage, or \$140,000 (\$2,000 multiplied by 70, that is, 100 minus 30). In this example, the cap therefore does not affect the amount of the assessable payment, which remains at \$60,000.

Reasons for Change

The excise tax for employers whose employees receive premium assistance credits or cost-sharing reductions interferes with market-driven compensation arrangements, encourages employers to cut hours and employees, and stifles new job creation. The Committee believes that repealing the excise tax will remove an unnecessary impediment preventing job creation, and lead to more jobs and increased economic growth.

Explanation of Provision

The provision repeals the employer mandate, so that it does not apply to any month beginning after December 31, 2014.

Effective Date

The provision is effective for months beginning after December 31, 2014.

**C. Repeal of Medical Device Excise Tax
(sec. 303 of the committee print and sec. 4191 of the Code)**

Present Law

Effective for sales after December 31, 2012, a tax equal to 2.3 percent of the sale price is imposed on the sale of any taxable medical device by the manufacturer, producer, or importer of such device.¹⁵ A taxable medical device is any device, as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act,¹⁶ intended for humans. Regulations further define a medical device as one that is listed by the Food and Drug Administration (“FDA”) under section 510(j) of the Federal Food, Drug, and Cosmetic Act and 21 C.F.R. Part 807, pursuant to FDA requirements.¹⁷

The excise tax does not apply to eyeglasses, contact lenses, hearing aids, or any other medical device determined by the Secretary to be of a type that is generally purchased by the general public at retail for individual use (“retail exemption”). Regulations provide guidance on the types of devices that are exempt under the retail exemption. A device is exempt under these provisions if: (1) it is regularly available for purchase and use by individual consumers who are not medical professionals; and (2) the design of the device demonstrates that it is not primarily intended for use in a medical institution or office or by a medical professional.¹⁸ Additionally, the regulations provide certain safe harbors for devices eligible for the retail exemption.¹⁹

The medical device excise tax is generally subject to the rules applicable to other manufacturers excise taxes. These rules include certain general manufacturers excise tax exemptions including the exemption for sales for use by the purchaser for further manufacture (or for resale to a second purchaser in further manufacture) or for export (or for resale to a

¹⁵ Sec. 4191, which was added to the Code by section 1405 of HCERA.

¹⁶ 21 U.S.C. sec. 321. Section 201(h) defines device as “an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is (1) recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.”

¹⁷ Treas. Reg. sec. 48.4191-2(a). The regulations also include as devices items that should have been listed as a device with the FDA as of the date the FDA notifies the manufacturer or importer that corrective action with respect to listing is required.

¹⁸ Treas. Reg. sec. 48.4191-2(b)(2).

¹⁹ Treas. Reg. sec. 48.4191-2(b)(2)(iii). The safe harbors include devices that are described as over-the-counter devices in relevant FDA classification headings as well as certain FDA device classifications listed in the regulations.

second purchaser for export).²⁰ If a medical device is sold free of tax for resale to a second purchaser for further manufacture or for export, the exemption does not apply unless, within the six-month period beginning on the date of sale by the manufacturer, the manufacturer receives proof that the medical device has been exported or resold for use in further manufacturing.²¹ In general, the exemption does not apply unless the manufacturer, the first purchaser, and the second purchaser are registered with the Secretary of the Treasury. Foreign purchasers of articles sold or resold for export are exempt from the registration requirement.

The lease of a medical device is generally considered to be a sale of such device.²² Special rules apply for the imposition of tax to each lease payment. The use of a medical device subject to tax by manufacturers, producers, or importers of such device, is treated as a sale for the purpose of imposition of excise taxes.²³

There are also rules for determining the price of a medical device on which the excise tax is imposed.²⁴ These rules provide for (1) the inclusion of containers, packaging, and certain transportation charges in the price, (2) determining a constructive sales price if a medical device is sold for less than the fair market price, and (3) determining the tax due in the case of partial payments or installment sales.

Reasons for Change

The U.S. medical device industry is a leader in medical technology innovation. The industry is an important contributor to the nation's economy, employing hundreds of thousands of people and manufacturing devices both for the U.S. and foreign markets. The United States is a net exporter of medical devices. The Committee believes that the excise tax on medical devices adversely affects the industry. The Committee believes that repealing the tax will decrease the cost of healthcare, encourage medical innovation, and lead to more jobs in the industry.

Explanation of Provision

The provision repeals the medical device excise tax.

Effective Date

The provision applies to sales in calendar quarters beginning after the date of enactment.

²⁰ Sec. 4221(a). Other general manufacturers excise tax exemptions (*i.e.*, the exemption for sales to purchasers for use as supplies for vessels or aircraft, to a State or local government, to a nonprofit educational organization, or to a qualified blood collector organization) do not apply to the medical device excise tax.

²¹ Sec. 4221(b).

²² Sec. 4217(a).

²³ Sec. 4218.

²⁴ Sec. 4216.

**D. Repeal of the Excise Tax on Employee Health Insurance Premiums
and Health Plan Benefits and Related Reporting Requirements
(sec. 304 of the committee print and secs. 4980I and 6051(a)(14) of the Code)**

Excise tax on high cost employer-sponsored health coverage

In general

Effective as of 2018, an excise tax is imposed on the provider of applicable employer-sponsored health coverage (the “coverage provider”) if the aggregate cost of the coverage for an employee (including a former employee, surviving spouse, or any other primary insured individual) exceeds a threshold amount (referred to as “high cost health coverage”).²⁵ The tax is 40 percent of the amount by which aggregate cost exceeds the threshold amount (the “excess benefit”).

The annual threshold amount for 2018 is \$10,200 for self-only coverage and \$27,500 for other coverage (such as family coverage), multiplied by a one-time health cost adjustment percentage.²⁶ This threshold is then adjusted annually (including for 2018) by an age and gender adjusted excess premium amount.²⁷ The age and gender adjusted excess premium amount is the excess, if any, of (1) the premium cost of standard FEHBP coverage for the type of coverage provided to an individual if priced for the age and gender characteristics of all employees of the employer, over (2) the premium cost of standard FEHBP coverage if priced for the age and gender characteristics of the national workforce. For this purpose, standard FEHBP coverage means the per employee cost of Blue Cross/Blue Shield standard benefit coverage under the Federal Employees Health Benefit Program.

The excise tax is determined on a monthly basis, by reference to the monthly aggregate cost of applicable employer-sponsored coverage for the month and 1/12 of the annual threshold amount. The excise tax is not deductible.²⁸

²⁵ Sec. 4980I, which was added to the Code by section 9001 of PPACA and amended by section 10901 of PPACA and section 1401 of HCERA.

²⁶ The health cost adjustment percentage is 100 percent plus the excess, if any, of (1) the percentage by which the cost of standard FEHBP coverage for 2018 (determined according to specified criteria) exceeds the cost of standard FEHBP coverage for 2010, over (2) 55 percent.

²⁷ Under section 4980I, the 2018 threshold amounts are increased by \$1,650 for self-only coverage or \$3,450 for other coverage in the case of certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines. For years after 2018, the threshold amounts (after application of the health cost adjustment percentage), and the increases for certain retirees and participants in a plan covering employees in a high-risk profession or repair or installation of electrical or telecommunications lines, are indexed to the Consumer Price Index for Urban Consumers (“CPI-U”) (CPI-U increased by one percentage point for 2019 only), rounded to the nearest \$50.

²⁸ Sec. 275(a)(6), referring to taxes imposed by chapter 43.

Applicable employer-sponsored coverage and determination of cost

Subject to certain exceptions, applicable employer-sponsored coverage is coverage under any group health plan offered to an employee by an employer that is excludible from the employee's gross income or that would be excludible if it were employer-sponsored coverage.²⁹ Thus, applicable employer-sponsored coverage includes coverage for which an employee pays on an after-tax basis. Applicable employer-sponsored coverage includes coverage under any group health plan established and maintained primarily for its civilian employees by the Federal government or any Federal agency or instrumentality, or the government of any State or political subdivision thereof or any agency or instrumentality of a State or political subdivision.

Applicable employer-sponsored coverage includes both insured and self-insured health coverage, including coverage in the form of reimbursements under a health flexible spending account ("health FSA") or a health reimbursement arrangement and contributions to a health savings account ("HSA") or Archer medical savings account ("Archer MSA").³⁰ In the case of a self-employed individual, coverage is treated as applicable employer-sponsored coverage if the self-employed individual is allowed a deduction for all or any portion of the cost of coverage.³¹

For purposes of the excise tax, the cost of applicable employer-sponsored coverage is generally determined under rules similar to the rules for determining the applicable premium for purposes of COBRA continuation coverage,³² except that any portion of the cost of coverage attributable to the excise tax is not taken into account. Cost is determined separately for self-only coverage and other coverage. Special valuation rules apply to retiree coverage, certain health FSAs, and contributions to HSAs and Archer MSAs.

Calculation of excess benefit and imposition of excise tax

In determining the excess benefit with respect to an employee (*i.e.*, the amount by which the cost of applicable employer-sponsored coverage for the employee exceeds the threshold amount), the aggregate cost of all applicable employer-sponsored coverage of the employee is

²⁹ Section 106 provides an exclusion for employer-provided coverage.

³⁰ Some types of coverage are not included in applicable employer-sponsored coverage, such as long-term care coverage, separate insurance coverage substantially all the benefits of which are for treatment of the mouth (including any organ or structure within the mouth) or of the eye, and certain excepted benefits. Excepted benefits for this purpose include (whether through insurance or otherwise) coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; and other similar insurance coverage (as specified in regulations), under which benefits for medical care are secondary or incidental to other insurance benefits. Applicable employer-sponsored coverage does not include coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity insurance if the cost of the coverage is not excludible from an employee's income or deductible by a self-employed individual.

³¹ Section 162(l) allows a deduction to a self-employed individual for the cost of health insurance.

³² Sec. 4980B(f)(4).

taken into account. The threshold amount for self-only coverage generally applies to an employee. The threshold amount for other coverage applies to an employee only if the employee and at least one other beneficiary are enrolled in coverage other than self-only coverage under a group health plan that provides minimum essential coverage and under which the benefits provided do not vary based on whether the covered individual is the employee or other beneficiary. For purposes of the threshold amount, any coverage provided under a multiemployer plan is treated as coverage other than self-only coverage.³³

The excise tax is imposed on the coverage provider.³⁴ In the case of insured coverage (*i.e.*, coverage under a policy, certificate, or contract issued by an insurance company), the health insurance issuer is liable for the excise tax. In the case of self-insured coverage, the person that administers the plan benefits (“plan administrator”) is generally liable for the excise tax. However, in the case of employer contributions to an HSA or an Archer MSA, the employer is liable for the excise tax.

The employer is generally responsible for calculating the amount of excess benefit allocable to each coverage provider and notifying each coverage provider (and the IRS) of the coverage provider’s allocable share. In the case of applicable employer-sponsored coverage under a multiemployer plan, the plan sponsor is responsible for the calculation and notification.³⁵

Reporting of cost of employer-sponsored health coverage on Form W-2

Every employer is required to furnish each employee and the Federal government with a statement of compensation information, including wages, paid by the employer to the employee, and the taxes withheld from such wages during the calendar year. The statement, made on Form W-2, must be provided to each employee by January 31 of the succeeding year.

Effective as of 2010, the ACA added the cost of employer-sponsored health coverage as an item of information required to be reported on each employee’s annual Form W-2.³⁶ For this reporting requirement, the definition of applicable employer-sponsored coverage for purposes of the excise tax on high cost health coverage applies. If an employee enrolls in applicable

³³ As defined in section 414(f), a multiemployer plan is generally a plan to which more than one employer is required to contribute and that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

³⁴ The excise tax is allocated pro rata among the coverage providers, with each responsible for the excise tax on an amount equal to the total excess benefit multiplied by a fraction, the numerator of which is the cost of the applicable employer-sponsored coverage of that coverage provider and the denominator of which is the aggregate cost of all applicable employer-sponsored coverage of the employee.

³⁵ The employer or multiemployer plan sponsor may be liable for a penalty if the total excise tax due exceeds the tax on the excess benefit calculated and allocated among coverage providers by the employer or plan sponsor.

³⁶ Sec. 6051(a)(14), which was added to the Code by section 9002 of PPACA.

employer-sponsored coverage under multiple plans, the employer must disclose the aggregate cost of all such health coverage (excluding any salary reduction contributions to a health FSA).

Reasons for Change

The excise tax on employee health insurance premiums punishes employers for complying with requirements to offer minimum essential coverage and ACA regulations driving up the cost of such coverage. The Committee believes that repealing the excise tax on employee health insurance premiums in the context of the broader current law health care regulatory environment will prevent job loss, will provide relief to employees who are facing increased premium costs, and will lead to increased economic growth.

Explanation of Provision

The provision repeals both the excise tax on high cost health coverage and the requirement to report the cost of employer-sponsored health coverage on each employee's annual Form W-2.

Effective Date

The provision to repeal the excise tax on high cost health coverage is effective for taxable years beginning after December 31, 2017. The provision to repeal the requirement to report the cost of employer-sponsored health coverage on each employee's Form W-2 is effective for calendar years beginning after December 31, 2014.

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 the Reconciliation Legislative Recommendations Relating to Repeal of Certain Excise Taxes Enacted in the Patient Protection and Affordable Care Act (Subtitle A), on September 29, 2015.

The Chairman's amendment in the nature of a substitute was adopted by a voice vote (with a quorum being present).

The budget reconciliation legislative recommendations relating to repeal of certain excise taxes enacted in PPACA were ordered favorably transmitted to the House Committee on the Budget by a roll call vote of 23 yeas to 14 nays (with a quorum being present). The vote was as follows:

Representative	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. Ryan	✓			Mr. Levin		✓	
Mr. Johnson	✓			Mr. Rangel		✓	
Mr. Brady	✓			Mr. McDermott		✓	
Mr. Nunes	✓			Mr. Lewis		✓	
Mr. Tiberi	✓			Mr. Neal		✓	
Mr. Reichert				Mr. Becerra		✓	
Mr. Boustany	✓			Mr. Doggett		✓	
Mr. Roskam	✓			Mr. Thompson		✓	
Mr. Price	✓			Mr. Larson			
Mr. Buchanan	✓			Mr. Blumenauer		✓	
Mr. Smith (NE)	✓			Mr. Kind		✓	
Ms. Jenkins	✓			Mr. Pascrell		✓	
Mr. Paulsen	✓			Mr. Crowley		✓	
Mr. Marchant	✓			Mr. Davis		✓	
Ms. Black	✓			Ms. Sanchez		✓	
Mr. Reed	✓						
Mr. Young	✓						
Mr. Kelly	✓						
Mr. Renacci	✓						
Mr. Meehan	✓						
Ms. Noem	✓						
Mr. Holding	✓						
Mr. Smith (MO)	✓						
Mr. Dold	✓						

IV. BUDGET EFFECTS OF THE PROVISIONS

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 “Budget Reconciliation Legislative Recommendations Relating to Repeal of Certain Excise Taxes Enacted in the Patient Protection and Affordable Care Act.”

The budget reconciliation legislative recommendations, as transmitted, are estimated to have the following effects on budget receipts for fiscal years 2016-2025:

**ESTIMATED BUDGET EFFECTS OF
THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS RELATING TO
REPEAL OF CERTAIN EXCISE TAXES ENACTED IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT,
AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS**

Fiscal Years 2016 - 2025

[Billions of Dollars]

Provision	Effective	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-20	2016-25
1. Repeal of individual and employer mandates enacted in the Affordable Care Act (the "ACA") [1] [2] [3].....	mba 12/31/14	-1.4	9.2	13.0	14.5	15.9	17.4	18.4	19.0	20.2	21.0	51.2	147.1
2. Repeal the excise tax on medical devices.....	si cqba DOE	-1.4	-2.0	-2.1	-2.2	-2.3	-2.5	-2.6	-2.8	-2.9	-3.1	-10.0	-23.9
3. Repeal of the tax on employee health insurance premiums and health plan benefits [1] [2] [3].....	tyba 12/31/17	---	---	-2.2	-7.2	-8.3	-9.9	-11.6	-14.0	-16.9	-20.9	-17.8	-91.1
4. Repeal W-2 reporting of value of health benefits.....	cyba 12/31/14	---	---	---	---	---	---	---	---	---	---	---	---
5. Interaction between the repeal of the mandates and the repeal of the high premium excise tax.....	---	---	---	[4]	2.1	2.0	1.7	1.7	1.6	1.6	1.4	4.1	12.1
NET TOTAL		-2.8	7.2	8.7	7.2	7.3	6.7	5.9	3.8	2.0	-1.6	27.5	44.2

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding. The date of enactment is assumed to be November 1, 2015.

Legend for "Effective" column:
 cqba = calendar quarters beginning after
 cyba = calendar years beginning after
 mba = months beginning after
 si = sales in
 tyba = taxable years beginning after

[1] Estimate provided by the staff of the Joint Committee on Taxation and the Congressional Budget Office.

[2] Estimate includes the following change in outlays:

Repeal of individual and employer mandates enacted in the ACA.....	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-20	2016-25
Repeal of the tax on employee health insurance premiums and health plan benefits and related reporting requirements.....	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9

[3] Estimate includes the following off-budget effects:

Repeal of individual and employer mandates enacted in the ACA.....	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-20	2016-25
Repeal of the tax on employee health insurance premiums and health plan benefits and related reporting requirements.....	1.5	4.0	4.4	4.4	4.6	4.8	5.0	5.2	5.6	5.8	19.0	45.4

[4] Gain of less than \$50 million.

**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 budget reconciliation legislative recommendation involves no new or increased budget authority. The Committee states further that the budget reconciliation legislative recommendation involves no new or increased 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 the CBO is provided.



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Keith Hall, Director

October 2, 2015

Honorable Paul Ryan
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the Reconciliation Recommendations of the House Committee on Ways and Means.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sarah Masi, who can be reached at 226-9010.

Sincerely,

A handwritten signature in black ink, appearing to read 'Keith Hall'.

Keith Hall

Enclosure

cc: Honorable Sander M. Levin
Ranking Member



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

October 2, 2015

**Reconciliation Recommendations
of the House Committee on Ways and Means**

As approved by the House Committee on Ways and Means on September 29, 2015

SUMMARY

S. Con. Res. 11, the Concurrent Resolution on the Budget for fiscal year 2016, instructed several committees of the House of Representatives to recommend legislative changes that would reduce deficits over the 2016-2025 period. As part of that reconciliation process, the House Committee on Ways and Means approved legislation on September 29, 2015, that would, on net, reduce deficits over that period.

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation—which would repeal several provisions of the Affordable Care Act (ACA)—would reduce federal deficits by \$37.1 billion over the 2016-2025 period. That total consists of \$12.5 billion in on-budget savings and \$24.6 billion in off-budget savings.

CBO and JCT estimate that enacting the legislation would not increase net direct spending by more than \$5 billion in either of the first two consecutive 10-year periods beginning in 2026; however, the agencies are not able to determine whether enacting the legislation would increase net direct spending in the third or fourth 10-year period. The agencies estimate that enacting the legislation would increase on-budget deficits by at least \$5 billion in each of the four consecutive 10-year periods beginning in 2026.

JCT has determined that subtitle A of the legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO has reviewed the non-tax provision of the legislation (subtitle B) and determined that it contains no intergovernmental or private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of the legislation is shown in the following table. The outlay effects of this legislation fall within budget function 550 (health) and 570 (Medicare).

