114TH CONGRESS
*2d Session*
HOUSE OF REPRESENTATIVES
REPORT
114–475

# PROTECTING TAXPAYERS BY RECOVERING IMPROPER OBAMACARE SUBSIDY OVERPAYMENTS ACT

MARCH 23, 2016.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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

# R E P O R T

together with

## DISSENTING VIEWS

[To accompany H.R. 4723]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 4723) to amend the Internal Revenue Code of 1986 to provide for the recovery of improper overpayments resulting from certain Federally subsidized health insurance, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE.**

This Act may be cited as the "Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayments Act".

**SEC. 2. RECOVERY OF IMPROPER OVERPAYMENTS RESULTING FROM CERTAIN FEDERALLY SUBSIDIZED HEALTH INSURANCE.**

(a) IN GENERAL.—Section 36B(f)(2) of the Internal Revenue Code of 1986 is amended by striking subparagraph (B).

(b) CONFORMING AMENDMENTS.—

(1) Clause (ii) of section 35(g)(12)(B) of such Code is amended by striking ", except that" and all that follows and inserting a period.

(2) So much of paragraph (2) of section 36B(f) of such Code as precedes "advance payments" is amended to read as follows:

"(2) EXCESS ADVANCE PAYMENTS.—If the".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2016.

# I. SUMMARY AND BACKGROUND

## A. PURPOSE AND SUMMARY

The bill, H.R. 4723, as reported by the Committee on Ways and Means, amends the provisions of the Internal Revenue Code of 1986 relating to premium assistance credits for the purchase of health insurance by removing the limits on the amount of excess advance premium assistance payments that must be repaid. Thus, under the bill, the full amount of excess advance premium assistance payments would be required to be repaid.

## B. BACKGROUND AND NEED FOR LEGISLATION

Given the Federal government's current fiscal situation and growing financial commitment to health care services, it is imperative that Congress scrutinize the Federal budget to identify potential improper payments resulting from waste, fraud, and abuse. Once identified, it is incumbent on Congress to amend statutes and address programs that fail to fully protect taxpayer dollars. The Patient Protection and Affordable Care Act's (PPACA) design of advanceable and refundable tax credits for the purchase of certain government-approved health insurance creates the potential for such waste, fraud, and abuse. The combination of income determination rules, limits on the amount of subsidy overpayments that can be recouped, and the large amount of Federal funds being expended (more than $800 billion will be spent over the next ten years on both Obamacare's advanceable refundable tax credits and cost-sharing reductions) make the program particularly susceptible

to improper payments. Accordingly, the bill seeks to reduce waste, fraud, and abuse by repealing the limit on the amount of improper overpayments the government can recoup.

### C. LEGISLATIVE HISTORY

*Background*

H.R. 4723 was introduced by Representative Lynn Jenkins (R–KS) on March 10, 2016, and was referred to the Committee on Ways and Means.

*Committee action*

The Committee on Ways and Means marked up H.R. 4723, the Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayments Act, on March 16, 2016, and ordered the bill, as amended, favorably reported by a vote of 22 yeas to 15 nays (with a quorum being present).

*Committee hearings*

The full Committee on Ways and Means held hearings regarding the President's Fiscal Year 2017 budget submission on February 10, 2016, and February 11, 2016, with Secretary of Health and Human Services Sylvia Burwell and Secretary of the Treasury Jacob Lew, respectively, in which implementation of PPACA was a focal point. The President's health care law also was discussed at hearings on the law's implementation with Secretary Burwell with the full Committee on June 10, 2015, and on the law's mandates with the Health Subcommittee on April 14, 2015.

## II. EXPLANATION OF THE BILL

### A. RECOVERY OF IMPROPER OVERPAYMENTS RESULTING FROM CERTAIN FEDERALLY SUBSIDIZED HEALTH INSURANCE (SEC. 2 OF THE BILL AND SEC. 36B OF THE CODE)

#### PRESENT LAW

*Premium assistance credit—in general*

A refundable tax credit (the "premium assistance credit") is available for certain taxpayers who purchase health insurance (referred to as a "qualified health plan") for themselves and their families through an American Health Benefit Exchange ("Exchange").[1] The premium assistance credit, which is payable in advance directly to the insurer, subsidizes the purchase of a qualified health plan through an Exchange.[2]

The premium assistance credit is available for taxpayers with household incomes between 100 and 400 percent of the Federal poverty level ("FPL") for the family size involved who do not receive health insurance through an employer or a spouse's employer, as discussed below, and are not eligible for certain other types of coverage, such as Medicare or Medicaid. Household income is defined as the sum of (1) the taxpayer's modified adjusted gross in-

[1] Sec. 36B. Unless otherwise specified, all section references are made to the Internal Revenue Code of 1986, as amended.

[2] Sections 1411 and 1412 of the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, provide rules relating to advance payment of the premium assistance credit.

come, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining that taxpayer's family size who are required to file a tax return for the taxable year. Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,[3] (2) any tax-exempt interest received or accrued during the tax year, and (3) an amount equal to the portion of the taxpayer's Social Security benefits that is not included in gross income (that is, the amount of the taxpayer's Social Security benefits that are excluded from gross income).[4] To be eligible for the premium assistance credit, taxpayers who are married must file a joint return. Individuals who are listed as dependents on a return are ineligible for the premium assistance credit.

Generally, a taxpayer who is an employee and is offered minimum essential coverage[5] under an employer-sponsored health plan is ineligible for the premium assistance credit.

However, if an employee's share of the premium for self-only coverage exceeds 9.66 percent (for 2016) of the employee's household income, or the plan's share of total allowed costs of benefits provided under the plan is less than 60 percent of such costs, and the employee declines the employer-offered coverage, the employee may be eligible for the premium assistance credit.

*Amount of credit*

The premium assistance credit amount is generally the lower of (1) the premium for the qualified health plan in which the individual or family enrolls and (2) the premium for the second lowest cost silver plan[6] in the rating area where the individual resides, reduced by the individual's or family's share of premiums.[7] As shown in Table 1 below, an individual's or family's share of premiums is a certain percentage of household income for household income up to 133 percent of FPL and is determined on a sliding scale in a linear manner as household income rises from 133 percent of FPL to 400 percent of FPL.

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[3] Sec. 911.

[4] The amount of Social Security benefits included in gross income is determined under section 86.

[5] Minimum essential coverage is defined in section 5000A(f).

[6] A qualified health plan is categorized by level (bronze, silver, gold or platinum), depending on its actuarial value, that is, the percentage of the plan's share of the total costs of benefits under the plan. A silver level plan must have an actuarial value of 70 percent.

[7] The premium assistance amount is determined on a monthly basis and the credit for a year is the sum of the monthly amounts.

TABLE 1—TAXPAYER'S SHARE OF PREMIUMS (for 2016) [8]

| *Household income (expressed as a percent of FPL)* | *Initial percentage of household income* | *Final percentage of household income* |
|---|---|---|
| 100% up to 133% | 2.03 | 2.03 |
| 133% up to 150% | 3.05 | 4.07 |
| 150% up to 200% | 4.07 | 6.41 |
| 200% up to 250% | 6.41 | 8.18 |
| 250% up to 300% | 8.18 | 9.66 |
| 300% up to 400% | 9.66 | 9.66 |

*Reconciliation*

A taxpayer on whose behalf advance payments of the premium assistance credit for a taxable year are made is required to file an income tax return to reconcile the advance payments with the credit to which the taxpayer is entitled for the taxable year.[9]

If the advance payments of the premium assistance credit exceed the amount of credit to which the taxpayer is entitled, the excess ("excess advance payments") is treated as an additional tax liability on the taxpayer's income tax return for the taxable year, subject to a limitation on the amount of liability in some cases.[10] For persons with household income below 400 percent of FPL, the liability for the overpayment for a taxable year is limited to a specific dollar amount (the "applicable dollar amount") as shown in Table 2 below (one-half of the applicable dollar amount shown in Table 2 for unmarried individuals who are not surviving spouses or filing as head of households).