By Fiscal Year, in Billions of Dollars												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-	2016-
											2020	2025
CHANGES IN DIRECT SPENDING												
Subtitle A												
Repeal Individual and Employer Mandates												
Estimated Budget Authority	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9
Estimated Outlays	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9
Repeal Excise Tax on High-Premium Insurance Plans												
Estimated Budget Authority	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2
Estimated Outlays	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2
Subtitle B												
Repeal IPAB												
Estimated Budget Authority	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1
Estimated Outlays	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1
Total Changes in Direct Spending												
Estimated Budget Authority	-8.7	-17.2	-21.7	-25.2	-27.8	-29.9	-32.1	-33.5	-35.7	-36.1	-100.6	-268.0
Estimated Outlays	-8.7	-17.2	-21.7	-25.2	-27.8	-29.9	-32.1	-33.5	-35.7	-36.1	-100.6	-268.0
CHANGES IN REVENUES												
Subtitle A												
Repeal Individual and Employer Mandates												
	-10.1	-8.0	-8.0	-9.8	-10.5	-10.9	-11.9	-12.9	-13.5	-14.1	-46.4	-109.8
Repeal Medical Device Tax	-1.4	-2.0	-2.1	-2.2	-2.3	-2.5	-2.6	-2.8	-2.9	-3.1	-10.0	-23.9
Repeal Excise Tax on High-Premium Insurance Plans	0	0	-2.9	-8.1	-9.7	-11.5	-14.0	-17.1	-20.8	-25.0	-20.8	-109.3
Interaction Effects	0	0	*	2.1	2.0	1.7	1.7	1.6	1.6	1.4	4.1	12.1
Total Changes in Revenues	-11.5	-10.0	-13.0	-18.0	-20.5	-23.2	-26.8	-31.2	-35.6	-40.8	-73.1	-230.9
On-Budget	-13.0	-14.0	-16.8	-21.5	-23.7	-26.1	-29.3	-33.0	-36.8	-41.0	-89.2	-255.5
Off-Budget ^a	1.5	4.0	3.8	3.5	3.2	2.9	2.5	1.8	1.2	0.2	16.1	24.6
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES												
Impact on Deficit	2.8	-7.2	-8.7	-7.2	-7.3	-6.7	-5.3	-2.3	-0.1	4.7	-27.5	-37.1
On-Budget	4.3	-3.2	-4.9	-3.7	-4.1	-3.8	-2.8	-0.5	1.1	4.9	-11.4	-12.5
Off-Budget ^a	-1.5	-4.0	-3.8	-3.5	-3.2	-2.9	-2.5	-1.8	-1.2	-0.2	-16.1	-24.6
Memorandum:												
Net Effect on Deficit												
Subtitle A	2.8	-7.2	-8.7	-7.2	-7.3	-6.7	-5.9	-3.8	-2.0	1.6	-27.5	-44.2
Subtitle B	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1

Sources: Congressional Budget Office, staff of the Joint Committee on Taxation.

Notes: Numbers may not sum to totals because of rounding. IPAB = Independent Payment Advisory Board;
* = increase in revenues between zero and \$500 million.

a. All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as "off-budget.")

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted near the end of calendar year 2015. On net, the agencies estimate that enacting the legislation would decrease federal deficits by \$37.1 billion over the 2016-2025 period; that change would result from a \$230.9 billion reduction in revenues and a \$268.0 billion decrease in direct spending. Most of the reduction in revenues would stem from eliminating several penalties and excise taxes; most of the reduction in direct spending would result from lower projected enrollment in health insurance coverage that is subsidized by the federal government. (See “Net Effects on Health Insurance Coverage” for a discussion of the combined effects of the legislation on health insurance coverage.)

Subtitle A—Revenue Provisions

Over the 2016-2025 period, CBO and JCT estimate that subtitle A of the legislation would decrease direct spending by \$275.1 billion and decrease revenues by \$230.9 billion, thereby reducing federal budget deficits, on net, by \$44.2 billion. Subtitle A would repeal the following provisions of the ACA:

- The requirement that most people in the United States must obtain health insurance coverage or pay a penalty for not doing so (a provision known as the individual mandate);
- Penalties imposed on large employers who decline to offer their employees health insurance coverage that meets specified standards (a provision known as the employer mandate)¹;
- The federal excise tax imposed on the sale of medical devices; and
- The federal excise tax imposed on some health insurance plans with high premiums along with related reporting requirements.

Repeal of the Individual and Employer Mandates. Section 301 of subtitle A would repeal the individual mandate and section 302 of subtitle A would repeal the employer mandate. CBO and JCT estimate that repealing the both mandates would result in net budgetary savings to the federal government of \$147.1 billion over the 2016-2025 period. That projected decrease in federal deficits over the 10-year period consists of a \$256.9 billion decrease in direct spending, partially offset by a \$109.8 billion reduction in

1. To meet the standards, the cost to the employee for self-only coverage must not exceed a specified share of income (which is 9.56 percent in 2015 and is indexed for inflation over time), and the plan must pay at least 60 percent of the cost of covered benefits. The employer mandate generally applies to employers with at least 50 full-time-equivalent employees.

revenues. The revenue decrease would result from an estimated \$155.2 billion reduction in on-budget revenues, partially offset by an estimated \$45.4 billion increase in off-budget (Social Security) revenues.

Individual Mandate. Under current law, people who do not obtain health insurance owe the greater of a flat dollar penalty or a percentage of a household's adjusted gross income in excess of the income threshold for mandatory tax-filing, both subject to a cap. Certain categories of people are exempt from paying penalties, including people with taxable income below the filing threshold, people without access to affordable coverage, unauthorized immigrants, and people who obtain a hardship waiver. If the individual mandate was repealed, penalty payments for being uninsured would no longer be collected; CBO and JCT estimate that loss in penalty payments would total \$43.3 billion over the 2016-2025 period.

In addition to eliminating penalties for uninsured individuals, CBO and JCT estimate that repealing the individual mandate would substantially reduce the number of people with health insurance coverage and, accordingly, reduce the estimated federal costs associated with some sources of health insurance coverage. Under current law, the agencies estimate that the existence of the individual mandate and its associated penalties spurs increased enrollment in federally-subsidized health insurance coverage through Medicaid, the Children's Health Insurance Program (CHIP), exchanges, and employment-based plans (which are subsidized indirectly because almost no premiums for that coverage are treated as taxable compensation). The estimated savings stemming from lower enrollment in such coverage would exceed the loss in revenues from eliminating penalty payments by uninsured people.

CBO and JCT estimate that repealing the individual mandate would also result in higher health insurance premiums in the nongroup market (that is, premiums for individually purchased health insurance) after 2016.² Insurers would still be required to provide coverage to any applicant, would not be able to vary premiums to reflect enrollees' health status or to limit coverage of preexisting medical conditions, and would be allowed to vary premiums by age only to a limited degree. Those features are most attractive to applicants with relatively high expected costs for health care, so the agencies expect that repealing the individual mandate would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people. Nevertheless, CBO and JCT anticipate that a significant number of relatively healthy people would still have a strong incentive to purchase insurance in the nongroup market because of the availability of government subsidies—and, therefore, that the market would not be subject to an unsustainable spiral of rising premiums. In years after 2016, CBO and JCT estimate that

2. CBO and JCT expect that insurers would not be able to change their 2016 premiums to reflect the increase in expected medical claims because the bill would be enacted after premiums are set for the 2016 plan year.

repealing the individual mandate would increase premiums for policies in the nongroup market by roughly 20 percent above what would be expected under current law, which would in turn increase the costs to the federal government of subsidies for eligible individuals who remain enrolled in individual policies purchased through the exchanges.

Employer Mandate. CBO and JCT estimate that repealing the employer mandate would yield two types of budgetary effects. First, employers that do not offer health insurance that meets specified standards would no longer be assessed penalties, which would reduce revenues by \$166.9 billion over the 2016-2025 period according to CBO and JCT's estimates. Second, the agencies estimate that there would be small changes in health insurance coverage that would yield largely offsetting budgetary effects. Specifically, the agencies expect that some employers that are projected to offer health insurance to their employees under current law would no longer do so if the employer mandate were repealed because eliminating penalties would lower the cost of not offering health insurance. However, CBO and JCT expect that the reduction in offers of employment-based coverage would be limited because most employers construct compensation packages that comprise a mix of wages and nonwage benefits that will attract the best available workers at the lowest cost.³ Those that would no longer enroll in employment-based coverage in the absence of the employer mandate would instead enroll in coverage through Medicaid, CHIP, the nongroup market (including individual policies purchased through the exchanges or directly from insurers in the nongroup market), or become uninsured.

Repeal of the Medical Device Tax. Section 303 of subtitle A would repeal the medical device excise tax established by the ACA. Under current law, a tax of 2.3 percent is imposed on the sale of medical devices by the manufacturer or importer. Medical devices that are regularly available at retail for individual use and not primarily intended for use by a medical professional are exempt from the tax. The tax went into effect on January 1, 2013, and its repeal by the legislation would be effective starting in the first calendar quarter after the date of enactment. JCT estimates that repealing the medical device tax would reduce revenues, thus increasing federal deficits, by about \$23.9 billion over the 2016-2025 period.

Repeal of the Excise Tax on High-Premium Insurance Plans. Section 304 of subtitle A would repeal a federal excise tax that will be imposed on employment-based health plans whose total value is greater than specified thresholds.⁴ Under current law, the excise tax

3. See Congressional Budget Office, *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012), <http://www.cbo.gov/publication/43082>.

4. The total value includes employers' and employees' contributions for health insurance premiums and contributions made through health reimbursement arrangements, flexible spending arrangements, and health savings accounts for other health care costs.

will take effect in 2018 and will be equal to 40 percent of the difference between the total value of contributions and the applicable threshold. CBO and JCT estimate that repealing the tax would result in net budgetary costs to the federal government of \$91.1 billion over the 2016-2025 period. That projected increase in federal deficits over the 10-year period consists of a \$109.3 billion decrease in revenues, partially offset by an \$18.2 billion decrease in direct spending.

The decrease in revenues over the 2016-2025 period primarily reflects an \$87.3 billion reduction in revenues stemming from forgone excise tax receipts and from fewer employers and workers shifting to lower-cost health insurance plans to avoid paying the tax. That is, relative to current law, more people would remain in higher-cost health insurance plans and a larger share of total compensation would take the form of non-taxable health benefits, decreasing the share taking the form of taxable wages and salaries. (Also, increased enrollment in higher-cost health plans would probably place upward pressure on health insurance premiums.)

CBO and JCT estimate that tax revenues would further decrease by \$12.5 billion over the 2016-2025 period as some employers who are expected to stop offering health insurance under current law (instead of offering insurance whose total value exceeds the specified thresholds for the excise tax) would no longer do so, thereby further reducing the share of compensation taking the form of taxable wages and salaries. Similarly, some employees who are not expected to enroll in insurance offered by their employer under current law, would do so. Both of those changes would further reduce the share of compensation taking the form of taxable wages and salaries.

The remaining portion of the estimated net decrease in revenues comprises a \$12.1 billion reduction in projected penalty payments from people who, under current law, would be uninsured because of the tax, and employers that, under current law, would pay penalties for not offering health insurance coverage that meets certain standards to their employees, and a \$2.6 billion increase in revenues from other smaller effects. In addition, CBO and JCT estimate that direct spending would decrease by \$18.2 billion over the 2016-2025 period primarily because some of the people who would newly enroll in employment-based coverage in the absence of the excise tax on high-premium plans would have otherwise been enrolled in insurance obtained through Medicaid and exchanges.

Interaction Effects. Repealing the excise tax on high-premium insurance plans would reduce the amount of penalty payments collected from employers and uninsured people. However, those penalties would be eliminated by the repeal of the individual and employer mandates. Therefore, the estimated cost of repealing the excise tax on high-premium insurance plans would be reduced if the provisions of subtitle A were enacted simultaneously. Accounting for the interactions, CBO and JCT project that the total

savings would be \$12.1 billion greater over the 2016-2025 period than the net savings from the two provisions when estimated separately.

Net Effects on Health Insurance Coverage

CBO and JCT estimate that the provisions of subtitle A would reduce the number of nonelderly people in the United States with health insurance coverage by about 14 million to 15 million in most years (about 20 percent of those are estimated to be children). Nearly all of that reduction in coverage would arise from repealing the mandate on individuals to obtain health insurance coverage; however, the other provisions in subtitle A would have small effects on coverage as discussed below. Specifically, CBO and JCT estimate:

- Roughly 3 million to 4 million fewer people, on net, would enroll in employment-based coverage. CBO and JCT estimate that 4 million fewer people would enroll in employment-based coverage because fewer employers would offer health insurance coverage to their employees in the absence of the employer mandate and fewer employees would take up such coverage in the absence of the individual mandate. However, CBO and JCT estimate that repealing the excise tax on high-premium insurance plans would offset that loss in employment-based coverage by roughly 500,000 to 1 million people because some employers who are not expected to offer coverage and some employees who are not expected to enroll in coverage under current law because of the tax on high-premium plans would do so.
- Roughly 7 million fewer people would obtain coverage through the nongroup market (including individual policies purchased through the exchanges or directly from insurers in the nongroup market). CBO and JCT estimate that repealing the individual mandate and, to a much lesser extent, repealing the excise tax on high-premium insurance plans would reduce the number of people that seek out and enroll in coverage through the nongroup market; however, that reduction would be partially offset by an increase in nongroup coverage among people who would no longer have an offer of employment-based coverage if the employer mandate was repealed.
- Roughly 4 million fewer people would enroll in Medicaid or CHIP (about 20 percent of those are estimated to be children). Nearly all of that reduction in coverage stems from people—particularly those with taxable income above the tax-filing threshold—who would have been induced to enroll in Medicaid or CHIP because of the existence of the individual mandate and associated penalties.

In years after 2016, CBO and JCT estimate that 41 million nonelderly people, or roughly 15 percent of the nonelderly population, would be uninsured if the provisions in subtitle A

were enacted. By comparison, the agencies project that 26 million to 27 million nonelderly people, or roughly 10 percent of the nonelderly population, will be uninsured under current law in those years.

Subtitle B—Repeal of Independent Payment Advisory Board

The legislation would repeal the provisions of the Affordable Care Act that established the Independent Payment Advisory Board (IPAB) and that created a process by which the board (or the Secretary of the Department of Health and Human Services) would be required under certain circumstances to modify the Medicare program to achieve specified savings.

CBO estimates that repealing the IPAB provision would not have any budgetary impact between 2015 and 2021, but would increase direct spending by \$7.1 billion over the 2022-2025 period.⁵

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO and JCT estimate that enacting the legislation would not increase net direct spending in either of the first two consecutive 10-year periods beginning in 2026; at some point the costs of repealing IPAB would exceed the savings from the other provisions, but the agencies cannot determine whether that would occur during the third or fourth 10-year periods after 2026 or later. The agencies estimate that enacting the legislation would increase on-budget deficits by at least \$5 billion in each of the four consecutive 10-year periods beginning in 2026.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

JCT has determined that subtitle A contains no intergovernmental or private-sector mandates as defined in UMRA. CBO has reviewed the non-tax provision of the legislation (subtitle B) and determined that it contains no intergovernmental or private-sector mandates as defined in UMRA.

5. For a discussion of the CBO's approach to estimating the budgetary effect of repealing the IPAB provision, see *H.R. 1190, Protecting Seniors' Access to Medicare Act of 2015*, June 11, 2015, <https://www.cbo.gov/publication/50294>

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

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of the budget reconciliation legislative recommendations that the Committee concluded that it is appropriate to transmit the legislative recommendations to the Committee on the Budget.

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 budget reconciliation legislative recommendations contain no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing 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 budget reconciliation legislative recommendations do not contain any private sector mandates. The Committee has determined that the budget reconciliation legislative recommendations do not impose any Federal intergovernmental mandates 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 provisions of the budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations do 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 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 budget reconciliation legislative recommendation contains no provisions that amend the Code 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 budget reconciliation legislative recommendations and states that the provisions of the legislative recommendations 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(g)(2) of H. Res. 5 (114th Congress), the Committee states that none of the budget reconciliation legislative recommendations 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 the Federal Program Information Act (Public Law 95-220, as amended by Public Law 98-169).

H. Disclosure of Directed Rule Makings

In compliance with Sec. 3(i) of H. Res. 5 (114th Congress), the following statement is made concerning directed rule makings: The Committee estimates that the budget reconciliation legislative recommendations require no directed rule makings within the meaning of such section.

**VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET RECONCILIATION
LEGISLATIVE RECOMMENDATION, AS TRANSMITTED**

**A. Text of Existing Law Amended or Repealed by the Budget Reconciliation Legislative
Recommendations, as Transmitted**

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the budget reconciliation legislative recommendations, as transmitted, is shown below:

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 italics and existing law in which no change is proposed is shown in roman):

INTERNAL REVENUE CODE OF 1986

* * * * *

Subtitle D—Miscellaneous Excise Taxes

* * * * *

CHAPTER 32—MANUFACTURERS EXCISE TAXES

* * * * *

[SUBCHAPTER E—MEDICAL DEVICES]

* * * * *

[Subchapter E—Medical Devices

[SEC. 4191. MEDICAL DEVICES.

[(a) IN GENERAL.—There is hereby imposed on the sale of any taxable medical device by the manufacturer, producer, or importer a tax equal to 2.3 percent of the price for which so sold.

[(b) TAXABLE MEDICAL DEVICE.—For purposes of this section—

[(1) IN GENERAL.—The term “taxable medical device” means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act) intended for humans.

[(2) EXEMPTIONS.—Such term shall not include—

[(A) eyeglasses,

[(B) contact lenses,

[(C) hearing aids, and

[(D) any other medical device determined by the Secretary to be of a type which is generally purchased by the general public at retail for individual use.]

* * * * *

Subchapter G—Exemptions, Registration, Etc

SEC. 4221. CERTAIN TAX-FREE SALES.

(a) GENERAL RULE.—Under regulations prescribed by the Secretary, no tax shall be imposed under this chapter (other than under section 4121 or 4081) on the sale by the manufacturer (or under subchapter C of chapter 31 on the first retail sale) of an article—

(1) for use by the purchaser for further manufacture, or for resale by the purchaser to a second purchaser for use by such second purchaser in further manufacture,

(2) for export, or for resale by the purchaser to a second purchaser for export,

(3) for use by the purchaser as supplies for vessels or aircraft,

(4) to a State or local government for the exclusive use of a State or local government,

(5) to a nonprofit educational organization for its exclusive use, or

(6) to a qualified blood collector organization (as defined in section 7701(a)(49)) for such organization's exclusive use in the collection, storage, or transportation of blood,

but only if such exportation or use is to occur before any other use. Paragraphs (4), (5), and (6) shall not apply to the tax imposed by section 4064. In the case of taxes imposed by section 4051, or 4071, paragraphs (4) and (5) shall not apply on and after October 1, 2016. In the case of the tax imposed by section 4131, paragraphs (3), (4), and (5) shall not apply and paragraph (2) shall apply only if the use of the exported vaccine meets such requirements as the Secretary may by regulations prescribe. In the case of taxes imposed by subchapter C or D, paragraph (6) shall not apply. **¶**In the case of the tax imposed by section 4191, paragraphs (3), (4), (5), and (6) shall not apply. **¶**

(b) **PROOF OF RESALE FOR FURTHER MANUFACTURE; PROOF OF EXPORT.**—Where an article has been sold free of tax under subsection (a)—

(1) for resale by the purchaser to a second purchaser for use by such second purchaser in further manufacture, or

(2) for export, or for resale by the purchaser to a second purchaser for export,

subsection (a) shall cease to apply in respect of such sale of such article unless, within the 6-month period which begins on the date of the sale by the manufacturer (or, if earlier, on the date of shipment by the manufacturer), the manufacturer receives proof that the article has been exported or resold for use in further manufacture.

(c) **MANUFACTURER RELIEVED FROM LIABILITY IN CERTAIN CASES.**—In the case of any article sold free of tax under this section (other than a sale to which subsection (b) applies), and in the case of any article sold free of tax under section 4053(6), if the manufacturer in good faith accepts a certification by the purchaser that the article will be used in accordance with the applicable provisions of law, no tax shall thereafter be imposed under this chapter in respect of such sale by such manufacturer.

(d) **DEFINITIONS.**—For purposes of this section—

(1) **MANUFACTURER.**—The term “manufacturer” includes a producer or importer of an article, and, in the case of taxes imposed by subchapter C of chapter 31, includes the retailer with respect to the first retail sale.

(2) **EXPORT.**—The term “export” includes shipment to a possession of the United States; and the term “exported” includes shipped to a possession of the United States.

(3) SUPPLIES FOR VESSELS OR AIRCRAFT.—The term “supplies for vessels or aircraft” means fuel supplies, ships’ stores, sea stores, or legitimate equipment on vessels of war of the United States or of any foreign nation, vessels employed in the fisheries or in the whaling business, or vessels actually engaged in foreign trade or trade between the Atlantic and Pacific ports of the United States or between the United States and any of its possessions. For purposes of the preceding sentence, the term “vessels” includes civil aircraft employed in foreign trade or trade between the United States and any of its possessions, and the term “vessels of war of the United States or of any foreign nation” includes aircraft owned by the United States or by any foreign nation and constituting a part of the armed forces thereof.

(4) STATE OR LOCAL GOVERNMENT.—The term “State or local government” means any State, any political subdivision thereof, or the District of Columbia.

(5) NONPROFIT EDUCATIONAL ORGANIZATION.—The term “nonprofit educational organization” means an educational organization described in section 170(b)(1)(A)(ii) which is exempt from income tax under section 501(a). The term also includes a school operated as an activity of an organization described in section 501(c)(3) which is exempt from income tax under section 501(a), if such school normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on.