TABLE 2.—RECONCILIATION LIMIT ON ADDITIONAL TAX LIABILITY (for 2016) [11]

| *Household income (expressed as a percent of FPL)* | *Applicable dollar amount* |
|---|---|
| Less than 200% | $600 |
| At least 200% but less than 300% | $1,500 |
| At least 300% but less than 400% | $2,550 |

[8] Rev. Proc. 2014–62, 2014–2 C.B. 948. The percentages are indexed to the excess of premium growth over income growth for the preceding calendar year. After 2018, if the aggregate amount of premium assistance credits (and cost-sharing reductions under section 1402 of PPACA) exceeds 0.504 percent of the gross domestic product for that year, the percentage of income is also adjusted to reflect the excess (if any) of premium growth over the rate of growth in the consumer price index for the preceding calendar year.

[9] A taxpayer is not required to apply for advance payments and may instead just claim the credit on his or her income tax return.

[10] Section 35 also provides an advanceable, refundable credit for the purchase of health insurance, the health coverage tax credit ("HCTC"), for certain individuals. Section 35(g)(12) provides rules for coordination between HCTC and premium assistance credit eligibility and advance payments.

[11] Rev. Proc. 2015–53, 2015–44 I.R.B. 615. The applicable dollar amounts are indexed to reflect cost-of-living increases, with the amount of any increase rounded down to the next lowest multiple of $50.

If the advance payments of the premium assistance credit for a taxable year are less than the amount of the credit to which the taxpayer is entitled, the additional credit amount is also reflected on the taxpayer's income tax return for the year.

REASONS FOR CHANGE

The Committee believes that overpayments resulting from certain Federally-subsidized health insurance programs should be fully recouped and that failure to do so will result in the mismanagement of taxpayer funds. The Committee believes that it is appropriate to align repayment requirements for this program with those of similar tax credits, like the earned income tax credit. Given that, in the case of an exchange subsidy underpayment, the Federal government is required to pay the filer the additional appropriate amount of funds, the Committee believes it is appropriate for the government to be able to recoup overpayments. Thus, the Committee believes that recipients should be required to repay the full amount of any overpayment of the advance premium assistance credit.

EXPLANATION OF PROVISION

The provision repeals the present-law rule under which, in the case of a taxpayer with household income below 400 percent of FPL, the additional tax liability resulting from excess advance payments is limited to the applicable dollar amount.[12] Thus, under the provision, the full amount of the excess advance payments would be required to be repaid.

EFFECTIVE DATE

The provision is effective for taxable years beginning after December 31, 2016.

## III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 4723, the "Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayments Act," on March 16, 2016.

MOTION TO REPORT THE BILL

The bill, H.R. 4723, as amended, was ordered favorably reported to the House of Representatives by a roll call vote of 22 yeas to 15 nays (with a quorum being present). The vote was as follows:

| Representative | Yea | Nay | Present | Representative | Yea | Nay | Present |
|---|---|---|---|---|---|---|---|
| Mr. Brady | X | | | Mr. Levin | | X | |
| Mr. Johnson | X | | | Mr. Rangel | | X | |
| Mr. Nunes | X | | | Mr. McDermott | | X | |
| Mr. Tiberi | X | | | Mr. Lewis | | X | |
| Mr. Reichert | X | | | Mr. Neal | | X | |
| Mr. Boustany | X | | | Mr. Becerra | | X | |
| Mr. Roskam | X | | | Mr. Doggett | | X | |

[12] The provision includes a conforming change to section 35(g)(12).

| Representative | Yea | Nay | Present | Representative | Yea | Nay | Present |
|---|---|---|---|---|---|---|---|
| Mr. Price | | | | Mr. Thompson | | X | |
| Mr. Buchanan | | | | Mr. Larson | | X | |
| Mr. Smith (NE) | X | | | Mr. Blumenauer | | X | |
| Ms. Jenkins | X | | | Mr. Kind | | X | |
| Mr. Paulsen | X | | | Mr. Pascrell | | X | |
| Mr. Marchant | X | | | Mr. Crowley | | X | |
| Ms. Black | X | | | Mr. Davis | | X | |
| Mr. Reed | X | | | Ms. Sanchez | | X | |
| Mr. Young | X | | | | | | |
| Mr. Kelly | X | | | | | | |
| Mr. Renacci | X | | | | | | |
| Mr. Meehan | X | | | | | | |
| Ms. Noem | X | | | | | | |
| Mr. Holding | X | | | | | | |
| Mr. Smith (MO) | X | | | | | | |
| Mr. Dold | X | | | | | | |
| Mr. Rice | X | | | | | | |

# IV. BUDGET EFFECTS OF THE BILL

## A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 4723, as reported.

The bill, as reported, is estimated to have the following effect on Federal fiscal year budget receipts for the period 2016–2026:

FISCAL YEARS

[Billions of Dollars]

| Item | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2016–21 | 2016–26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| On-budget revenues | — | 0.3 | 1.6 | 1.7 | 1.7 | 1.7 | 1.8 | 1.8 | 1.9 | 2.0 | 2.0 | 7.1 | 16.6 |
| Off-budget revenues | — | [1] | −0.1 | −0.1 | −0.1 | −0.1 | −0.1 | −0.1 | −0.1 | −0.1 | −0.1 | −0.3 | −0.7 |
| Outlays[2] | — | 2.7 | 4.2 | 4.3 | 4.3 | 4.5 | 4.7 | 4.9 | 5.2 | 5.4 | 5.6 | 19.9 | 45.8 |
| Total | — | 3.0 | 5.7 | 5.9 | 6.0 | 6.1 | 6.4 | 6.7 | 7.0 | 7.3 | 7.5 | 26.7 | 61.6 |

NOTE: Details may not add to totals due to rounding.
[1] Loss of less than $50 million.
[2] Reduction in outlays.

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

## B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee further states that there are 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.

U.S. Congress,
Congressional Budget Office,
*Washington, DC, March 22, 2016.*

Hon. Kevin Brady,
*Chairman, Committee on Ways and Means,*
*House of Representatives, Washington, DC.*

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4723, the Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayments Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Nathaniel Frentz, who can be reached at 226–2860.

Sincerely,

Keith Hall.

Enclosure.

*H.R. 4723—Protecting Taxpayers by Recovering Improper Obamacare Subsidy Overpayments Act*

H.R. 4723 would amend the Internal Revenue Code to provide for the recovery of overpayments resulting from certain federally subsidized health insurance. Under current law, qualified taxpayers are eligible to receive refundable tax credits to assist in the purchase of health insurance through the health insurance marketplaces established by the Affordable Care Act. The amount of those premium assistance credits are based on family size and income, and the advance payments of the credits is based on income estimated for the current year. If taxpayers' circumstances change and their advance payments exceed the premium assistance credits to which they are entitled, they may be required to repay some or all of the credits, subject to certain limits based on income. Enacting H.R. 4723 would eliminate existing limits on the amounts required to be repaid by taxpayers. Taxpayers would therefore be liable for the full amount of overpayments, beginning in tax year 2017.

The staff of the Joint Committee on Taxation (JCT) estimates that relative to CBO's January 2016 baseline, the legislation would decrease outlays by $45.8 billion and increase revenues by $15.8 billion over the 2016–2026 period. JCT therefore estimates that the legislation would reduce federal budget deficits by $61.6 billion over the 2016–2026 period. The change in revenues includes a reduction of about $718 million over the 2016–2026 period that would result from changes in off-budget revenues (from Social Security payroll taxes).