(6) USE IN FURTHER MANUFACTURE.—An article shall be treated as sold for use in further manufacture if—

(A) such article is sold for use by the purchaser as material in the manufacture or production of, or as a component part of, another article taxable under this chapter to be manufactured or produced by him; or

(B) in the case of gasoline taxable under section 4081, such gasoline is sold for use by the purchaser, for nonfuel purposes, as a material in the manufacture or production of another article to be manufactured or produced by him.

(7) QUALIFIED BUS.—

(A) IN GENERAL.—The term “qualified bus” means—

- (i) an intercity or local bus, and
- (ii) a school bus.

(B) INTERCITY OR LOCAL BUS.—The term “intercity or local bus” means any automobile bus which is used predominantly in furnishing (for compensation) passenger land transportation available to the general public if—

- (i) such transportation is scheduled and along regular routes, or
- (ii) the seating capacity of such bus is at least 20 adults (not including the driver).

(C) SCHOOL BUS.—The term “school bus” means any automobile bus substantially all the use of which is in transporting students and employees of schools. For purposes of the preceding sentence, the term “school” means an educational organization which normally maintains a

regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are carried on.

(e) SPECIAL RULES.—

(1) RECIPROCITY REQUIRED IN CASE OF CIVIL AIRCRAFT.—In the case of articles sold for use as supplies for aircraft, the privileges granted under subsection (a)(3) in respect of civil aircraft employed in foreign trade or trade between the United States and any of its possessions, in respect of aircraft registered in a foreign country, shall be allowed only if the Secretary of the Treasury has been advised by the Secretary of Commerce that he has found that such foreign country allows, or will allow, substantially reciprocal privileges in respect of aircraft registered in the United States. If the Secretary of the Treasury is advised by the Secretary of Commerce that he has found that a foreign country has discontinued or will discontinue the allowance of such privileges, the privileges granted under subsection (a)(3) shall not apply thereafter in respect of civil aircraft registered in that foreign country and employed in foreign trade or trade between the United States and any of its possessions.

(2) TIRES.—

(A) TAX-FREE SALES.—Under regulations prescribed by the Secretary, no tax shall be imposed under section 4071 on the sale by the manufacturer of a tire if—

(i) such tire is sold for use by the purchaser for sale on or in connection with the sale of another article manufactured or produced by such purchaser; and

(ii) such other article is to be sold by such purchaser in a sale which either will satisfy the requirements of paragraph (2), (3), (4), or (5) of subsection (a) for a tax-free sale, or would satisfy such requirements but for the fact that such other article is not subject to tax under this chapter.

(B) PROOF.—Where a tire has been sold free of tax under this paragraph, this paragraph shall cease to apply unless, within the 6-month period which begins on the date of the sale by him (or, if earlier on the date of the shipment by him), the manufacturer of such tire receives proof that the other article referred to in clause (ii) of subparagraph (A) has been sold in a manner which satisfies the requirements of such clause (ii) (including in the case of a sale for export, proof of export of such other article).

(C) SUBSECTION(A)(1) DOES NOT APPLY.—Paragraph (1) of subsection (a) shall not apply with respect to the tax imposed under section 4071 on the sale of a tire.

(3) TIRES USED ON INTERCITY, LOCAL, AND SCHOOL BUSES.—Under regulations prescribed by the Secretary, the tax imposed by section 4071 shall not apply in the case of tires sold for use by the purchaser on or in connection with a qualified bus.

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CHAPTER 43—QUALIFIED PENSION, ETC., PLANS

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【Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.】

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SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS REGARDING HEALTH COVERAGE.

(a) **LARGE EMPLOYERS NOT OFFERING HEALTH COVERAGE.—If—**

(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(b) **LARGE EMPLOYERS OFFERING COVERAGE WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX CREDITS OR COST-SHARING REDUCTIONS.—**

(1) **IN GENERAL.—If—**

(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(B) 1 or more full-time employees of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and an amount equal to $\frac{1}{12}$ of \$3,000.

(2) **OVERALL LIMITATION.—**The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(c) **DEFINITIONS AND SPECIAL RULES.—**For purposes of this section—

(1) APPLICABLE PAYMENT AMOUNT.—The term “applicable payment amount” means, with respect to any month, $\frac{1}{12}$ of \$2,000.

(2) APPLICABLE LARGE EMPLOYER.—

(A) IN GENERAL.—The term “applicable large employer” means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

(i) IN GENERAL.—An employer shall not be considered to employ more than 50 full-time employees if—

(I) the employer’s workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

(II) the employees in excess of 50 employed during such 120-day period were seasonal workers.

(ii) DEFINITION OF SEASONAL WORKERS.—The term “seasonal worker” means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500.20(s)(1) of title 29, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(iii) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) APPLICATION OF EMPLOYER SIZE TO ASSESSABLE PENALTIES.—

(i) IN GENERAL.—The number of individuals employed by an applicable large employer as full-time employees during any month shall be reduced by 30 solely for purposes of calculating—

(I) the assessable payment under subsection (a),

or

(II) the overall limitation under subsection (b)(2).

(ii) AGGREGATION.—In the case of persons treated as 1 employer under subparagraph (C)(i), only 1 reduction under subclause (I) or (II) shall be allowed with

respect to such persons and such reduction shall be allocated among such persons ratably on the basis of the number of full-time employees employed by each such person.

(E) FULL-TIME EQUIVALENTS TREATED AS FULL-TIME EMPLOYEES.—Solely for purposes of determining whether an employer is an applicable large employer under this paragraph, an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120.

(F) EXEMPTION FOR HEALTH COVERAGE UNDER TRICARE OR THE VETERANS ADMINISTRATION.—Solely for purposes of determining whether an employer is an applicable large employer under this paragraph for any month, an individual shall not be taken into account as an employee for such month if such individual has medical coverage for such month under—

(i) chapter 55 of title 10, United States Code, including coverage under the TRICARE program, or

(ii) under a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary.

(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term “applicable premium tax credit and cost-sharing reduction” means—

(A) any premium tax credit allowed under section 36B,

(B) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act, and

(C) any advance payment of such credit or reduction under section 1412 of such Act.

(4) FULL-TIME EMPLOYEE.—

(A) IN GENERAL.—The term “full-time employee” means, with respect to any month, an employee who is employed on average at least 30 hours of service per week.

(B) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

[(5) INFLATION ADJUSTMENT.—

[(A) IN GENERAL.—In the case of any calendar year after 2014, each of the dollar amounts in subsection (b) and paragraph (1) shall be increased by an amount equal to the product of—

[(i) such dollar amount, and

[(ii) the premium adjustment percentage (as defined in section 1302(c)(4) of the Patient Protection and Affordable Care Act) for the calendar year.

[(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of \$10, such increase shall be rounded to the next lowest multiple of \$10.]

(6) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

(7) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

(d) ADMINISTRATION AND PROCEDURE.—

(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) TIME FOR PAYMENT.—The Secretary may provide for the payment of any assessable payment provided by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.

(3) COORDINATION WITH CREDITS, ETC.—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed, and the assessable payment would not have been required to be made but for such allowance or payment.

(e) TERMINATION.—*This section shall not apply with respect to any month beginning after December 31, 2014.*

[SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

[(a) IMPOSITION OF TAX.—If—

[(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

[(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

[(b) EXCESS BENEFIT.—For purposes of this section—

[(1) IN GENERAL.—The term “excess benefit” means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the excess amounts determined under paragraph (2) for months during the taxable period.

[(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

[(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

[(B) an amount equal to $\frac{1}{12}$ of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

[(3) ANNUAL LIMITATION.—For purposes of this subsection—

[(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

[(B) APPLICABLE ANNUAL LIMITATION.—

[(i) IN GENERAL.—Except as provided in clause (ii), the annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

[(ii) MULTIEMPLOYER PLAN COVERAGE.—Any coverage provided under a multiemployer plan (as defined in section 414(f)) shall be treated as coverage other than self-only coverage.

[(C) APPLICABLE DOLLAR LIMIT.—

[(i) 2018.—In the case of 2018, the dollar limit under this subparagraph is—

[(I) in the case of an employee with self-only coverage, \$10,200 multiplied by the health cost adjustment percentage (determined by only taking into account self-only coverage), and

[(II) in the case of an employee with coverage other than self-only coverage, \$27,500 multiplied by the health cost adjustment percentage (determined by only taking into account coverage other than self-only coverage).

[(ii) HEALTH COST ADJUSTMENT PERCENTAGE.—For purposes of clause (i), the health cost adjustment percentage is equal to 100 percent plus the excess (if any) of—

[(I) the percentage by which the per employee cost for providing coverage under the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for plan year 2018 (determined by using the benefit package for such coverage in 2010) exceeds such cost for plan year 2010, over

[(II) 55 percent.

[(iii) AGE AND GENDER ADJUSTMENT.—

[(I) IN GENERAL.—The amount determined under subclause (I) or (II) of clause (i), whichever is applicable, for any taxable period shall be increased by the amount determined under subclause (II).

[(II) AMOUNT DETERMINED.—The amount determined under this subclause is an amount equal to the excess (if any) of—

[(aa) the premium cost of the Blue Cross/Blue Shield standard benefit option under the Federal Employees Health Benefits Plan for the type of coverage provided such individual in such taxable period if priced for the age and gender characteristics of all employees of the individual's employer, over

[(bb) that premium cost for the provision of such coverage under such option in such taxable period if priced for the age and gender characteristics of the national workforce.

[(iv) EXCEPTION FOR CERTAIN INDIVIDUALS.—In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical or telecommunications lines—

[(I) the dollar amount in clause (i)(I) shall be increased by \$1,650, and

[(II) the dollar amount in clause (i)(II) shall be increased by \$3,450,

[(v) SUBSEQUENT YEARS.—In the case of any calendar year after 2018, each of the dollar amounts under clauses (i) (after the application of clause (ii)) and (iv) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

[(I) such amount as so in effect, multiplied by

[(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substituting the calendar year that is 2 years before such year for “1992” in subparagraph (B) thereof), increased by 1 percentage point in the case of determinations for calendar years beginning before 2020.

If any amount determined under this clause is not a multiple of \$50, such amount shall be rounded to the nearest multiple of \$50.

[(c) LIABILITY TO PAY TAX.—

[(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

[(2) COVERAGE PROVIDER.—For purposes of this subsection, the term “coverage provider” means each of the following:

[(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

[(B) HSA AND MSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

[(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

[(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider’s applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

[(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

[(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

[(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

[(A) IN GENERAL.—Each employer shall—

[(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

[(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

[(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

[(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

[(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

[(A) IN GENERAL.—The term “applicable employer-sponsored coverage” means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

[(B) EXCEPTIONS.—The term “applicable employer-sponsored coverage” shall not include—

[(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1) (other than subparagraph (G) thereof) or for long-term care, or

[(ii) any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye, or

[(iii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

[(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

[(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing

health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion of the cost of the coverage.

[(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

[(2) DETERMINATION OF COST.—

[(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be calculated separately for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

[(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

[(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

[(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

[(C) ARCHER MSAS AND HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

[(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

[(3) EMPLOYEE.—The term “employee” includes any former employee, surviving spouse, or other primary insured individual.

[(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

[(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

[(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

[(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

[(2) LIMITATIONS ON PENALTY.—

[(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

[(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

[(i) such failure was due to reasonable cause and not to willful neglect, and

[(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

[(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

[(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

[(1) COVERAGE DETERMINATIONS.—

[(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer.

[(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 5000A(f)) to the employee and at least one other beneficiary, and the benefits provided under such minimum essential coverage do not vary based on whether any individual covered under such coverage is the employee or another beneficiary.

[(2) QUALIFIED RETIREE.—The term “qualified retiree” means any individual who—

[(A) is receiving coverage by reason of being a retiree,
 [(B) has attained age 55, and
 [(C) is not entitled to benefits or eligible for enrollment
 under the Medicare program under title XVIII of the So-
 cial Security Act.

[(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The
 term “employees engaged in a high-risk profession” means law
 enforcement officers (as such term is defined in section 1204 of
 the Omnibus Crime Control and Safe Streets Act of 1968), em-
 ployees in fire protection activities (as such term is defined in
 section 3(y) of the Fair Labor Standards Act of 1938), individ-
 uals who provide out- of-hospital emergency medical care (in-
 cluding emergency medical technicians, paramedics, and first-
 responders), individuals whose primary work is longshore work
 (as defined in section 258(b) of the Immigration and Nation-
 ality Act (8 U.S.C. 1288(b)), determined without regard to
 paragraph (2) thereof), and individuals engaged in the con-
 struction, mining, agriculture (not including food processing),
 forestry, and fishing industries. Such term includes an em-
 ployee who is retired from a high-risk profession described in
 the preceding sentence, if such employee satisfied the require-
 ments of such sentence for a period of not less than 20 years
 during the employee’s employment.

[(4) GROUP HEALTH PLAN.—The term “group health plan”
 has the meaning given such term by section 5000(b)(1).

[(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE
 ISSUER.—

[(A) HEALTH INSURANCE COVERAGE.—The term “health
 insurance coverage” has the meaning given such term by
 section 9832(b)(1) (applied without regard to subparagraph
 (B) thereof, except as provided by the Secretary in regula-
 tions).

[(B) HEALTH INSURANCE ISSUER.—The term “health in-
 surance issuer” has the meaning given such term by sec-
 tion 9832(b)(2).

[(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The
 term “person that administers the plan benefits” shall include
 the plan sponsor if the plan sponsor administers benefits under
 the plan.

[(7) PLAN SPONSOR.—The term “plan sponsor” has the mean-
 ing given such term in section 3(16)(B) of the Employee Retirement
 Income Security Act of 1974.

[(8) TAXABLE PERIOD.—The term “taxable period” means the
 calendar year or such shorter period as the Secretary may pre-
 scribe. The Secretary may have different taxable periods for
 employers of varying sizes.

[(9) AGGREGATION RULES.—All employers treated as a single
 employer under subsection (b), (c), (m), or (o) of section 414
 shall be treated as a single employer.

[(10) DENIAL OF DEDUCTION.—For denial of a deduction for
 the tax imposed by this section, see section 275(a)(6).

[(g) REGULATIONS.—The Secretary shall prescribe such regula-
 tions as may be necessary to carry out this section.]

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CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) **REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) **SHARED RESPONSIBILITY PAYMENT.**—

(1) **IN GENERAL.**—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) **INCLUSION WITH RETURN.**—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) **PAYMENT OF PENALTY.**—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) **AMOUNT OF PENALTY.**—

(1) **IN GENERAL.**—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) **MONTHLY PENALTY AMOUNTS.**—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to $\frac{1}{12}$ of the greater of the following amounts:

(A) **FLAT DOLLAR AMOUNT.**—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

[(ii) 2.0 percent for taxable years beginning in 2015.

[(iii) 2.5 percent for taxable years beginning after 2015.]

(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is \$695.

(B) PHASE IN.—The applicable dollar amount is \$95 for [2014 and \$325 for 2015.]2014.

(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

[(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$695, increased by an amount equal to—

[(i) \$695, multiplied by

[(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2015” 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.

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

(A) 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.

(B) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer for any taxable year, 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.
- (C) 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, and
 - (ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.
- (d) APPLICABLE INDIVIDUAL.—For purposes of this section—
- (1) IN GENERAL.—The term “applicable individual” means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).
 - (2) RELIGIOUS EXEMPTIONS.—
 - (A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—
 - (i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and
 - (ii) an adherent of established tenets or teachings of such sect or division as described in such section.
 - (B) HEALTH CARE SHARING MINISTRY.—
 - (i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.
 - (ii) HEALTH CARE SHARING MINISTRY.—The term “health care sharing ministry” means an organization—
 - (I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
 - (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,
 - (III) members of which retain membership even after they develop a medical condition,
 - (IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and
 - (V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) **INDIVIDUALS NOT LAWFULLY PRESENT.**—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) **INCARCERATED INDIVIDUALS.**—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) **EXEMPTIONS.**—No penalty shall be imposed under subsection (a) with respect to—

(1) **INDIVIDUALS WHO CANNOT AFFORD COVERAGE.**—

(A) **IN GENERAL.**—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) **REQUIRED CONTRIBUTION.**—For purposes of this paragraph, the term “required contribution” means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) **SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.**—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

(D) **INDEXING.**—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for “8 percent” the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between

the preceding calendar year and 2013 over the rate of income growth for such period.】

(2) **TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.**—Any applicable individual for any month during a calendar year if the individual’s household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) **MEMBERS OF INDIAN TRIBES.**—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) **MONTHS DURING SHORT COVERAGE GAPS.**—

(A) **IN GENERAL.**—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) **SPECIAL RULES.**—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) **HARDSHIPS.**—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) **MINIMUM ESSENTIAL COVERAGE.**—For purposes of this section—

(1) **IN GENERAL.**—The term “minimum essential coverage” means any of the following:

(A) **GOVERNMENT SPONSORED PROGRAMS.**—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Sec-

retary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and

Affordable Care Act shall have the same meaning as when used in such title.

(g) ADMINISTRATION AND PROCEDURE.—

(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) SPECIAL RULES.—Notwithstanding any other provision of law—

(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

(h) TERMINATION.—*This section shall not apply with respect to any month beginning after December 31, 2014.*

* * * * *

Subtitle F—Procedure and Administration

* * * * *

CHAPTER 61—INFORMATION AND RETURNS

* * * * *

Subchapter A—Returns and Records

* * * * *

PART III—INFORMATION RETURNS

* * * * *

Subpart C—Information Regarding Wages Paid Employees

SEC. 6051. RECEIPTS FOR EMPLOYEES.

(a) REQUIREMENT.—Every person required to deduct and withhold from an employee a tax under section 3101 or 3402, or who would have been required to deduct and withhold a tax under section 3402 (determined without regard to subsection (n)) if the employee had claimed no more than one withholding exemption, or every employer engaged in a trade or business who pays remuneration for services performed by an employee, including the cash value of such remuneration paid in any medium other than cash, shall furnish to each such employee in respect of the remuneration

paid by such person to such employee during the calendar year, on or before January 31 of the succeeding year, or, if his employment is terminated before the close of such calendar year, within 30 days after the date of receipt of a written request from the employee if such 30-day period ends before January 31, a written statement showing the following:

- (1) the name of such person,
- (2) the name of the employee (and his social security account number if wages as defined in section 3121(a) have been paid),
- (3) the total amount of wages as defined in section 3401(a),
- (4) the total amount deducted and withheld as tax under section 3402,
- (5) the total amount of wages as defined in section 3121(a),
- (6) the total amount deducted and withheld as tax under section 3101,
- (8) the total amount of elective deferrals (within the meaning of section 402(g)(3)) and compensation deferred under section 457, including the amount of designated Roth contributions (as defined in section 402A),
- (9) the total amount incurred for dependent care assistance with respect to such employee under a dependent care assistance program described in section 129(d),
- (10) in the case of an employee who is a member of the Armed Forces of the United States, such employee's earned income as determined for purposes of section 32 (relating to earned income credit),
- (11) the amount contributed to any Archer MSA (as defined in section 220(d)) of such employee or such employee's spouse,
- (12) the amount contributed to any health savings account (as defined in section 223(d)) of such employee or such employee's spouse,*and*
- (13) the total amount of deferrals for the year under a non-qualified deferred compensation plan (within the meaning of section 409A(d))**], and**].

[(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

[(A) coverage to which paragraphs (11) and (12) apply,
or

[(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).]

In the case of compensation paid for service as a member of a uniformed service, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(2). In the case of compensation paid for service as a volunteer or volunteer leader within the meaning of the Peace Corps Act, the statement shall show, in lieu of the amount required to be shown by paragraph (5), the total amount of wages as defined in section 3121(a), computed in accordance with such section and section 3121(i)(3). In the case of tips received by an employee in the course of his employment, the amounts re-

quired to be shown by paragraphs (3) and (5) shall include only such tips as are included in statements furnished to the employer pursuant to section 6053(a). The amounts required to be shown by paragraph (5) shall not include wages which are exempted pursuant to sections 3101(c) and 3111(c) from the taxes imposed by sections 3101 and 3111. In the case of the amounts required to be shown by paragraph (13), the Secretary may (by regulation) establish a minimum amount of deferrals below which paragraph (13) does not apply.