The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending and revenues. The estimated net decrease in the deficit is shown in the following table. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 4723, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON MARCH 16, 2016

| | By fiscal year, in millions of dollars— | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2016–2021 | 2016–2026 |
| | NET DECREASE (−) IN THE DEFICIT | | | | | | | | | | | | |
| Statutory Pay-As-You-Go Impact | 0 | −3,015 | −5,763 | −5,992 | −6,024 | −6,204 | −6,496 | −6,778 | −7,076 | −7,344 | −7,622 | −27,000 | −62,315 |
| Memorandum: [a] | | | | | | | | | | | | | |
| Change in Outlays | 0 | −2,724 | −4,156 | −4,272 | −4,306 | −4,478 | −4,719 | −4,943 | −5,176 | −5,386 | −5,603 | −19,936 | −45,763 |
| Change in On-Budget Revenues | 0 | 291 | 1,607 | 1,720 | 1,718 | 1,726 | 1,777 | 1,835 | 1,900 | 1,958 | 2,019 | 7,064 | 16,552 |
| *Change in Off-Budget Revenues* | *0* | *0* | *−64* | *−69* | *−72* | *−76* | *−80* | *−84* | *−87* | *−91* | *−94* | *−282* | *−718* |

Source: Staff of the Joint Committee on Taxation.

[a] A negative sign for outlays indicates a reduction in outlays. A positive sign for revenues indicates an increase in revenues.

JCT estimates that enacting the bill would not increase net direct spending or on-budget deficits in any of the four 10-year periods beginning in 2027.

JCT has determined that the bill contains no intergovernmental mandates but would impose a private-sector mandate as defined in the Unfunded Mandates Reform Act (UMRA). Based on information provided by JCT, the cost of the provision's private-sector mandate would exceed the annual threshold established in UMRA for private-sector mandates ($157 million in 2017, adjusted annually for inflation) beginning in 2017.

The CBO staff contact for this estimate is Nathaniel Frentz. The estimate was approved by Mark Booth, Unit Chief, Revenue Estimating.

## 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 H.R. 4723 that the Committee concluded that it is appropriate to report the bill, as amended, favorably to the House of Representatives with the recommendation that the bill do pass.

### B. Statement of General Performance Goals and Objectives

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

### C. Information Relating to Unfunded Mandates

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

The Committee has determined that the bill contains one private sector mandate: changes to the limitations on recapture of overpayments resulting from advance premium assistance payments for Federally-subsidized health insurance. The Committee has determined that the bill does not impose a Federal intergovernmental mandate on State, local, or tribal governments.

### D. Applicability of House Rule XXI 5(b)

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

### E. Tax Complexity Analysis

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

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

### F. Congressional Earmarks, Limited Tax Benefits, and Limited Tariff Benefits

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

### G. Duplication of Federal Programs

In compliance with Sec. 3(g)(2) of H. Res. 5 (114th Congress), the Committee states that no provision of the bill establishes or reauthorizes: (1) a program of the Federal Government known to be duplicative of another Federal program, (2) a program included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or (3) a program related to a program identified in the most recent Catalog of Federal Domestic Assistance, published pursuant to 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 bill requires no directed rule makings within the meaning of such section.

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

### A. Text of Existing Law Amended or Repealed by the Bill, as Reported

In compliance with clause 3(e)(1)(A) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the bill, as reported, is shown below:

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e)(1)(A) of rule XIII of the Rules of the House of Representatives, the text of each section proposed to be amended or repealed by the bill, as reported, is shown below:

**INTERNAL REVENUE CODE OF 1986**

# Subtitle A—Income Taxes

* * * * * * *

## CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * * * *

## Subchapter A—Determination of Tax Liability

* * * * * * *

### PART IV—CREDITS AGAINST TAX

* * * * * * *

#### Subpart C—Refundable Credits

* * * * * * *

**SEC. 35. HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.**

(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by subtitle A an amount equal to 72.5 percent of the amount paid by the taxpayer for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

(b) ELIGIBLE COVERAGE MONTH.—For purposes of this section—

(1) IN GENERAL.—The term "eligible coverage month" means any month if—

(A) as of the first day of such month, the taxpayer—

(i) is an eligible individual,

(ii) is covered by qualified health insurance, the premium for which is paid by the taxpayer,

(iii) does not have other specified coverage, and

(iv) is not imprisoned under Federal, State, or local authority, and

(B) such month begins more than 90 days after the date of the enactment of the Trade Act of 2002, and before January 1, 2020.