(b) SPECIAL RULE AS TO COMPENSATION OF MEMBERS OF ARMED FORCES.—In the case of compensation paid for service as a member of the Armed Forces, the statement required by subsection (a) shall be furnished if any tax was withheld during the calendar year under section 3402, or if any of the compensation paid during such year is includible in gross income under chapter 1, or if during the calendar year any amount was required to be withheld as tax under section 3101. In lieu of the amount required to be shown by paragraph (3) of subsection (a), such statement shall show as wages paid during the calendar year the amount of such compensation paid during the calendar year which is not excluded from gross income under chapter 1 (whether or not such compensation constituted wages as defined in section 3401(a)).

(c) ADDITIONAL REQUIREMENTS.—The statements required to be furnished pursuant to this section in respect of any remuneration shall be furnished at such other times, shall contain such other information, and shall be in such form as the Secretary may by regulations prescribe. The statements required under this section shall also show the proportion of the total amount withheld as tax under section 3101 which is for financing the cost of hospital insurance benefits under part A of title XVIII of the Social Security Act.

(d) STATEMENTS TO CONSTITUTE INFORMATION RETURNS.—A duplicate of any statement made pursuant to this section and in accordance with regulations prescribed by the Secretary shall, when required by such regulations, be filed with the Secretary.

(e) RAILROAD EMPLOYEES.—

(1) ADDITIONAL REQUIREMENT.—Every person required to deduct and withhold tax under section 3201 from an employee shall include on or with the statement required to be furnished such employee under subsection (a) a notice concerning the provisions of this title with respect to the allowance of a credit or refund of the tax on wages imposed by section 3101(b) and the tax on compensation imposed by section 3201 or 3211 which is treated as a tax on wages imposed by section 3101(b).

(2) INFORMATION TO BE SUPPLIED TO EMPLOYEES.—Each person required to deduct and withhold tax under section 3201 during any year from an employee who has also received wages during such year subject to the tax imposed by section 3101(b) shall, upon request of such employee, furnish to him a written statement showing—

(A) the total amount of compensation with respect to which the tax imposed by section 3201 was deducted,

(B) the total amount deducted as tax under section 3201,
and

(C) the portion of the total amount deducted as tax under section 3201 which is for financing the cost of hospital insurance under part A of title XVIII of the Social Security Act.

(f) STATEMENTS REQUIRED IN CASE OF SICK PAY PAID BY THIRD PARTIES.—

(1) STATEMENTS REQUIRED FROM PAYOR.—

(A) IN GENERAL.—If, during any calendar year, any person makes a payment of third-party sick pay to an employee, such person shall, on or before January 15 of the succeeding year, furnish a written statement to the employer in respect of whom such payment was made showing—

- (i) the name and, if there is withholding under section 3402(o), the social security number of such employee,
- (ii) the total amount of the third-party sick pay paid to such employee during the calendar year, and
- (iii) the total amount (if any) deducted and withheld from such sick pay under section 3402.

For purposes of the preceding sentence, the term “third-party sick pay” means any sick pay (as defined in section 3402(o)(2)(C)) which does not constitute wages for purposes of chapter 24 (determined without regard to section 3402(o)(1)).

(B) SPECIAL RULES.—

(i) STATEMENTS ARE IN LIEU OF OTHER REPORTING REQUIREMENTS.—The reporting requirements of subparagraph (A) with respect to any payments shall, with respect to such payments, be in lieu of the requirements of subsection (a) and of section 6041.

(ii) PENALTIES MADE APPLICABLE.—For purposes of sections 6674 and 7204, the statements required to be furnished by subparagraph (A) shall be treated as statements required under this section to be furnished to employees.

(2) INFORMATION REQUIRED TO BE FURNISHED BY EMPLOYER.—Every employer who receives a statement under paragraph (1)(A) with respect to sick pay paid to any employee during any calendar year shall, on or before January 31 of the succeeding year, furnish a written statement to such employee showing—

- (A) the information shown on the statement furnished under paragraph (1)(A), and
- (B) if any portion of the sick pay is excludable from gross income under section 104(a)(3), the portion which is not so excludable and the portion which is so excludable.

To the extent practicable, the information required under the preceding sentence shall be furnished on or with the statement (if any) required under subsection (a).

* * * * *

CHAPTER 65—ABATEMENTS, CREDITS, AND REFUNDS

* * * * *

Subchapter B—Rules of Special Application

* * * * *

SEC. 6416. CERTAIN TAXES ON SALES AND SERVICES.

(a) **CONDITION TO ALLOWANCE.**—

(1) **GENERAL RULE.**—No credit or refund of any overpayment of tax imposed by chapter 31 (relating to retail excise taxes), or chapter 32 (manufacturers taxes), shall be allowed or made unless the person who paid the tax establishes, under regulations prescribed by the Secretary, that he—

(A) has not included the tax in the price of the article with respect to which it was imposed and has not collected the amount of the tax from the person who purchased such article;

(B) has repaid the amount of the tax to the ultimate purchaser of the article;

(C) in the case of an overpayment under subsection (b)(2) of this section—

(i) has repaid or agreed to repay the amount of the tax to the ultimate vendor of the article, or

(ii) has obtained the written consent of such ultimate vendor to the allowance of the credit or the making of the refund; or

(D) has filed with the Secretary the written consent of the person referred to in subparagraph (B) to the allowance of the credit or the making of the refund.

(2) **EXCEPTIONS.**—This subsection shall not apply to—

(A) the tax imposed by section 4041 (relating to tax on special fuels) on the use of any liquid, and

(B) an overpayment of tax under paragraph (1), (3)(A), (4), (5), or (6) of subsection (b) of this section.

(3) **SPECIAL RULE.**—For purposes of this subsection, in any case in which the Secretary determines that an article is not taxable, the term “ultimate purchaser” (when used in paragraph (1)(B) of this subsection) includes a wholesaler, jobber, distributor, or retailer who, on the 15th day after the date of such determination, holds such article for sale; but only if claim for credit or refund by reason of this paragraph is filed on or before the date for filing the return with respect to the taxes imposed under chapter 32 for the first period which begins more than 60 days after the date on such determination.

(4) **REGISTERED ULTIMATE VENDOR OR CREDIT CARD ISSUER TO ADMINISTER CREDITS AND REFUNDS OF GASOLINE TAX.**—

(A) **IN GENERAL.**—For purposes of this subsection, except as provided in subparagraph (B), if an ultimate vendor purchases any gasoline on which tax imposed by section 4081 has been paid and sells such gasoline to an ultimate purchaser described in subparagraph (C) or (D) of sub-

section (b)(2) (and such gasoline is for a use described in such subparagraph), such ultimate vendor shall be treated as the person (and the only person) who paid such tax, but only if such ultimate vendor is registered under section 4101.

(B) CREDIT CARD ISSUER.—For purposes of this subsection, if the purchase of gasoline described in subparagraph (A) (determined without regard to the registration status of the ultimate vendor) is made by means of a credit card issued to the ultimate purchaser, paragraph (1) shall not apply and the person extending the credit to the ultimate purchaser shall be treated as the person (and the only person) who paid the tax, but only if such person—

(i) is registered under section 4101,

(ii) has established, under regulations prescribed by the Secretary, that such person—

(I) has not collected the amount of the tax from the person who purchased such article, or

(II) has obtained the written consent from the ultimate purchaser to the allowance of the credit or refund, and

(iii) has so established that such person—

(I) has repaid or agreed to repay the amount of the tax to the ultimate vendor,

(II) has obtained the written consent of the ultimate vendor to the allowance of the credit or refund, or

(III) has otherwise made arrangements which directly or indirectly provides the ultimate vendor with reimbursement of such tax.

If clause (i), (ii), or (iii) is not met by such person extending the credit to the ultimate purchaser, then such person shall collect an amount equal to the tax from the ultimate purchaser and only such ultimate purchaser may claim such credit or payment.

(C) TIMING OF CLAIMS.—The procedure and timing of any claim under subparagraph (A) or (B) shall be the same as for claims under section 6427(i)(4), except that the rules of section 6427(i)(3)(B) regarding electronic claims shall not apply unless the ultimate vendor or credit card issuer has certified to the Secretary for the most recent quarter of the taxable year that all ultimate purchasers of the vendor or credit card issuer are certified and entitled to a refund under subparagraph (C) or (D) of subsection (b)(2).

(b) SPECIAL CASES IN WHICH TAX PAYMENTS CONSIDERED OVERPAYMENTS.—Under regulations prescribed by the Secretary, credit or refund (without interest) shall be allowed or made in respect of the overpayments determined under the following paragraphs:

(1) PRICE READJUSTMENTS.—

(A) IN GENERAL.—Except as provided in subparagraph (B) or (C), if the price of any article in respect of which a tax, based on such price, is imposed by chapter 31 or 32, is readjusted by reason of the return or repossession of the article or a covering or container, or by a bona fide dis-

count, rebate, or allowance, including a readjustment for local advertising (but only to the extent provided in section 4216(e)(2) and (3)), the part of the tax proportionate to the part of the price repaid or credited to the purchaser shall be deemed to be an overpayment.

(B) FURTHER MANUFACTURE.—Subparagraph (A) shall not apply in the case of an article in respect of which tax was computed under section 4223(b)(2); but if the price for which such article was sold is readjusted by reason of the return or repossession of the article, the part of the tax proportionate to the part of such price repaid or credited to the purchaser shall be deemed to be an overpayment.

(C) ADJUSTMENT OF TIRE PRICE.—No credit or refund of any tax imposed by subsection (a) or (b) of section 4071 shall be allowed or made by reason of an adjustment of a tire pursuant to a warranty or guarantee.

(2) SPECIFIED USES AND REALES.—The tax paid under chapter 32 (or under subsection (a) or (d) of section 4041 in respect of sales or under section 4051) in respect of any article shall be deemed to be an overpayment if such article was, by any person—

(A) exported;

(B) used or sold for use as supplies for vessels or aircraft;

(C) sold to a State or local government for the exclusive use of a State or local government;

(D) sold to a nonprofit educational organization for its exclusive use;

(E) sold to a qualified blood collector organization (as defined in section 7701(a)(49)) for such organization's exclusive use in the collection, storage, or transportation of blood;

(F) in the case of any tire taxable under section 4071(a), sold to any person for use as described in section 4221(e)(3); or

(G) in the case of gasoline, used or sold for use in the production of special fuels referred to in section 4041.

Subparagraphs (C), (D), and (E) shall not apply in the case of any tax paid under section 4064. In the case of the tax imposed by section 4131, subparagraphs (B), (C), (D), and (E) shall not apply and subparagraph (A) shall apply only if the use of the exported vaccine meets such requirements as the Secretary may by regulations prescribe. This paragraph shall not apply in the case of any tax imposed under section 4041(a)(1) or 4081 on diesel fuel or kerosene and any tax paid under section 4121. Subparagraphs (C) and (D) shall not apply in the case of any tax imposed on gasoline under section 4081 if the requirements of subsection (a)(4) are not met. In the case of taxes imposed by subchapter C or D of chapter 32, subparagraph (E) shall not apply. **[In the case of the tax imposed by section 4191, subparagraphs (B), (C), (D), and (E) shall not apply.]**

(3) TAX-PAID ARTICLES USED FOR FURTHER MANUFACTURE, ETC.—If the tax imposed by chapter 32 has been paid with respect to the sale of any article (other than coal taxable under

section 4121) by the manufacturer, producer, or importer thereof and such article is sold to a subsequent manufacturer or producer before being used, such tax shall be deemed to be an overpayment by such subsequent manufacturer or producer if—

(A) in the case of any article other than any fuel taxable under section 4081, such article is used by the subsequent manufacturer or producer as material in the manufacture or production of, or as a component part of—

(i) another article taxable under chapter 32, or

(ii) an automobile bus chassis or an automobile bus body, manufactured or produced by him; or

(B) in the case of any fuel taxable under section 4081, such fuel is used by the subsequent manufacturer or producer, for nonfuel purposes, as a material in the manufacture or production of any other article manufactured or produced by him.

(4) TIRES.—If—

(A) the tax imposed by section 4071 has been paid with respect to the sale of any tire by the manufacturer, producer, or importer thereof, and

(B) such tire is sold by any person on or in connection with, or with the sale of, any other article, such tax shall be deemed to be an overpayment by such person if such other article is—

(i) an automobile bus chassis or an automobile bus body,

(ii) by such person exported, sold to a State or local government for the exclusive use of a State or local government, sold to a nonprofit educational organization for its exclusive use, or used or sold for use as supplies for vessels or aircraft, or

(iii) sold to a qualified blood collector organization for its exclusive use in connection with a vehicle the organization certifies will be primarily used in the collection, storage, or transportation of blood.

(5) RETURN OF CERTAIN INSTALLMENT ACCOUNTS.—If—

(A) tax was paid under section 4216(d)(1) in respect of any installment account,

(B) such account is, under the agreement under which the account was sold, returned to the person who sold such account, and

(C) the consideration is readjusted as provided in such agreement,

the part of the tax paid under section 4216(d)(1) allocable to the part of the consideration repaid or credited to the purchaser of such account shall be deemed to be an overpayment.

(6) TRUCK CHASSIS, BODIES, AND SEMITRAILERS USED FOR FURTHER MANUFACTURE.—If—

(A) the tax imposed by section 4051 has been paid with respect to the sale of any article, and

(B) before any other use, such article is by any person used as a component part of another article taxable under section 4051 manufactured or produced by him,

such tax shall be deemed to be an overpayment by such person. For purposes of the preceding sentence, an article shall be treated as having been used as a component part of another article if, had it not been broken or rendered useless in the manufacture or production of such other article, it would have been so used.

This subsection shall apply in respect of an article only if the exportation or use referred to in the applicable provision of this subsection occurs before any other use, or, in the case of a sale or resale, the use referred to in the applicable provision of this subsection is to occur before any other use.

(c) REFUND TO EXPORTER OR SHIPPER.—Under regulations prescribed by the Secretary the amount of any tax imposed by chapter 31, or chapter 32 erroneously or illegally collected in respect of any article exported to a foreign country or shipped to a possession of the United States may be refunded to the exporter or shipper thereof, if the person who paid such tax waives his claim to such amount.

(d) CREDIT ON RETURNS.—Any person entitled to a refund of tax imposed by chapter 31 or 32, paid to the Secretary may, instead of filing a claim for refund, take credit therefor against taxes imposed by such chapter due on any subsequent return. The preceding sentence shall not apply to the tax imposed by section 4081 in the case of refunds described in section 4081(e).

(e) ACCOUNTING PROCEDURES FOR LIKE ARTICLES.—Under regulations prescribed by the Secretary, if any person uses or resells like articles, then for purposes of this section the manufacturer, producer, or importer of any such article may be identified, and the amount of tax paid under chapter 32 in respect of such article may be determined—

- (1) on a first-in-first-out basis,
- (2) on a last-in-first-out basis, or
- (3) in accordance with any other consistent method approved by the Secretary.

(f) MEANING OF TERMS.—For purposes of this section, any term used in this section has the same meaning as when used in chapter 31, 32, or 33, as the case may be.

* * * * *

VII. DISSENTING VIEWS

Congress of the United States
U.S. House of Representatives

COMMITTEE ON WAYS AND MEANS

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JANICE MAYS,
 MINORITY CHIEF COUNSEL

October 1, 2015

Dissenting Views

The reconciliation package considered today by the Committee on Ways and Means and referred to the Committee on Budget was not a serious exercise in legislating. As Members of Congress, our time should be used focusing on things that matter to hardworking Americans under the jurisdiction of this committee, including financing a long-term highway bill, impacting trade negotiations, and reforming our tax system to address income inequality and create good paying jobs in the U.S. Instead, we have become unwilling co-conspirators in a parliamentary process of reconciliation that will not advance our economy. These budget provisions are a blatant attempt to appeal to the far right, while the majority postpones having to actually govern until December.

The package considered by the Committee undermines the Affordable Care Act by gutting individual and employer shared responsibility provisions. While the total package saves over \$37 billion over 10 years, much of the savings is derived from reduced uptake of the premium tax credits and the Medicaid expansion established in the ACA to make health care affordable for individuals. Reduced uptake of the Medicaid expansion and the tax credits disproportionately impacts low- and middle-income Americans, and once again places them at risk for health insecurity and unexpected medical expenses. Roughly 15 million Americans are expected to lose their insurance coverage because of this legislation.

Individual- and employer-shared responsibility provisions are key to maintaining the robust and health risk pools that allow the ACA health insurance reforms to improve consumer protections while controlling health care costs. This legislation would repeal both the individual and employer shared responsibility provisions, increasing premiums by an estimated 20 percent in the individual market alone. This latest repeal effort comes after millions of Americans have

enrolled in the health insurance Marketplaces, many using the available financial assistance, and millions more have enrolled in expanded Medicaid programs.

Finally, we object to the Majority's continued attacks on the ACA without putting forward any comprehensive legislation to address the health insurance needs of the nation. Since January of 2009, the Majority voted to repeal or undermine the ACA over 60 times, including earlier votes on repealing the medical device tax and the Independent Payment Advisory Board. When the reconciliation bill comes to the floor, it will be the 61st vote to undermine or repeal the ACA, and the Republicans still refuse to provide any meaningful alternative.

Sincerely,

SANDER M. LEVIN,
Ranking Member.

COMMITTEE PRINT

**Budget Reconciliation Legislative Recommendations Relating
to Repeal of Independent Payment Advisory Board**

**1 Subtitle B—Repeal of Independent
2 Payment Advisory Board**

**3 SEC. 11. REPEAL OF INDEPENDENT PAYMENT ADVISORY
4 BOARD.**

5 Effective as of the enactment of the Patient Protec-
6 tion and Affordable Care Act (Public Law 111– 148), sec-
7 tions 3403 and 10320 of such Act (including the amend-
8 ments made by such sections) are repealed, and any provi-
9 sion of law amended by such sections is hereby restored
10 as if such sections had not been enacted into law.



CONTENTS

SUBTITLE B – REPEAL OF INDEPENDENT PAYMENT ADVISORY BOARD

	<u>Page</u>
I. SUMMARY AND BACKGROUND	1
A. Purpose and Summary	1
B. Background and Need for Legislation	1
C. Legislative History	1
II. EXPLANATION OF THE PROVISIONS	3
III. VOTES OF THE COMMITTEE	6
IV. BUDGET EFFECTS OF THE PROVISIONS	6
A. Committee Estimate of Budgetary Effects	6
B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority	6
C. Cost Estimate Prepared by the Congressional Budget Office	6
V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE	7
A. Committee Oversight Findings and Recommendations	7
B. Statement of General Performance Goals and Objectives	7
C. Information Relating to Unfunded Mandates	7
D. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits	7
E. Duplication of Federal Programs	7
F. Disclosure of Directed Rule Makings	8
VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET RECONCILIATION LEGISLATIVE RECOMMENDATIONS, AS TRANSMITTED	9
A. Text of Existing Law Amended or Repealed by the Budget Reconciliation Legislative Recommendation, as Transmitted	9

I. SUMMARY AND BACKGROUND

A. Purpose and Summary

In response to the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2016 (S.Con.Res. 11), the Committee on Ways and Means, favorably transmitted (with a quorum being present) the Budget Reconciliation Legislative Recommendations Relating to Repeal of the Repeal of the Independent Payment Advisory Board (“IPAB”) created by the Patient Protection and Affordable Care Act of 2010 (“PPACA”), Pub. L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (“HCERA”), Pub. L. No. 111-152 (March 30, 2010).¹ The Committee’s recommendation repeals Section 1899A of the Social Security Act which contains the IPAB provisions.

B. Background and Need for Legislation

S. Con. Res. 11, the Congressional Budget for Fiscal Year 2016, included reconciliation instructions for several committees, including the Committee on Ways and Means. The Committee considered the Budget Reconciliation Legislative Recommendations Relating to Repeal of the Independent Payment Advisory Board as part of achieving the instruction set in S. Con. Res. 11.

IPAB falls within the jurisdiction of the Committee because the legislation includes Medicare provisions, including relevant provisions of the Social Security Act (SSA). The Committee has multiple concerns about IPAB, including: IPAB will consist of unelected officials whose primary responsibility will be to cut Medicare spending which could result in restricting access to health care services and/or de facto rationing of care; IPAB will not be accountable to patients, providers, or Congress as it is allowed to operate in private; IPAB is free from judicial review; and IPAB delegates too much power to the Executive Branch.

C. Legislative History

Background

On April 30, 2015, the House of Representatives approved H. Rept. 114-96, the Conference Report for S. Con. Res. 11, the budget resolution for fiscal year 2016. Pursuant to section 2002(a)(3) of S. Con. Res. 11, the Committee on Ways and Means was directed to submit to the Committee on the Budget recommendations for changes in law within the jurisdiction of the Committee on Ways and Means sufficient to reduce the deficit by \$1,000,000,000 for the period of fiscal years 2016 through 2025.

Committee action

On September 29, 2015, in response to its instructions under the budget resolution, the Committee on Ways and Means marked up the budget reconciliation legislative

¹ PPACA and HCERA are collectively referred to as the Affordable Care Act (“ACA”).

recommendations relating to repeal of the Independent Payment Advisory Board and ordered the legislative recommendation favorably transmitted by voice vote (with a quorum being present).

Committee Hearings

The Committee favorably reported H.R. 1190, a bill to repeal the Independent Payment Advisory Board on June 2, 2015.

On March 6, 2012, the Subcommittee on Health of the House Committee on Ways and Means held a hearing to specifically examine how IPAB will impact the Medicare program, its beneficiaries, and health care providers.

The Committee also discussed IPAB during a February 28, 2012, hearing with Health and Human Services (HHS) Secretary Kathleen Sebelius on the President's FY13 Budget Proposal, a February 10, 2011, hearing on the Affordable Care Act's (ACA; P.L. 111-148 and 111-152) impact on Medicare and its beneficiaries, and a January 26, 2011, hearing on the ACA's impact on jobs, employers, and the economy.

The Subcommittee on Health also discussed IPAB during a June 22, 2011, hearing on the 2011 Medicare's Trustees Report.

II. EXPLANATION OF THE PROVISIONS

The Budget Reconciliation Legislative Recommendations Relating to Repeal of the Independent Payment Advisory Board

Present Law

IPAB was created by Sections 3403 and 10320 of the Patient Protection and Affordable Care Act (P.L. 111-148). Beginning in 2014, IPAB is tasked with making recommendations to cut per capita Medicare spending if such spending exceeds certain economic growth targets.

By April 30, 2013, and each subsequent year, the Chief Actuary at the Centers for Medicare and Medicaid Services (CMS) is required to calculate whether the projected growth in average per beneficiary Medicare spending over a five-year period (beginning two years before the year in which the calculation is being made and ending two years after) exceeds projected Medicare spending growth targets. From 2015-2019, the Medicare spending growth targets will be the projected 5-year increase in the average of the urban consumer price index (CPI-U) and medical inflation (CPI-M). Beginning in 2020, the Medicare spending growth target will be GDP +1 percent.

If the Chief Actuary determines that projected Medicare spending growth exceeds the projected spending growth targets, then the Chief Actuary must establish a savings target to rein in Medicare spending in the last year of the five-year period being examined. Savings targets are capped at the lesser of a pre-determined percentage (which increases from 0.5 percent of total Medicare spending in 2015 to 1.5 percent in 2018 and beyond) or the actual difference between estimated Medicare spending growth and the spending growth target.

If Medicare per capita spending were projected to outpace the target, IPAB would then recommend Medicare cuts that, if enacted, would meet the savings target identified by the CMS Chief Actuary (IPAB's recommended savings could exceed the savings target). IPAB is prohibited from recommending policies that would ration care (although "ration" is not defined in law), raise beneficiary premiums, increase cost sharing, or otherwise restrict benefits or eligibility.

IPAB's recommendations are due to the President and Congress by January 15th following the year in which the Chief Actuary sets the savings target. IPAB is prohibited from making its first recommendations before January 15, 2014, and IPAB-related spending reductions cannot be implemented before August 15, 2014. If IPAB does not submit recommendations (*e.g.*, a majority of IPAB members do not vote in favor of a final package to send to Congress and the President that meets the targeted savings), the HHS Secretary would draft a proposal to achieve the necessary cuts (due to the President by January 25th, who would then send to Congress). Similarly, if the Senate fails to confirm the President's IPAB appointees, the HHS Secretary would be responsible for developing the legislation to cut Medicare to achieve the savings target and submitting that plan to the President. The President would then have two days to submit that plan to Congress.

IPAB's recommendations are afforded expedited procedures for consideration by the House and Senate. In the years in which IPAB makes recommendations, the Committees of jurisdiction would have until April 1st to report legislation that complies with the spending cuts (either by adopting the IPAB's recommendations in whole or in part) or the IPAB recommendations would be discharged to floor. Congress would have until August 15th to pass such legislation. Congress can change the specific policy recommended by IPAB, but the savings targets must be met.

If Congress does not pass legislation that meets IPAB's savings requirements, the HHS Secretary would implement IPAB's recommendations beginning August 15th of the year in which the IPAB issued such recommendations. If Congress' response to IPAB recommendations is to pass a different collection of Medicare cuts, the President can issue a veto (which requires the standard two-thirds vote to override).

In 2017, Congress can discontinue IPAB via a joint resolution, which receives "fast track" treatment in the Senate, so long as the resolution is introduced before February 1st and contains specific language outlined in the Democrats' health care overhaul. Such a repeal would require a three-fifths supermajority vote in both the House and Senate. Repeal efforts in other years would not enjoy the special Senate floor procedures.

IPAB will consist of 15 members appointed by the President and confirmed by the Senate. The President is to "consult" with the Senate Majority and Minority Leaders and with the Speaker and House Minority Leader on 12 of the 15 members (3 to each leader). IPAB members are to have expertise in health finance, actuarial science, health plans, or integrated delivery systems and would consist of physicians or other health professionals, academics, economists, and urban/rural, consumer, and seniors interests. However, the majority of IPAB members cannot be health care providers. IPAB members could generally serve a maximum of two, six-year terms. The HHS Secretary, CMS Administrator, and the Health Resources and Services Administration (HRSA) Administrator will serve as non-voting IPAB members. IPAB receives its operation funding from the Medicare trust funds.

Special exemptions from IPAB-recommended cuts were granted to those providers who, in the ACA, received a cut to their annual base Medicare payment adjustment and a "productivity adjustment" cut. Specifically, providers cannot be cut by the IPAB in years in which they are subject to the productivity cuts and a cut to their payment update. As such, the hospital and hospice industries are exempt from IPAB cuts until 2019, while clinical laboratories are exempt from IPAB cuts through 2015. Given that a significant sector of the health care industry is exempt from cuts, other providers such as physicians, nursing homes, home health agencies, Medicare Advantage, and Part D plans would likely bear the brunt of the cuts, at least until 2019.

Reasons for Change

The Committee believes that appointing an unelected and unaccountable board to cut Medicare spending will harm beneficiary access to care and force health care providers to limit the number of beneficiaries they will treat or even stop participating in Medicare altogether.

While the statute suggests that IPAB will be prohibited from recommending policies that ration health care, the term “ration” is not defined in the statute, meaning its definition and application would be determined by IPAB members. Further, nothing would preclude IPAB from de facto rationing care by way of driving down reimbursements for treatments and procedures to levels where no provider would provide the care.

The Committee also has significant concerns about the degree of institutional power that will be taken from Congress and provided to IPAB and the Executive Branch. The President controls IPAB appointments, whether considered by Congress or recess appointed. If IPAB is unable to submit a proposal to cut Medicare to Congress, the HHS Secretary submits a proposal instead. Congress has limited ability to override the Medicare cuts proposed by IPAB and HHS, and any override could be vetoed by the President, ensuring that the President’s IPAB or HHS proposal becomes law.

The Committee objects to IPAB’s ability to conduct its proceedings outside of the public domain, as well as its exemption from judicial review. Such authority hinders consideration of beneficiary and provider input while robbing them of any recourse through the judicial system or appeal of IPAB decisions.

Explanation of Provision

The Budget Reconciliation Legislative Recommendations Relating to Repeal of the Independent Payment Advisory Board would repeal Section 1899A of the Social Security Act, which contains the IPAB provisions.

Effective Date

The bill would be effective upon enactment.

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 the Reconciliation Legislative Recommendations Relating to Repeal of the Independent Payment Advisory Board (Subtitle B) on September 29, 2015.

The budget reconciliation legislative recommendations relating to IPAB repeal was ordered favorably transmitted without amendment to the House Committee on the Budget by a voice vote (with a quorum being present).

IV. BUDGET EFFECTS OF THE PROVISIONS

A. Committee Estimate of Budgetary Effects

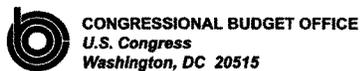
In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the "Budget Reconciliation Legislative Recommendations Relating to Repeal of the Independent Payment Advisory Board," as transmitted. The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO), which is included below as Insert A.

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 the Budget Reconciliation Legislative Recommendations Relating to Repeal of the Independent Payment Advisory Board, as reported, would increase direct spending by \$7.1 billion over the 2016-2025 period. The Committee states further that the bill involves no new or increased 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.



Keith Hall, Director

October 2, 2015

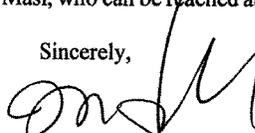
Honorable Paul Ryan
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate for the Reconciliation Recommendations of the House Committee on Ways and Means.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sarah Masi, who can be reached at 226-9010.

Sincerely,



Keith Hall

Enclosure

cc: Honorable Sander M. Levin
Ranking Member



**CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE**

October 2, 2015

**Reconciliation Recommendations
of the House Committee on Ways and Means**

As approved by the House Committee on Ways and Means on September 29, 2015

SUMMARY

S. Con. Res. 11, the Concurrent Resolution on the Budget for fiscal year 2016, instructed several committees of the House of Representatives to recommend legislative changes that would reduce deficits over the 2016-2025 period. As part of that reconciliation process, the House Committee on Ways and Means approved legislation on September 29, 2015, that would, on net, reduce deficits over that period.

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation—which would repeal several provisions of the Affordable Care Act (ACA)—would reduce federal deficits by \$37.1 billion over the 2016-2025 period. That total consists of \$12.5 billion in on-budget savings and \$24.6 billion in off-budget savings.

CBO and JCT estimate that enacting the legislation would not increase net direct spending by more than \$5 billion in either of the first two consecutive 10-year periods beginning in 2026; however, the agencies are not able to determine whether enacting the legislation would increase net direct spending in the third or fourth 10-year period. The agencies estimate that enacting the legislation would increase on-budget deficits by at least \$5 billion in each of the four consecutive 10-year periods beginning in 2026.

JCT has determined that subtitle A of the legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO has reviewed the non-tax provision of the legislation (subtitle B) and determined that it contains no intergovernmental or private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary effect of the legislation is shown in the following table. The outlay effects of this legislation fall within budget function 550 (health) and 570 (Medicare).

	By Fiscal Year, in Billions of Dollars											2016-	2016-
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020	2025	
CHANGES IN DIRECT SPENDING													
Subtitle A													
Repeal Individual and Employer Mandates													
Estimated Budget Authority	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9	
Estimated Outlays	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9	
Repeal Excise Tax on High-Premium Insurance Plans													
Estimated Budget Authority	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2	
Estimated Outlays	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2	
Subtitle B													
Repeal IPAB													
Estimated Budget Authority	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1	
Estimated Outlays	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1	
Total Changes in Direct Spending													
Estimated Budget Authority	-8.7	-17.2	-21.7	-25.2	-27.8	-29.9	-32.1	-33.5	-35.7	-36.1	-100.6	-268.0	
Estimated Outlays	-8.7	-17.2	-21.7	-25.2	-27.8	-29.9	-32.1	-33.5	-35.7	-36.1	-100.6	-268.0	
CHANGES IN REVENUES													
Subtitle A													
Repeal Individual and Employer Mandates													
	-10.1	-8.0	-8.0	-9.8	-10.5	-10.9	-11.9	-12.9	-13.5	-14.1	-46.4	-109.8	
Repeal Medical Device Tax	-1.4	-2.0	-2.1	-2.2	-2.3	-2.5	-2.6	-2.8	-2.9	-3.1	-10.0	-23.9	
Repeal Excise Tax on High-Premium Insurance Plans	0	0	-2.9	-8.1	-9.7	-11.5	-14.0	-17.1	-20.8	-25.0	-20.8	-109.3	
Interaction Effects	0	0	*	2.1	2.0	1.7	1.7	1.6	1.6	1.4	4.1	12.1	
Total Changes in Revenues													
On-Budget	-11.5	-10.0	-13.0	-18.0	-20.5	-23.2	-26.8	-31.2	-35.6	-40.8	-73.1	-230.9	
Off-Budget ^a	-13.0	-14.0	-16.8	-21.5	-23.7	-26.1	-29.3	-33.0	-36.8	-41.0	-89.2	-255.5	
	1.5	4.0	3.8	3.5	3.2	2.9	2.5	1.8	1.2	0.2	16.1	24.6	
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES													
Impact on Deficit													
On-Budget	2.8	-7.2	-8.7	-7.2	-7.3	-6.7	-5.3	-2.3	-0.1	4.7	-27.5	-37.1	
Off-Budget ^a	4.3	-3.2	-4.9	-3.7	-4.1	-3.8	-2.8	-0.5	1.1	4.9	-11.4	-12.5	
	-1.5	-4.0	-3.8	-3.5	-3.2	-2.9	-2.5	-1.8	-1.2	-0.2	-16.1	-24.6	
Memorandum:													
Net Effect on Deficit													
Subtitle A	2.8	-7.2	-8.7	-7.2	-7.3	-6.7	-5.9	-3.8	-2.0	1.6	-27.5	-44.2	
Subtitle B	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1	
Sources: Congressional Budget Office, staff of the Joint Committee on Taxation.													
Notes: Numbers may not sum to totals because of rounding; IPAB = Independent Payment Advisory Board;													
* = increase in revenues between zero and \$500 million.													
a. All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as "off-budget.")													

BASIS OF ESTIMATE

For this estimate, CBO and JCT assume that the legislation will be enacted near the end of calendar year 2015. On net, the agencies estimate that enacting the legislation would decrease federal deficits by \$37.1 billion over the 2016-2025 period; that change would result from a \$230.9 billion reduction in revenues and a \$268.0 billion decrease in direct spending. Most of the reduction in revenues would stem from eliminating several penalties and excise taxes; most of the reduction in direct spending would result from lower projected enrollment in health insurance coverage that is subsidized by the federal government. (See “Net Effects on Health Insurance Coverage” for a discussion of the combined effects of the legislation on health insurance coverage.)

Subtitle A—Revenue Provisions

Over the 2016-2025 period, CBO and JCT estimate that subtitle A of the legislation would decrease direct spending by \$275.1 billion and decrease revenues by \$230.9 billion, thereby reducing federal budget deficits, on net, by \$44.2 billion. Subtitle A would repeal the following provisions of the ACA:

- The requirement that most people in the United States must obtain health insurance coverage or pay a penalty for not doing so (a provision known as the individual mandate);
- Penalties imposed on large employers who decline to offer their employees health insurance coverage that meets specified standards (a provision known as the employer mandate)¹;
- The federal excise tax imposed on the sale of medical devices; and
- The federal excise tax imposed on some health insurance plans with high premiums along with related reporting requirements.

Repeal of the Individual and Employer Mandates. Section 301 of subtitle A would repeal the individual mandate and section 302 of subtitle A would repeal the employer mandate. CBO and JCT estimate that repealing the both mandates would result in net budgetary savings to the federal government of \$147.1 billion over the 2016-2025 period. That projected decrease in federal deficits over the 10-year period consists of a \$256.9 billion decrease in direct spending, partially offset by a \$109.8 billion reduction in

1. To meet the standards, the cost to the employee for self-only coverage must not exceed a specified share of income (which is 9.56 percent in 2015 and is indexed for inflation over time), and the plan must pay at least 60 percent of the cost of covered benefits. The employer mandate generally applies to employers with at least 50 full-time-equivalent employees.

revenues. The revenue decrease would result from an estimated \$155.2 billion reduction in on-budget revenues, partially offset by an estimated \$45.4 billion increase in off-budget (Social Security) revenues.

Individual Mandate. Under current law, people who do not obtain health insurance owe the greater of a flat dollar penalty or a percentage of a household's adjusted gross income in excess of the income threshold for mandatory tax-filing, both subject to a cap. Certain categories of people are exempt from paying penalties, including people with taxable income below the filing threshold, people without access to affordable coverage, unauthorized immigrants, and people who obtain a hardship waiver. If the individual mandate was repealed, penalty payments for being uninsured would no longer be collected; CBO and JCT estimate that loss in penalty payments would total \$43.3 billion over the 2016-2025 period.

In addition to eliminating penalties for uninsured individuals, CBO and JCT estimate that repealing the individual mandate would substantially reduce the number of people with health insurance coverage and, accordingly, reduce the estimated federal costs associated with some sources of health insurance coverage. Under current law, the agencies estimate that the existence of the individual mandate and its associated penalties spurs increased enrollment in federally-subsidized health insurance coverage through Medicaid, the Children's Health Insurance Program (CHIP), exchanges, and employment-based plans (which are subsidized indirectly because almost no premiums for that coverage are treated as taxable compensation). The estimated savings stemming from lower enrollment in such coverage would exceed the loss in revenues from eliminating penalty payments by uninsured people.

CBO and JCT estimate that repealing the individual mandate would also result in higher health insurance premiums in the nongroup market (that is, premiums for individually purchased health insurance) after 2016.² Insurers would still be required to provide coverage to any applicant, would not be able to vary premiums to reflect enrollees' health status or to limit coverage of preexisting medical conditions, and would be allowed to vary premiums by age only to a limited degree. Those features are most attractive to applicants with relatively high expected costs for health care, so the agencies expect that repealing the individual mandate would tend to reduce insurance coverage less among older and less healthy people than among younger and healthier people. Nevertheless, CBO and JCT anticipate that a significant number of relatively healthy people would still have a strong incentive to purchase insurance in the nongroup market because of the availability of government subsidies—and, therefore, that the market would not be subject to an unsustainable spiral of rising premiums. In years after 2016, CBO and JCT estimate that

2. CBO and JCT expect that insurers would not be able to change their 2016 premiums to reflect the increase in expected medical claims because the bill would be enacted after premiums are set for the 2016 plan year.

repealing the individual mandate would increase premiums for policies in the nongroup market by roughly 20 percent above what would be expected under current law, which would in turn increase the costs to the federal government of subsidies for eligible individuals who remain enrolled in individual policies purchased through the exchanges.

Employer Mandate. CBO and JCT estimate that repealing the employer mandate would yield two types of budgetary effects. First, employers that do not offer health insurance that meets specified standards would no longer be assessed penalties, which would reduce revenues by \$166.9 billion over the 2016-2025 period according to CBO and JCT's estimates. Second, the agencies estimate that there would be small changes in health insurance coverage that would yield largely offsetting budgetary effects. Specifically, the agencies expect that some employers that are projected to offer health insurance to their employees under current law would no longer do so if the employer mandate were repealed because eliminating penalties would lower the cost of not offering health insurance. However, CBO and JCT expect that the reduction in offers of employment-based coverage would be limited because most employers construct compensation packages that comprise a mix of wages and nonwage benefits that will attract the best available workers at the lowest cost.³ Those that would no longer enroll in employment-based coverage in the absence of the employer mandate would instead enroll in coverage through Medicaid, CHIP, the nongroup market (including individual policies purchased through the exchanges or directly from insurers in the nongroup market), or become uninsured.

Repeal of the Medical Device Tax. Section 303 of subtitle A would repeal the medical device excise tax established by the ACA. Under current law, a tax of 2.3 percent is imposed on the sale of medical devices by the manufacturer or importer. Medical devices that are regularly available at retail for individual use and not primarily intended for use by a medical professional are exempt from the tax. The tax went into effect on January 1, 2013, and its repeal by the legislation would be effective starting in the first calendar quarter after the date of enactment. JCT estimates that repealing the medical device tax would reduce revenues, thus increasing federal deficits, by about \$23.9 billion over the 2016-2025 period.

Repeal of the Excise Tax on High-Premium Insurance Plans. Section 304 of subtitle A would repeal a federal excise tax that will be imposed on employment-based health plans whose total value is greater than specified thresholds.⁴ Under current law, the excise tax

3. See Congressional Budget Office, *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012), <http://www.cbo.gov/publication/43082>.

4. The total value includes employers' and employees' contributions for health insurance premiums and contributions made through health reimbursement arrangements, flexible spending arrangements, and health savings accounts for other health care costs.

will take effect in 2018 and will be equal to 40 percent of the difference between the total value of contributions and the applicable threshold. CBO and JCT estimate that repealing the tax would result in net budgetary costs to the federal government of \$91.1 billion over the 2016-2025 period. That projected increase in federal deficits over the 10-year period consists of a \$109.3 billion decrease in revenues, partially offset by an \$18.2 billion decrease in direct spending.

The decrease in revenues over the 2016-2025 period primarily reflects an \$87.3 billion reduction in revenues stemming from forgone excise tax receipts and from fewer employers and workers shifting to lower-cost health insurance plans to avoid paying the tax. That is, relative to current law, more people would remain in higher-cost health insurance plans and a larger share of total compensation would take the form of non-taxable health benefits, decreasing the share taking the form of taxable wages and salaries. (Also, increased enrollment in higher-cost health plans would probably place upward pressure on health insurance premiums.)

CBO and JCT estimate that tax revenues would further decrease by \$12.5 billion over the 2016-2025 period as some employers who are expected to stop offering health insurance under current law (instead of offering insurance whose total value exceeds the specified thresholds for the excise tax) would no longer do so, thereby further reducing the share of compensation taking the form of taxable wages and salaries. Similarly, some employees who are not expected to enroll in insurance offered by their employer under current law, would do so. Both of those changes would further reduce the share of compensation taking the form of taxable wages and salaries.

The remaining portion of the estimated net decrease in revenues comprises a \$12.1 billion reduction in projected penalty payments from people who, under current law, would be uninsured because of the tax, and employers that, under current law, would pay penalties for not offering health insurance coverage that meets certain standards to their employees, and a \$2.6 billion increase in revenues from other smaller effects. In addition, CBO and JCT estimate that direct spending would decrease by \$18.2 billion over the 2016-2025 period primarily because some of the people who would newly enroll in employment-based coverage in the absence of the excise tax on high-premium plans would have otherwise been enrolled in insurance obtained through Medicaid and exchanges.

Interaction Effects. Repealing the excise tax on high-premium insurance plans would reduce the amount of penalty payments collected from employers and uninsured people. However, those penalties would be eliminated by the repeal of the individual and employer mandates. Therefore, the estimated cost of repealing the excise tax on high-premium insurance plans would be reduced if the provisions of subtitle A were enacted simultaneously. Accounting for the interactions, CBO and JCT project that the total

savings would be \$12.1 billion greater over the 2016-2025 period than the net savings from the two provisions when estimated separately.

Net Effects on Health Insurance Coverage

CBO and JCT estimate that the provisions of subtitle A would reduce the number of nonelderly people in the United States with health insurance coverage by about 14 million to 15 million in most years (about 20 percent of those are estimated to be children). Nearly all of that reduction in coverage would arise from repealing the mandate on individuals to obtain health insurance coverage; however, the other provisions in subtitle A would have small effects on coverage as discussed below. Specifically, CBO and JCT estimate:

- Roughly 3 million to 4 million fewer people, on net, would enroll in employment-based coverage. CBO and JCT estimate that 4 million fewer people would enroll in employment-based coverage because fewer employers would offer health insurance coverage to their employees in the absence of the employer mandate and fewer employees would take up such coverage in the absence of the individual mandate. However, CBO and JCT estimate that repealing the excise tax on high-premium insurance plans would offset that loss in employment-based coverage by roughly 500,000 to 1 million people because some employers who are not expected to offer coverage and some employees who are not expected to enroll in coverage under current law because of the tax on high-premium plans would do so.
- Roughly 7 million fewer people would obtain coverage through the nongroup market (including individual policies purchased through the exchanges or directly from insurers in the nongroup market). CBO and JCT estimate that repealing the individual mandate and, to a much lesser extent, repealing the excise tax on high-premium insurance plans would reduce the number of people that seek out and enroll in coverage through the nongroup market; however, that reduction would be partially offset by an increase in nongroup coverage among people who would no longer have an offer of employment-based coverage if the employer mandate was repealed.
- Roughly 4 million fewer people would enroll in Medicaid or CHIP (about 20 percent of those are estimated to be children). Nearly all of that reduction in coverage stems from people—particularly those with taxable income above the tax-filing threshold—who would have been induced to enroll in Medicaid or CHIP because of the existence of the individual mandate and associated penalties.

In years after 2016, CBO and JCT estimate that 41 million nonelderly people, or roughly 15 percent of the nonelderly population, would be uninsured if the provisions in subtitle A

were enacted. By comparison, the agencies project that 26 million to 27 million nonelderly people, or roughly 10 percent of the nonelderly population, will be uninsured under current law in those years.

Subtitle B—Repeal of Independent Payment Advisory Board

The legislation would repeal the provisions of the Affordable Care Act that established the Independent Payment Advisory Board (IPAB) and that created a process by which the board (or the Secretary of the Department of Health and Human Services) would be required under certain circumstances to modify the Medicare program to achieve specified savings.

CBO estimates that repealing the IPAB provision would not have any budgetary impact between 2015 and 2021, but would increase direct spending by \$7.1 billion over the 2022-2025 period.⁵

INCREASE IN LONG-TERM DIRECT SPENDING AND DEFICITS

CBO and JCT estimate that enacting the legislation would not increase net direct spending in either of the first two consecutive 10-year periods beginning in 2026; at some point the costs of repealing IPAB would exceed the savings from the other provisions, but the agencies cannot determine whether that would occur during the third or fourth 10-year periods after 2026 or later. The agencies estimate that enacting the legislation would increase on-budget deficits by at least \$5 billion in each of the four consecutive 10-year periods beginning in 2026.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

JCT has determined that subtitle A contains no intergovernmental or private-sector mandates as defined in UMRA. CBO has reviewed the non-tax provision of the legislation (subtitle B) and determined that it contains no intergovernmental or private-sector mandates as defined in UMRA.

5. For a discussion of the CBO's approach to estimating the budgetary effect of repealing the IPAB provision, see *H.R. 1190, Protecting Seniors' Access to Medicare Act of 2015*, June 11, 2015, <https://www.cbo.gov/publication/50294>

ESTIMATE PREPARED BY:

Federal Costs: Sarah Masi, Kate Fritzsche, Alexandra Minicozzi, Daniel Hoople,
Robert Stewart, Staff of the Joint Committee on Taxation

Impact on State, Local, and Tribal Governments: J'nell Blanco Suchy, Staff of the
Joint Committee on Taxation

Impact on the Private Sector: Amy Petz, Staff of the Joint Committee on Taxation

ESTIMATE APPROVED BY:

Holly Harvey
Deputy Assistant Director for Budget Analysis

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE**A. Committee Oversight Findings and Recommendations**

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's review of the provisions of the budget reconciliation legislative recommendations relating to repeal of IPAB that the Committee concluded that it is appropriate to transmit the legislative recommendations to the Committee on the Budget.

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 budget reconciliation legislative recommendations contain no measure that authorizes funding, so no statement of general performance goals and objectives for which any measure authorizing 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 budget reconciliation legislative recommendations do not contain Federal mandates on the private sector. The Committee has determined that the budget reconciliation legislative recommendation do not impose a Federal intergovernmental mandate on State, local, or tribal governments.

D. 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 budget reconciliation legislative recommendations and states that the provisions of the budget reconciliation legislative recommendations do not contain any congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of the rule.

E. Duplication of Federal Programs

In compliance with Sec. 3(g)(2) of H. Res. 5 (114th Congress), the Committee states that none of the budget reconciliation legislative recommendations 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 the Federal Program Information Act (Pub. L. No. 95-220, as amended by Pub. L. No. 98-169).

F. Disclosure of Directed Rule Makings

In compliance with Sec. 3(i) of H. Res. 5 (114th Congress), the following statement is made concerning directed rule makings: The Committee estimates that the budget reconciliation legislative recommendations requires no directed rule makings within the meaning of such section.

**VI. CHANGES IN EXISTING LAW MADE BY THE BUDGET RECONCILIATION
LEGISLATIVE RECOMMENDATION,
AS TRANSMITTED**

**A. Text of Existing Law Amended or Repealed by the Budget Reconciliation Legislative
Recommendation, as Transmitted**

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the budget reconciliation legislative recommendations, as transmitted, is shown below:

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 and existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

* * * * *

Subtitle E—Ensuring Medicare Sustainability

* * * * *

[SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

[(a) BOARD.—

[(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

["INDEPENDENT MEDICARE ADVISORY BOARD

["SEC.1899A. (a) ESTABLISHMENT.—There is established an independent board to be known as the ‘Independent Medicare Advisory Board’.

["(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

["(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as ‘a determination year’) the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as ‘an implementation year’);

["(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as ‘a proposal year’) a proposal containing recommendations to reduce the Medicare per capita growth rate to the extent required by this section; and

["(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

["(c) BOARD PROPOSALS.—

["(1) DEVELOPMENT.—

【“(A) IN GENERAL.—The Board shall develop detailed and specific proposals related to the Medicare program in accordance with the succeeding provisions of this section.

【“(B) ADVISORY REPORTS.—Beginning January 15, 2014, the Board may develop and submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Board’s recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d). In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.

【“(2) PROPOSALS.—

【“(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

【“(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

【“(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

【“(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d))

scheduled, pursuant to the amendments made by section 3401 of the Patient Protection and Affordable Care Act, to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

[(iv) As appropriate, the proposal shall include recommendations to reduce Medicare payments under parts C and D, such as reductions in direct subsidy payments to Medicare Advantage and prescription drug plans specified under paragraph (1) and (2) of section 1860D–15(a) that are related to administrative expenses (including profits) for basic coverage, denying high bids or removing high bids for prescription drug coverage from the calculation of the national average monthly bid amount under section 1860D–13(a)(4), and reductions in payments to Medicare Advantage plans under clauses (i) and (ii) of section 1853(a)(1)(B) that are related to administrative expenses (including profits) and performance bonuses for Medicare Advantage plans under section 1853(n). Any such recommendation shall not affect the base beneficiary premium percentage specified under 1860D–13(a) or the full premium subsidy under section 1860D–14(a).

[(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

[(vi) The proposal shall only include recommendations related to the Medicare program.

[(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.

[(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Board shall, to the extent feasible—

[(i) give priority to recommendations that extend Medicare solvency;

[(ii) include recommendations that—

[(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

[(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

【“(iii) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

【“(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

【“(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates;

【“(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX; and

【“(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.

【“(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year period starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

【“(D) CONSULTATION WITH MEDPAC.—The Board shall submit a draft copy of each proposal to be submitted under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The Board shall submit such draft copy by not later than September 1 of the determination year.

【“(E) REVIEW AND COMMENT BY THE SECRETARY.—The Board shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary’s review and comment. The Board shall submit such draft copy by not later than September 1 of the determination year. Not later than March 1 of the submission year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (5)(A) in that year.

【“(F) CONSULTATIONS.—In carrying out its duties under this section, the Board shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

【“(3) SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT.—

【“(A) IN GENERAL.—

【“(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall submit a proposal under this section to Congress and the President on January 15 of each year (beginning with 2014).

[(ii) EXCEPTION.—The Board shall not submit a proposal under clause (i) in a proposal year if the year is—

[(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph; or

[(II) a year in which the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the projected percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the projected percentage increase (if any) in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year.

[(iii) START-UP PERIOD.—The Board may not submit a proposal under clause (i) prior to January 15, 2014.

[(B) REQUIRED INFORMATION.—Each proposal submitted by the Board under subparagraph (A)(i) shall include—

[(i) the recommendations described in paragraph (2)(A)(i);

[(ii) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation;

[(iii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2);

[(iv) a legislative proposal that implements the recommendations; and

[(v) other information determined appropriate by the Board.

[(4) PRESIDENTIAL SUBMISSION TO CONGRESS.—Upon receiving a proposal from the Secretary under paragraph (5), the President shall within 2 days submit such proposal to Congress.

[(5) CONTINGENT SECRETARIAL DEVELOPMENT OF PROPOSAL.—If, with respect to a proposal year, the Board is required, but fails, to submit a proposal to Congress and the President by the deadline applicable under paragraph (3)(A)(i), the Secretary shall develop a detailed and specific proposal that satisfies the requirements of subparagraphs (A) and (C) (and, to the extent feasible, subparagraph (B)) of paragraph (2) and contains the information required paragraph (3)(B)). By not later than January 25 of the year, the Secretary shall transmit—

[(A) such proposal to the President; and

[(B) a copy of such proposal to the Medicare Payment Advisory Commission for its review.

[(6) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

[(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

[(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

[(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

[(B) MEDICARE PER CAPITA GROWTH RATE.—

[(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending (calculated as the sum of per capita spending under each of parts A, B, and D).

[(ii) REQUIREMENT.—The projection under clause (i) shall—

[(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

[(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

[(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in—

[(i) with respect to a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

[(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

[(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

[(ii) with respect to a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

[(7) SAVINGS REQUIREMENT.—

【“(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (6)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

【“(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

【“(i) the total amount of projected Medicare program spending for the proposal year; and

【“(ii) the applicable percent for the implementation year.

【“(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for an implementation year is the lesser of—

【“(i) in the case of—

【“(I) implementation year 2015, 0.5 percent;

【“(II) implementation year 2016, 1.0 percent;

【“(III) implementation year 2017, 1.25 percent;

and

【“(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

【“(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

【“(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in national health care expenditures.

【“(d) CONGRESSIONAL CONSIDERATION.—

【“(1) INTRODUCTION.—

【“(A) IN GENERAL.—On the day on which a proposal is submitted by the Board or the President to the House of Representatives and the Senate under subsection (c)(3)(A)(i) or subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

【“(B) NOT IN SESSION.—If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in subparagraph (A), on the first day thereafter on which that House is in session.

¶“(C) ANY MEMBER.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

¶“(D) REFERRAL.—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce and the Committee on Ways and Means in the House of Representatives.

¶“(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

¶“(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is submitted by the Board or the President to Congress under this section, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate may report the bill referred to the Committee under paragraph (1)(D) with committee amendments related to the Medicare program.

¶“(B) CALCULATIONS.—In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

¶“(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

¶“(D) DISCHARGE.—If, with respect to the House involved, the committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

¶“(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

¶“(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, or amendment, pursuant to this subsection or conference report thereon, that fails to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

¶“(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS IN OTHER LEGISLATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report (other than pursuant to this section) that would repeal or otherwise change the recommendations of the Board if that change would fail to satisfy the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

【“(C) LIMITATION ON CHANGES TO THIS SUBSECTION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

【“(D) WAIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

【“(E) APPEALS.—An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

【“(4) EXPEDITED PROCEDURE.—

【“(A) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

【“(B) AMENDMENT.—

【“(i) TIME LIMITATION.—Debate in the Senate on any amendment to a bill under this section shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader’s designee.

【“(ii) GERMANE.—No amendment that is not germane to the provisions of such bill shall be received.

【“(iii) ADDITIONAL TIME.—The leaders, or either of them, may, from the time under their control on the passage of the bill, allot additional time to any Senator during the consideration of any amendment, debatable motion, or appeal.

【“(iv) AMENDMENT NOT IN ORDER.—It shall not be in order to consider an amendment that would cause the bill to result in a net reduction in total Medicare program spending in the implementation year that is less than the applicable savings target established under subsection (c)(7)(B) for such implementation year.

【“(v) WAIVER AND APPEALS.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. An affirmative vote of three-fifths of the Members of the Senate, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

【“(C) CONSIDERATION BY THE OTHER HOUSE.—

【“(i) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of a bill introduced pursuant to paragraph (1) shall not apply

to such a bill that is received by one House from the other House if such a bill was not introduced in the receiving House.

【“(ii) BEFORE PASSAGE.—If a bill that is introduced pursuant to paragraph (1) is received by one House from the other House, after introduction but before disposition of such a bill in the receiving House, then the following shall apply:

【“(I) The receiving House shall consider the bill introduced in that House through all stages of consideration up to, but not including, passage.

【“(II) The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

【“(iii) AFTER PASSAGE.—If a bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, then the vote on passage of the bill that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

【“(iv) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, it shall no longer be in order to consider the bill that originates in the receiving House.

【“(v) LIMITATION.—Clauses (ii), (iii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

【“(I) is related only to the program under this title; and

【“(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

【“(D) SENATE LIMITS ON DEBATE.—

【“(i) IN GENERAL.—In the Senate, consideration of the bill and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between the majority and minority leaders or their designees.

【“(ii) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

【“(iii) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

【“(iv) FINAL DISPOSITION.—After 30 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all amendments not then pending before the Senate at that time and to the exclusion of all motions, except a motion to table, or to reconsider and one quorum call on demand to estab-

lish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

【“(E) CONSIDERATION IN CONFERENCE.—

【“(i) IN GENERAL.—Consideration in the Senate and the House of Representatives on the conference report or any messages between Houses shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees.

【“(ii) TIME LIMITATION.—Debate in the Senate on any amendment under this subparagraph shall be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the bill, and debate on any amendment to an amendment, debatable motion, or appeal shall be limited to 30 minutes, to be equally divided between, and controlled by, the mover and the manager of the bill, except that in the event the manager of the bill is in favor of any such amendment, motion, or appeal, the time in opposition thereto shall be controlled by the minority leader or such leader’s designee.

【“(iii) FINAL DISPOSITION.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all motions not then pending before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a motion to table, or to reconsider and one quorum call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final vote begins.

【“(iv) LIMITATION.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

【“(I) is related only to the program under this title; and

【“(II) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2).

【“(F) VETO.—If the President vetoes the bill debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

【“(5) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

【“(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be fol-

lowed in that House in the case of bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

【“(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

【“(e) IMPLEMENTATION OF PROPOSAL.—

【“(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

【“(2) APPLICATION.—

【“(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

【“(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

【“(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

【“(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

【“(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

【“(3) EXCEPTIONS.—

【“(A) IN GENERAL.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or the President to Congress pursuant to this section if—

【“(i) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: ‘This Act supercedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act.’; and

[(ii) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

[(B) LIMITED ADDITIONAL EXCEPTION.—

[(i) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—

[(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

[(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).

[(ii) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

[(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—

[(I) the requirement of the Board or the President to submit a proposal to Congress in a proposal year in accordance with the provisions of this section; or

[(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).

[(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

[(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

[(f) JOINT RESOLUTION REQUIRED TO DISCONTINUE THE BOARD.—

[(1) IN GENERAL.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

[(A) that is introduced in 2017 by not later than February 1 of such year;

[(B) which does not have a preamble;

【“(C) the title of which is as follows: ‘Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act’; and

【“(D) the matter after the resolving clause of which is as follows: ‘That Congress approves the discontinuation of the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act.’

【“(2) PROCEDURE.—

【“(A) REFERRAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

【“(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may be discharged from further consideration of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

【“(C) CONSIDERATION.—

【“(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a committee is discharged (under subparagraph (C)) from further consideration of a joint resolution described in paragraph (1), it is at any time thereafter in order (even though a previous motion to the same effect has been disagreed to) for a motion to proceed to the consideration of the joint resolution to be made, and all points of order against the joint resolution (and against consideration of the joint resolution) are waived, except for points of order under the Congressional Budget act of 1974 or under budget resolutions pursuant to that Act. The motion is not debatable. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the joint resolution is agreed to, the joint resolution shall remain the unfinished business of the Senate until disposed of.

【“(ii) DEBATE LIMITATION.—In the Senate, consideration of the joint resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 10 hours, which shall be divided equally between the majority leader and the minority leader, or their designees. A motion further to limit debate is in order and not debatable. An amendment to, or a motion to postpone, or a motion to pro-

ceed to the consideration of other business, or a motion to recommit the joint resolution is not in order.

【“(iii) PASSAGE.—In the Senate, immediately following the conclusion of the debate on a joint resolution described in paragraph (1), and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the Senate, the vote on passage of the joint resolution shall occur.

【“(iv) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate to the procedure relating to a joint resolution described in paragraph (1) shall be decided without debate.

【“(D) OTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

【“(i) The joint resolution of the other House shall not be referred to a committee.

【“(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

【“(I) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

【“(II) the vote on final passage shall be on the joint resolution of the other House.

【“(E) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

【“(F) MAJORITY REQUIRED FOR ADOPTION.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

【“(3) TERMINATION.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

【“(A) the Chief Actuary of the Medicare & Medicaid Services shall not—

【“(i) make any determinations under subsection (c)(6) after May 1, 2017; or

【“(ii) provide any opinion pursuant to subsection (c)(3)(B)(iii) after January 16, 2018;

【“(B) the Board shall not submit any proposals, advisory reports, or advisory recommendations under this section or produce the public report under subsection (n) after January 16, 2018; and

【“(C) the Board and the consumer advisory council under subsection (k) shall terminate on August 16, 2018.

【“(g) BOARD MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

【“(1) MEMBERSHIP.—

【“(A) IN GENERAL.—The Board shall be composed of—

【“(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

【“(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

【“(B) QUALIFICATIONS.—

【“(i) IN GENERAL.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

【“(ii) INCLUSION.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

【“(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title shall not constitute a majority of the appointed membership of the Board.

【“(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Board of financial and other potential conflicts of interest relating to such members. Appointed members of the Board shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

【“(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

【“(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Board, the President shall consult with—

【“(i) the majority leader of the Senate concerning the appointment of 3 members;

【“(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

【“(iii) the minority leader of the Senate concerning the appointment of 3 members; and

[(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

[(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

[(A) a member may not serve more than 2 full consecutive terms (but may be reappointed to 2 full consecutive terms after being appointed to fill a vacancy on the Board);

[(B) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

[(C) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

[(D) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

[(3) CHAIRPERSON.—

[(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

[(B) DUTIES.—The Chairperson shall be the principal executive officer of the Board, and shall exercise all of the executive and administrative functions of the Board, including functions of the Board with respect to—

[(i) the appointment and supervision of personnel employed by the Board;

[(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Board; and

[(iii) the use and expenditure of funds.

[(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Board and by the decisions, findings, and determinations the Board shall by law be authorized to make.

[(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Board may not be submitted by the Chairperson without the prior approval of a majority vote of the Board.

[(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

[(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

[(1) VACANCIES.—No vacancy on the Board shall impair the right of the remaining members to exercise all the powers of the Board.

[(2) QUORUM.—A majority of the appointed members of the Board shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

【“(3) SEAL.—The Board shall have an official seal, of which judicial notice shall be taken.

【“(4) VICE CHAIRPERSON.—The Board shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

【“(5) VOTING ON PROPOSALS.—Any proposal of the Board must be approved by the majority of appointed members present.

【“(i) POWERS OF THE BOARD.—

【“(1) HEARINGS.—The Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Board considers advisable to carry out this section.

【“(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Board may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

【“(3) OBTAINING OFFICIAL DATA.—The Board may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Board on an agreed upon schedule.

【“(4) POSTAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

【“(5) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

【“(6) OFFICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

【“(j) PERSONNEL MATTERS.—

【“(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

【“(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

【“(3) STAFF.—

【“(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Board to per-

form its duties. The employment of an executive director shall be subject to confirmation by the Board.

【“(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

【“(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

【“(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

【“(k) CONSUMER ADVISORY COUNCIL.—

【“(1) IN GENERAL.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

【“(2) MEMBERSHIP.—

【“(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

【“(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

【“(3) DUTIES.—The consumer advisory council shall, subject to the call of the Board, meet not less frequently than 2 times each year in the District of Columbia.

【“(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

【“(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

【“(6) APPLICATION OF FACCA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

【“(1) DEFINITIONS.—In this section:

【“(1) BOARD; CHAIRPERSON; MEMBER.—The terms ‘Board’, ‘Chairperson’, and ‘Member’ mean the Independent Medicare Advisory Board established under subsection (a) and the Chairperson and any Member thereof, respectively.

【“(2) MEDICARE.—The term ‘Medicare’ means the program established under this title, including parts A, B, C, and D.

【“(3) MEDICARE BENEFICIARY.—The term ‘Medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

[(4) MEDICARE PROGRAM SPENDING.—The term ‘Medicare program spending’ means program spending under parts A, B, and D net of premiums.

[(m) FUNDING.—

[(1) IN GENERAL.—There are appropriated to the Board to carry out its duties and functions—

[(A) for fiscal year 2012, \$15,000,000; and

[(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

[(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

[(n) ANNUAL PUBLIC REPORT.—

[(1) IN GENERAL.—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

[(2) REQUIREMENTS.—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

[(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

[(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

[(C) Epidemiological shifts and demographic changes.

[(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

[(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

[(o) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—

[(1) IN GENERAL.—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

【“(A) that the Secretary or other Federal agencies can implement administratively;

【“(B) that may require legislation to be enacted by Congress in order to be implemented;

【“(C) that may require legislation to be enacted by State or local governments in order to be implemented;

【“(D) that private sector entities can voluntarily implement; and

【“(E) with respect to other areas determined appropriate by the Board.

【“(2) COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

【“(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.”.

【(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

【“(3) MEMBERS OF THE INDEPENDENT MEDICARE ADVISORY BOARD.—

【“(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Independent Medicare Advisory Board under section 1899A.

【“(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.”.

【(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

【(1) INITIAL STUDY AND REPORT.—

【“(A) STUDY.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

【(i) Medicare beneficiary access to providers and items and services;

【(ii) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

[(iii) the potential impact of changes on other government or private-sector purchasers and payers of care; and

[(iv) quality of patient care, including patient experience, outcomes, and other measures of care.

[(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

[(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payments policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

[(c) CONFORMING AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

[(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

[(2) by inserting after paragraph (3) the following:

[(4) REVIEW AND COMMENT ON THE INDEPENDENT MEDICARE ADVISORY BOARD OR SECRETARIAL PROPOSAL.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.”.]

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**TITLE X—STRENGTHENING QUALITY,
AFFORDABLE HEALTH CARE FOR ALL
AMERICANS**

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Subtitle C—Provisions Relating to Title III

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[SEC. 10320. EXPANSION OF THE SCOPE OF, AND ADDITIONAL IMPROVEMENTS TO, THE INDEPENDENT MEDICARE ADVISORY BOARD.

[(a) IN GENERAL.—Section 1899A of the Social Security Act, as added by section 3403, is amended—

[(1) in subsection (c)—

[(A) in paragraph (1)(B), by adding at the end the following new sentence: “In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.”;

[(B) in paragraph (2)(A)—

[(i) in clause (iv), by inserting “or the full premium subsidy under section 1860D–14(a)” before the period at the end of the last sentence; and

[(ii) by adding at the end the following new clause:

[(vii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination described in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (8) while maintaining or enhancing beneficiary access to quality care under this title.”;

[(C) in paragraph (2)(B)—

[(i) in clause (v), by striking “and” at the end;

[(ii) in clause (vi), by striking the period at the end and inserting “; and”; and

[(iii) by adding at the end the following new clause:

[(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that can most effectively promote the delivery of efficient, high quality care to Medicare beneficiaries.”;

[(D) in paragraph (3)—

[(i) in the heading, by striking “TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT” and inserting “SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT”;

[(ii) in subparagraph (A)(i), by striking “transmit a proposal under this section to the President” and insert “submit a proposal under this section to Congress and the President”; and

[(iii) in subparagraph (A)(ii)—

[(I) in subclause (I), by inserting “or” at the end;

[(II) in subclause (II), by striking “; or” and inserting a period; and

[(III) by striking subclause (III);

[(E) in paragraph (4)—

[(i) by striking “the Board under paragraph (3)(A)(i) or”; and

[(ii) by striking “immediately” and inserting “within 2 days”;

[(F) in paragraph (5)—

[(i) by striking “to but” and inserting “but”; and

[(ii) by inserting “Congress and” after “submit a proposal to”; and

- [(G) in paragraph (6)(B)(i), by striking “per unduplicated enrollee” and inserting “(calculated as the sum of per capita spending under each of parts A, B, and D)”;
- [(2) in subsection (d)—
- [(A) in paragraph (1)(A)—
- [(i) by inserting “the Board or” after “a proposal is submitted by”; and
- [(ii) by inserting “subsection (c)(3)(A)(i) or” after “the Senate under”; and
- [(B) in paragraph (2)(A), by inserting “the Board or” after “a proposal is submitted by”;
- [(3) in subsection (e)—
- [(A) in paragraph (1), by inserting “the Board or” after “a proposal submitted by”; and
- [(B) in paragraph (3)—
- [(i) By striking “EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by” and inserting
- [(A) IN GENERAL.—The Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or”;
- [(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and
- [(iii) by adding at the end the following new subparagraph:
- [(B) LIMITED ADDITIONAL EXCEPTION.—
- [(i) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2019) if—
- [(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and
- [(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (c)(8) exceeds the growth rate described in subsection (c)(6)(A)(i).
- [(ii) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—This subparagraph shall not apply if the recommendations contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.
- [(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—
- [(I) the requirement of the Board or the President to submit a proposal to Congress in a pro-

positional year in accordance with the provisions of this section; or

[(II) Congressional consideration of a legislative proposal (described in subsection (c)(3)(B)(iv)) contained such a proposal in accordance with subsection (d).”];

[(4) in subsection (f)(3)(B)—

[(A) by striking “or advisory reports to Congress” and inserting “, advisory reports, or advisory recommendations”; and

[(B) by inserting “or produce the public report under subsection (n)” after “this section”; and

[(5) by adding at the end the following new subsections:

[(n) ANNUAL PUBLIC REPORT.—

[(1) IN GENERAL.—Not later than July 1, 2014, and annually thereafter, the Board shall produce a public report containing standardized information on system-wide health care costs, patient access to care, utilization, and quality-of-care that allows for comparison by region, types of services, types of providers, and both private payers and the program under this title.

[(2) REQUIREMENTS.—Each report produced pursuant to paragraph (1) shall include information with respect to the following areas:

[(A) The quality and costs of care for the population at the most local level determined practical by the Board (with quality and costs compared to national benchmarks and reflecting rates of change, taking into account quality measures described in section 1890(b)(7)(B)).

[(B) Beneficiary and consumer access to care, patient and caregiver experience of care, and the cost-sharing or out-of-pocket burden on patients.

[(C) Epidemiological shifts and demographic changes.

[(D) The proliferation, effectiveness, and utilization of health care technologies, including variation in provider practice patterns and costs.

[(E) Any other areas that the Board determines affect overall spending and quality of care in the private sector.

[(o) ADVISORY RECOMMENDATIONS FOR NON-FEDERAL HEALTH CARE PROGRAMS.—

[(1) IN GENERAL.—Not later than January 15, 2015, and at least once every two years thereafter, the Board shall submit to Congress and the President recommendations to slow the growth in national health expenditures (excluding expenditures under this title and in other Federal health care programs) while preserving or enhancing quality of care, such as recommendations—

[(A) that the Secretary or other Federal agencies can implement administratively;

[(B) that may require legislation to be enacted by Congress in order to be implemented;

[(C) that may require legislation to be enacted by State or local governments in order to be implemented;

【“(D) that private sector entities can voluntarily implement; and

【“(E) with respect to other areas determined appropriate by the Board.

【“(2)COORDINATION.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

【“(3) AVAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.”.

【(b) NAME CHANGE.—Any reference in the provisions of, or amendments made by, section 3403 to the “Independent Medicare Advisory Board” shall be deemed to be a reference to the “Independent Payment Advisory Board”.

【(c) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall preclude the Independent Medicare Advisory Board, as established under section 1899A of the Social Security Act (as added by section 3403), from solely using data from public or private sources to carry out the amendments made by subsection (a)(4).】

* * * * *

VOTES OF THE COMMITTEE ON THE BUDGET

Clause 3(b) of House Rule XIII requires each committee report to accompany any bill or resolution of a public character to include the total number of votes cast for and against each roll call vote, on a motion to report and any amendments offered to the measure or matter, together with the names of those voting for and against.

Listed below are the actions taken in the Committee on the Budget of the House of Representatives on the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015.

On October 9, 2015, the Committee met in open session, a quorum being present.

Mr. Rokita asked unanimous consent that the Chair be authorized, consistent with clause 4 of House Rule XVI, to declare a recess at any time during the Committee meeting.

There was no objection to the unanimous consent request.

The Committee adopted and ordered reported the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015.

The Committee on the Budget took the following votes:

Mr. Rokita made a motion that the Committee report the bill with the recommendation that the bill do pass.

The motion was agreed to by a roll call vote of 21 ayes to 11 noes.

ROLLCALL VOTE NO. 1

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
PRICE (GA) (Chairman)	X			VAN HOLLEN (MD) (Ranking)		X	
ROKITA (IN)	X			YARMUTH (KY)		X	
GARRETT (NJ)	X			PASCARELL (NJ)		X	
DIAZ-BALART (FL)	X			RYAN (OH)		X	
COLE (OK)	X			MOORE (WI)		X	
McCLINTOCK (CA)	X			CASTOR (FL)		X	
BLACK (TN)	X			McDERMOTT (WA)		X	
WOODALL (GA)	X			LEE (CA)		X	
BLACKBURN (TN)	X			POCAN (WI)		X	
HARTZLER (MO)	X			LUJAN GRISHAM (NM)			
RICE (SC)	X			DINGELL (MI)			
STUTZMAN (IN)	X			LIEU (CA)			

ROLLCALL VOTE NO. 1—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
SANFORD (SC)				NORCROSS (NJ)		X	
BUCHANAN (FL)	X			MOULTON (MA)		X	
WOMACK (AR)	X						
BRAT (VA)	X						
BLUM (IA)	X						
MOONEY (WV)	X						
GROTHMMAN (WI)	X						
PALMER (AL)	X						
MOOLENAAR (MI)	X						
WESTERMAN (AR)	X						

Mr. Rokita made a motion that, pursuant to clause 1 of rule XXII, the Chair be authorized to offer motions to go to conference and file any related conference report; the staff be authorized to make any necessary technical and conforming corrections prior to filing the bill, such as inserting the short title of the bill; and the motion to reconsider be laid on the table.

The motion was agreed to without objection.

MOTIONS ON THE RULE FOR CONSIDERATION OF THE RESTORING
AMERICANS' HEALTHCARE FREEDOM RECONCILIATION ACT OF 2015

A Motion Offered by Mr. Van Hollen

1. Representative Van Hollen moved that the Committee on the Budget direct its Chairman to request on behalf of the Committee that the rule for consideration of the reconciliation bill make in order an amendment that would (1) strike all of the underlying text, which is an irresponsible attack on women's health care and the Affordable Care Act, and (2) replace it with the text of H.R. 3708, which calls for bipartisan negotiations to raise the discretionary spending caps for fiscal year 2016 or, if those negotiations fail, raises the defense and non-defense discretionary caps by equal amounts to the President's requested level to allow appropriations action to proceed and fund essential services at necessary levels.

The motion was not agreed to by a roll call vote of 13 ayes to 19 noes.

ROLLCALL VOTE NO. 2

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
PRICE (GA) (Chairman)		X		VAN HOLLEN (MD) (Ranking)	X		
ROKITA (IN)		X		YARMUTH (KY)	X		
GARRETT (NJ)		X		PASCARELL (NJ)	X		

ROLLCALL VOTE NO. 2—Continued

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
DIAZ-BALART (FL)		X		RYAN (OH)	X		
COLE (OK)		X		MOORE (WI)	X		
McCLINTOCK (CA)		X		CASTOR (FL)	X		
BLACK (TN)		X		McDERMOTT (WA)	X		
WOODALL (GA)		X		LEE (CA)	X		
BLACKBURN (TN)		X		POCAN (WI)	X		
HARTZLER (MO)		X		LUJAN GRISHAM (NM)	X		
RICE (SC)		X		DINGELL (MI)			
STUTZMAN (IN)		X		LIEU (CA)	X		
SANFORD (SC)				NORCROSS (NJ)	X		
BUCHANAN (FL)		X		MOULTON (MA)	X		
WOMACK (AR)		X					
BRAT (VA)		X					
BLUM (IA)		X					
MOONEY (WV)		X					
GROTHMMAN (WI)							
PALMER (AL)							
MOOLENAAR (MI)		X					
WESTERMAN (AR)		X					

Pursuant to a unanimous consent request made by Chairman Price, Representative Palmer requested that the record reflect he would have voted no on the roll call vote, but was unable to be present because he was voting at the Committee on Oversight and Government Reform when the vote in the Committee on the Budget was called.

A Motion Offered by Mr. Rokita

2. Representative Rokita moved that the Chairman of the Committee on the Budget be provided the discretion to request the Committee on Rules report a rule that would make in order an amendment to the Restoring Americans' Healthcare Freedom Reconciliation Act of 2015, as reported.

The motion was agreed to by a roll call vote of 21 ayes to 13 noes.

ROLLCALL VOTE NO. 3

Name & State	Aye	No	Answer Present	Name & State	Aye	No	Answer Present
PRICE (GA) (Chairman)	X			VAN HOLLEN (MD) (Ranking)		X	
ROKITA (IN)	X			YARMUTH (KY)		X	
GARRETT (NJ)	X			PASCARELL (NJ)		X	
DIAZ-BALART (FL)	X			RYAN (OH)		X	
COLE (OK)	X			MOORE (WI)		X	
McCLINTOCK (CA)	X			CASTOR (FL)		X	
BLACK (TN)	X			McDERMOTT (WA)		X	
WOODALL (GA)	X			LEE (CA)		X	
BLACKBURN (TN)	X			POCAN (WI)		X	
HARTZLER (MO)	X			LUJAN GRISHAM (NM)		X	
RICE (SC)	X			DINGELL (MI)			
STUTZMAN (IN)	X			LIEU (CA)		X	
SANFORD (SC)				NORCROSS (NJ)		X	
BUCHANAN (FL)	X			MOULTON (MA)		X	
WOMACK (AR)	X						
BRAT (VA)	X						
BLUM (IA)	X						
MOONEY (WV)	X						
GROTHMMAN (WI)	X						
PALMER (AL)	X						
MOOLENAAR (MI)	X						
WESTERMAN (AR)	X						

OTHER HOUSE REPORT REQUIREMENTS

Committee Oversight Findings

Clause 3(c)(1) of rule XIII of the Rules of the House of Representatives requires the report of a committee on a measure to contain oversight findings and recommendations required pursuant to clause (2)(b)(1) of rule X. The Committee on the Budget has examined its activities over the past session and has determined that there are no specific oversight findings on the text of the reported bill.

Committee Cost Estimate

For purposes of clauses 3(c)(2) and (3) of rule XIII of the Rules of the House of Representatives and section 308(a)(1) of the Congressional Budget Act of 1974 (relating to estimates of new budget authority, new spending authority, new credit authority, or increased or decreased revenues or tax expenditures), the committee report incorporates the cost estimate prepared by the Director of the Congressional Budget Office pursuant to sections 402 and 423 of the Congressional Budget Act of 1974.

ESTIMATE OF THE BUDGETARY EFFECTS OF DRAFT LEGISLATION TO PROVIDE FOR RECONCILIATION

[Pursuant to Title II of the Concurrent Resolution on the Budget for Fiscal Year 2016, as posted on the website of the House Committee on the Budget on October 8, 2015—without macroeconomic feedback]

	Billions of dollars, by fiscal year										2016–	2016–	
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020	2025	
CHANGES IN DIRECT SPENDING													
Title I—Committee on Education and the Workforce:													
Auto-Enrollment for Certain Large Employers:													
Estimated Budget Authority	0	0.1	0.2	0.4	0.5	0.5	0.5	0.6	0.6	0.7	1.3	4.3	
Estimated Outlays	0	0.1	0.2	0.4	0.5	0.5	0.5	0.6	0.6	0.7	1.3	4.3	
Title II—Committee on Energy and Commerce:													
Prevention and Public Health Fund:													
Estimated Budget Authority	-1.0	-1.0	-1.3	-1.3	-1.5	-1.5	-2.0	-2.0	-2.0	-2.0	-6.0	-15.5	
Estimated Outlays	-0.2	-0.5	-0.9	-1.1	-1.3	-1.4	-1.6	-1.8	-1.9	-2.0	-4.1	-12.7	
Medicaid:													
Estimated Budget Authority	-0.2	*	*	*	*	*	*	*	*	0	-0.2	-0.2	
Estimated Outlays	-0.2	*	*	*	*	*	*	*	*	0	-0.2	-0.2	
Community Health Center Program													
Estimated Budget Authority	0.2	0.2	0	0	0	0	0	0	0	0	0.5	0.5	
Estimated Outlays	0.1	0.2	0.1	*	0	0	0	0	0	0	0.5	0.5	
Title III—Committee on Ways and Means:													
Repeal Individual and Employer Mandates:													
Estimated Budget Authority	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9	
Estimated Outlays	-8.7	-17.2	-21.0	-24.3	-26.4	-28.3	-30.3	-31.9	-33.7	-35.1	-97.6	-256.9	
Repeal Excise Tax on High-Premium Insurance Plans:													
Estimated Budget Authority	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2	
Estimated Outlays	0	0	-0.7	-0.9	-1.4	-1.6	-2.4	-3.1	-3.9	-4.1	-3.0	-18.2	
Repeal IPAB:													
Estimated Budget Authority	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1	
Estimated Outlays	0	0	0	0	0	0	0.6	1.5	1.9	3.1	0	7.1	
Interaction Effects Across Titles:^a													
Estimated Budget Authority	0	*	-0.1	-0.2	-0.3	-0.3	-0.3	-0.3	-0.2	-0.3	-0.7	-2.0	
Estimated Outlays	0	*	-0.1	-0.2	-0.3	-0.3	-0.3	-0.3	-0.2	-0.3	-0.7	-2.0	
Total Changes in Direct Spending:													
Estimated Budget Authority	-9.7	-17.9	-22.8	-26.2	-29.0	-31.1	-33.8	-35.3	-37.3	-37.7	-105.7	-281.0	
Estimated Outlays	-9.1	-17.5	-22.4	-26.1	-28.8	-31.0	-33.4	-35.0	-37.2	-37.7	-103.8	-278.2	
CHANGES IN REVENUES													
Title I—Committee on Education and the Workforce:													
Auto-Enrollment for Certain Large Employers	0	0.2	0.8	1.4	0.8	1.1	1.7	1.9	2.1	2.2	3.3	12.2	

Title III—Committee on Ways and Means:												
Repeal Individual and Employer Mandates	-10.1	-8.0	-8.0	-9.8	-10.5	-10.9	-11.9	-12.9	-13.5	-14.1	-46.4	-109.8
Repeal Medical Device Tax	-1.4	-2.0	-2.1	-2.2	-2.3	-2.5	-2.6	-2.8	-2.9	-3.1	-10.0	-23.9
Repeal Excise Tax on High-Premium Insurance Plans	0	0	-2.9	-8.1	-9.7	-11.5	-14.0	-17.1	-20.8	-25.0	-20.8	-109.3
Interaction Effects within Title III	0	0	*	2.1	2.0	1.7	1.7	1.6	1.6	1.4	4.1	12.1
Interaction Effects Across Titles ^a	0	0.3	1.0	1.7	2.3	2.5	2.5	2.8	3.1	3.4	5.2	19.4
Total Changes in Revenues	-11.5	-9.4	-11.2	-15.0	-17.5	-19.7	-22.6	-26.5	-30.5	-35.2	-64.6	-199.3
On-Budget	-13.0	-13.7	-15.8	-19.7	-21.8	-24.1	-26.8	-30.2	-33.8	-37.7	-84.1	-236.6
Off-Budget ^b	1.5	4.3	4.6	4.8	4.4	4.4	4.2	3.7	3.3	2.4	19.7	37.6
NET INCREASE OR DECREASE (-) IN THE DEFICIT FROM CHANGES IN DIRECT SPENDING AND REVENUES ^c												
Impact on Deficit	2.4	-8.0	-11.2	-11.1	-11.4	-11.4	-10.8	-8.5	-6.7	-2.4	-39.2	-78.9
On-Budget	3.9	-3.8	-6.6	-6.4	-7.0	-6.0	-6.5	-4.8	-3.4	*	-19.5	-41.3
Off-Budget ^b	-1.5	-4.3	-4.6	-4.8	-4.4	-4.4	-4.2	-3.7	-3.3	-2.4	-19.7	-37.6
Memorandum:												
Net Effect on Deficit:												
Title I	0	-0.2	-0.6	-0.9	-0.2	-0.5	-1.1	-1.3	-1.4	-1.5	-2.0	-7.9
Title II	-0.4	-0.3	-0.8	-1.1	-1.3	-1.4	-1.6	-1.8	-1.9	-2.0	-3.8	-12.5
Title III	2.8	-7.2	-8.7	-7.2	-7.3	-6.7	-5.3	-2.3	-0.1	4.7	-27.5	-37.1
Interaction Effects Across Titles	0	-0.4	-1.1	-1.9	-2.5	-2.7	-2.8	-3.1	-3.3	-3.6	-5.9	-21.4

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation
Notes: Numbers may not add up to totals because of roundings; IPAB = Independent Payment Advisory Board; * = an increase or decrease between zero and \$500 million; This legislation meets the threshold established in section 3112 of the Concurrent Resolution on the Budget for Fiscal Year 2016, which requires that the CBO estimate incorporate macroeconomic effects. CBO has not yet completed an analysis of those effects. An estimate including that analysis will be released at a later date
a. includes the additional effects of combining the repeal of the auto-enrollment requirement for large employers with the repeal of the individual and employer mandates
b. All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as off-budget)
c. CBO and JCT estimate that enacting the legislation would not increase net direct spending in either of the first two consecutive 10-year periods beginning in 2026; at some point the costs of repealing IPAB would exceed the savings from the other provisions, but the agencies cannot determine whether that would occur during the third or fourth 10-year period after 2026 or later. On a preliminary basis, the agencies estimate that enacting the legislation would increase on-budget deficits by at least \$5 billion in one or more of the four consecutive 10-year periods beginning in 2026

Macroeconomic Estimates

Clause 8 of rule XIII of the Rules of the House of Representatives requires that the estimates provided under section 402 of the Congressional Budget Act of 1974 for major legislation to include, to the extent practicable, the budgetary effects of changes in economic output, employment, capital stock, and other macroeconomic variables resulting from such legislation. It was not practicable for the Congressional Budget Office to produce the macroeconomic estimates prior to the deadline for filing this bill. It is anticipated that such estimate will be available prior to the consideration of this bill by the House, which will be made available on the Congressional Budget Office's website.

Performance Goals and Objectives

Clause 3(c)(4) of rule XIII of the Rules of the House of Representatives requires the report of a committee on a measure to include a statement of general performance goals and objectives, including outcome-related goals and objectives, for which the measure authorizes funding. This bill is reported pursuant to section 2002 of S. Con. Res. 11, the Concurrent Resolution on the Budget for Fiscal Year 2016. The goals and objectives of this bill are to reduce the deficit by at least \$3 billion over the 10-year period and clear the way for real health care reform that meets the principles set forth in the introduction of this report.

Constitutional Authority Statement

Clause 7(c)(1) of rule XII of the Rules of the House of Representatives requires each report of a committee on a public bill or public joint resolution contain a statement citing the specific powers granted to Congress in the Constitution to enact the law proposed by the bill or joint resolution. The Committee on the Budget finds the Constitutional authority for this legislation in Article I of the Constitution, Sections 5 and 8.

Changes in Existing Law Made by the Bill, as Reported

Clause 3(e) of rule XIII of the Rules of the House of Representatives requires each report of a committee on a bill or joint resolution contain the text of statutes that are proposed to be repealed and a comparative print of that part of the bill proposed to be amended whenever the bill repeals or amends any statute. The required matter is included in the report language for each title, or in the case of the Committee on Ways and Means each subtitle, of the legislative recommendations submitted by the appropriate authorizing committees and reported to the House by the Committee on the Budget.

Federal Mandates Statement

Section 423 of the Congressional Budget and Impoundment Control Act of 1974 requires a statement of whether the provisions of the reported bill include unfunded mandates. The Congressional Budget Office has determined that the bill contains no intergovernmental or private sector mandates within the narrow definition of

the Unfunded Mandates Reform Act of 1995. Any statements regarding unfunded mandates for the legislative recommendations submitted by each of the authorizing committees are included under the appropriate titles.

Advisory on Earmarks

In accordance with clause 9 of rule XXI of the Rules of the House of Representatives, the bill does not contain any congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9(e), 9(f), or 9(g) of rule XXI of the Rules of the House of Representatives.

Duplication of Federal Programs

Section 3(g)(2) of H. Res. 5 requires reports for measures creating or reauthorizing programs of the Federal Government to include a statement indicating whether any such program is known to be duplicative of another such program. The reconciliation bill reported by the Committee on the Budget does not establish or authorize any new Federal programs.

Disclosure of Directed Rulemakings

Section 3(i) of H. Res. 5 requires committee reports on any bill or joint resolution to include a statement estimating the number directed makings required by the measure. This bill does not require any directed rulemakings.

VIEWS OF COMMITTEE MEMBERS

Clause 2(c) of rule XIII of the Rules of the House of Representatives requires each report by a committee on a public matter to include any additional, minority, supplemental, or dissenting views submitted pursuant to clause 2(1) of rule XI by one or more members of the committee. In addition, this report includes views from members of committees submitting reconciliation recommendations pursuant to section 2002 of S. Con. Res. 11 under the appropriate titles or subtitles, as the case may be, of this report. The [minority and additional views] of members of the Committee on the Budget are as follows:

ROD BLUM
1ST DISTRICT, IOWA

COMMITTEE ON
OVERSIGHT AND GOVERNMENT REFORM

COMMITTEE ON THE BUDGET

Congress of the United States
House of Representatives
Washington, DC 20515-1501

213 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-2911

1050 MAIN STREET
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301 3RD STREET SE
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(319) 364-2288

Additional Views of Mr. Blum

I have the distinct privilege of representing the First District of Iowa in the U.S. House of Representatives, including many of my constituents whom would be adversely affected by the implementation of a 40 percent excise tax on the cost of health premiums over a statutory threshold for “excessive” plans - more commonly known as the “Cadillac Tax”. Beginning in 2018, the fixed threshold amount for starts at \$10,200 for self-only coverage or \$27,500 for any other coverage and is indexed for inflation.

More than 160 million Americans rely on employer coverage to meet their health care needs. In response to the excise tax and government mandates on insurance coverage, employers have already begun offering health insurance plans that shifts more costs onto the employees. With these cost shifts, the tax ends up hurting hard working middle class constituents in my district, and many others, including retirees who are ineligible for Medicare benefits. Unfortunately, these employers have few other options, particularly as the premiums increase at a pace greater than inflation index, capturing more and more employer based plans. This is especially harmful to retirees, who will not receive additional wage increases to cover the new costs despite evidence of rising premiums.

Even the Office of Personal Management, the United Auto Workers, and Democratic President candidate Hillary Clinton have gone on the record opposing this tax. I am relieved that the reconciliation package repeals this tax provision and Congress can begin to address the rising premiums and health care costs by pursuing patient-centered health care reform.

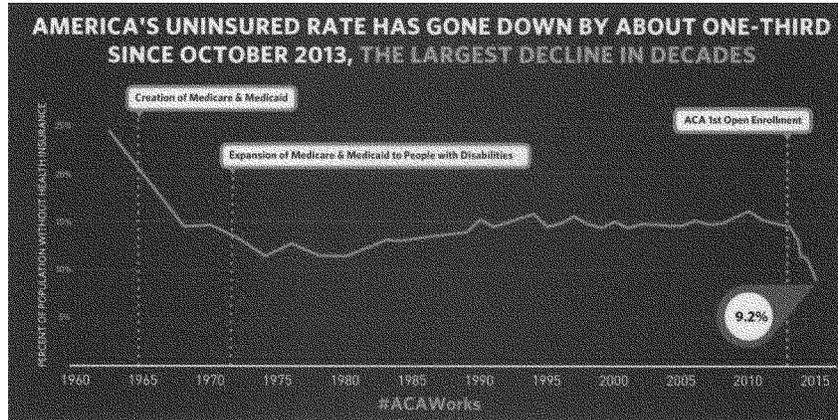
ROD L. BLUM.

MINORITY VIEWS**This Reconciliation Legislation Is an Irresponsible Attack on Women's Health Care and the Affordable Care Act**

It is mind boggling that the Budget Committee is wasting time and taxpayer resources on this piece of legislation at this time. Everyone on this Committee knows there is a crisis of leadership within the Republican caucus. While that may be just a matter of political intrigue to some, the reality is that it is causing harm to the country. We have a huge number of pressing issues facing the nation right now. There is the threat of another government shutdown in mid-December. The federal debt ceiling needs to be addressed so that the United States makes good on its full faith and credit and we do not put our economy at great risk. We have a transportation authorization bill that expires within weeks. Rather than tackling the urgent issues confronting the nation, Republicans are for the 61st time trying to dismantle the Affordable Care Act, and on top of that, attack women's health programs, including Planned Parenthood.

Let us also consider the Congressional Budget Office's (CBO's) analysis of this reconciliation bill. As we all know, CBO has nonpartisan experts, and the agency's current director was recommended by the Republican chairmen of the House and Senate Budget Committees. CBO reports that the major provisions in this bill would "reduce the number of nonelderly people in the United States with health insurance coverage by about 14 million to 15 million in most years (about 20 percent of those are estimated to be children)."

As the accompanying chart shows, the Affordable Care Act has had a dramatic impact in reducing the number of uninsured in this country. It is doing its intended job and has provided affordable health care to 18 million previously uninsured people since 2010, including children. And yet, the priority of our Republican colleagues in the House, at this time of dysfunction and pressing issues, is to pass a piece of legislation that will take that health insurance away from up to 15 million Americans each year going forward. This is wrong.



At the same time, we see a continuing attack on women's health programs. This House has had three committees investigating Planned Parenthood. On September 30, the Chairman of the Oversight and Government Reform Committee announced the following conclusion on national television, on CNN's The Situation Room with Wolf Blitzer:

Blitzer: "Is there any evidence, in your opinion, that Planned Parenthood has broken any law?"

Chairman Chaffetz: "No, I'm not suggesting that they broke the law."

Yet here we are, considering legislation designed to deprive up to 15 million Americans of affordable health care, designed to go after women's health programs and to continue a witch hunt against an organization that provides cervical cancer screenings and other important preventive health measures for American women. These are the priorities of this Republican Congress.

Republicans claim that the reconciliation bill reduces the deficit. While the reconciliation bill does reduce deficits by \$79 billion within the 10-year budget window, it actually increases deficits beyond the 10-year window, making the long-term deficit situation worse. An October 8 analysis of the bill by CBO and the Joint Committee on Taxation makes this clear. It states: "the agencies estimate that enacting the legislation would increase on-budget deficits by at least \$5 billion in one or more of the four consecutive 10-year periods beginning in 2026."

The reconciliation bill's 10-year deficit reduction of \$79 billion is miniscule compared with what Republicans claimed to do in their fiscal year 2016 budget resolution, which assumed \$4 trillion of deficit reduction from cuts in mandatory spending. This bill is the Majority's one shot at budget reconciliation. Through this bill, they are telling the world that they did not mean it when they put forward that budget resolution. Their budget resolution does not come close to balancing; that was all smoke and mirrors. Instead, they are now putting forth a reconciliation

bill that, in the long run, actually increases the deficit. The bottom line is that all of the talk from Republicans about balanced budgets is just nonsense.

This whole exercise of the reconciliation package comes at the expense of millions of Americans who now have affordable health care. The Majority is using reconciliation to try to take that away and launch an attack on women's health programs and an organization that the Republicans' own chairman of the oversight committee has said has not violated any laws.

Instead of passing this bill, Congress should be working on preventing another government shutdown. During the markup, Democrats offered a motion to replace the reconciliation bill with legislation that does just that. Democrats and Republicans should agree on that goal. But sadly every Republican voted against the motion.

SIGNATORIES

Chris Van Hollen
John Yarmuth
Bill Pascrell, Jr.
Tim Ryan
Gwen Moore
Kathy Castor
Jim McDermott
Barbara Lee
Mark Pocan
Michelle Lujan Grisham
Debbie Dingell
Ted Lieu
Donald Norcross
Seth Moulton

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Restoring Americans’ Healthcare Freedom Reconciliation Act of 2015”.

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

Sec. 1. Short title; table of contents.

TITLE I—COMMITTEE ON EDUCATION AND THE WORKFORCE

Sec. 101. Repeal of automatic enrollment requirement.

TITLE II—COMMITTEE ON ENERGY AND COMMERCE

Sec. 201. Repeal of the Prevention and Public Health Fund.

Sec. 202. Federal payment to States.

Sec. 203. Funding for community health center program.

TITLE III—COMMITTEE ON WAYS AND MEANS

Subtitle A—Revenue Provisions

Sec. 301. Repeal of individual mandate.

Sec. 302. Repeal of employer mandate.

Sec. 303. Repeal of medical device excise tax.

Sec. 304. Repeal of the tax on employee health insurance premiums and health plan benefits and related reporting requirements.

Subtitle B—Repeal of Independent Payment Advisory Board

Sec. 311. Repeal of Independent Payment Advisory Board.

TITLE I—COMMITTEE ON EDUCATION AND THE WORKFORCE

SEC. 101. REPEAL OF AUTOMATIC ENROLLMENT REQUIREMENT.

The Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.) is amended by repealing section 18A (as added by section 1511 of the Patient Protection and Affordable Care Act (Public Law 111–148)).

TITLE II—COMMITTEE ON ENERGY AND COMMERCE

SEC. 201. REPEAL OF THE PREVENTION AND PUBLIC HEALTH FUND.

(a) **IN GENERAL.**—Section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–11) is repealed.

(b) **RESCISSION OF UNOBLIGATED FUNDS.**—Of the funds made available by such section 4002, the unobligated balance is rescinded.

SEC. 202. FEDERAL PAYMENT TO STATES.

(a) **IN GENERAL.**—Notwithstanding sections 504(a), 1902(a)(23), 2002, 2005(a)(4), 2102(a)(7), or 2105(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396b(a)(23), 1397a, 1397d(a)(4), 1397bb(a)(2), 1397ee(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the one-year period beginning on the date of the enactment of this Act

no Federal funds may be made available to a State for payments to a prohibited entity.

(b) **DEFINITION OF PROHIBITED ENTITY.**—In this section, the term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinics—

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

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

(B) is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations, that is primarily engaged in family planning services, reproductive health, and related medical care; and

(C) provides for elective abortions; and

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

SEC. 203. FUNDING FOR COMMUNITY HEALTH CENTER PROGRAM.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting after “Section 10503(b)(1)(E) of the Patient Protection and Affordable Care Act (42 U.S.C. 254b-2(b)(1)(E)) is amended” the following: “by striking ‘\$3,600,000,000’ and inserting ‘\$3,835,000,000’ and”.

TITLE III—COMMITTEE ON WAYS AND MEANS

Subtitle A—Revenue Provisions

SEC. 301. REPEAL OF INDIVIDUAL MANDATE.

(a) **IN GENERAL.**—Section 5000A of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“(h) **TERMINATION.**—This section shall not apply with respect to any month beginning after December 31, 2014.”.

(b) **CONFORMING AMENDMENTS.**—

(1) Section 5000A(c) of such Code is amended—

(A) in paragraph (2)(B) by striking clauses (ii) and (iii),

(B) in paragraph (3)(B) by striking “2014” and all that follows and inserting “2014.”, and

(C) in paragraph (3) by striking subparagraph (D).

(2) Section 5000A(e)(1) of such Code is amended by striking subparagraph (D).

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to months beginning after December 31, 2014.

SEC. 302. REPEAL OF EMPLOYER MANDATE.

(a) **IN GENERAL.**—Section 4980H of the Internal Revenue Code of 1986 is amended by adding at the end the following:

“(e) **TERMINATION.**—This section shall not apply with respect to any month beginning after December 31, 2014.”.

(b) **CONFORMING AMENDMENT.**—Section 4980H(c) of such Code is amended by striking paragraph (5).

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to months beginning after December 31, 2014.

SEC. 303. REPEAL OF MEDICAL DEVICE EXCISE TAX.

(a) **IN GENERAL.**—Chapter 32 of the Internal Revenue Code of 1986 is amended by striking subchapter E.

(b) **CONFORMING AMENDMENTS.**—

(1) Subsection (a) of section 4221 of such Code is amended by striking the last sentence.

(2) Paragraph (2) of section 6416(b) of such Code is amended by striking the last sentence.

(c) **CLERICAL AMENDMENT.**—The table of subchapters for chapter 32 of such Code is amended by striking the item relating to subchapter E.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to sales in calendar quarters beginning after the date of the enactment of this Act.

SEC. 304. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS AND RELATED REPORTING REQUIREMENTS.

(a) **EXCISE TAX.**—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking section 4980I.

(b) **REPORTING REQUIREMENT.**—Section 6051(a) of such Code is amended by inserting “and” at the end of paragraph (12), by striking “, and” at the end of paragraph (13) and inserting a period, and by striking paragraph (14).

(c) **CLERICAL AMENDMENT.**—The table of sections for chapter 43 of such Code is amended by striking the item relating to section 4980I.

(d) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—Except as provided by paragraph (2), the amendments made by this section shall apply to taxable years beginning after December 31, 2017.

(2) **REPORTING REQUIREMENT.**—The amendment made by subsection (b) shall apply to calendar years beginning after December 31, 2014.

Subtitle B—Repeal of Independent Payment Advisory Board

SEC. 311. REPEAL OF INDEPENDENT PAYMENT ADVISORY BOARD.

Effective as of the enactment of the Patient Protection and Affordable Care Act (Public Law 111–148), sections 3403 and 10320 of such Act (including the amendments made by such sections) are

repealed, and any provision of law amended by such sections is hereby restored as if such sections had not been enacted into law.