(2) JOINT RETURNS.—In the case of a joint return, the requirements of paragraph (1)(A) shall be treated as met with respect to any month if at least 1 spouse satisfies such requirements.

(c) ELIGIBLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term "eligible individual" means—

(A) an eligible TAA recipient,

(B) an eligible alternative TAA recipient, and

(C) an eligible PBGC pension recipient.

(2) ELIGIBLE TAA RECIPIENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "eligible TAA recipient" means, with respect to any month, any individual who is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974 or who would be eligible to receive such allowance if section 231 of such Act were applied without regard to subsection (a)(3)(B) of such section. An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(B) SPECIAL RULE.—In the case of any eligible coverage month beginning after the date of the enactment of this paragraph, the term "eligible TAA recipient" means, with respect to any month, any individual who—

(i) is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974,

(ii) would be eligible to receive such allowance except that such individual is in a break in training provided under a training program approved under section 236 of such Act that exceeds the period specified in section 233(e) of such Act, but is within the period for receiving such allowances provided under section 233(a) of such Act, or

(iii) is receiving unemployment compensation (as defined in section 85(b)) for any day of such month and who would be eligible to receive such allowance for such month if section 231 of such Act were applied without regard to subsections (a)(3)(B) and (a)(5) thereof.

An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(3) ELIGIBLE ALTERNATIVE TAA RECIPIENT.—The term "eligible alternative TAA recipient" means, with respect to any month, any individual who—

(A) is a worker described in section 246(a)(3)(B) of the Trade Act of 1974 who is participating in the program established under section 246(a)(1) of such Act, and

(B) is receiving a benefit for such month under section 246(a)(2) of such Act.

An individual shall continue to be treated as an eligible alternative TAA recipient during the first month that such individual would otherwise cease to be an eligible alternative TAA recipient by reason of the preceding sentence.

(4) ELIGIBLE PBGC PENSION RECIPIENT.—The term "eligible PBGC pension recipient" means, with respect to any month, any individual who—

(A) has attained age 55 as of the first day of such month, and

(B) is receiving a benefit for such month any portion of which is paid by the Pension Benefit Guaranty Corporation under title IV of the Employee Retirement Income Security Act of 1974.

(d) QUALIFYING FAMILY MEMBER.—For purposes of this section—

(1) IN GENERAL.—The term "qualifying family member" means—

(A) the taxpayer's spouse, and

(B) any dependent of the taxpayer with respect to whom the taxpayer is entitled to a deduction under section 151(c).

Such term does not include any individual who has other specified coverage.

(2) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC..—If section 152(e) applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in paragraph (1)(B) with respect to the custodial parent (as defined in section 152(e)(4)(A)) and not with respect to the noncustodial parent.

(e) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

(1) IN GENERAL.—The term "qualified health insurance" means any of the following:

(A) Coverage under a COBRA continuation provision (as defined in section 9832(d)(1)).

(B) State-based continuation coverage provided by the State under a State law that requires such coverage.

(C) Coverage offered through a qualified State high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

(D) Coverage under a health insurance program offered for State employees.

(E) Coverage under a State-based health insurance program that is comparable to the health insurance program offered for State employees.

(F) Coverage through an arrangement entered into by a State and—

(i) a group health plan (including such a plan which is a multiemployer plan as defined in section 3(37) of the Employee Retirement Income Security Act of 1974),

(ii) an issuer of health insurance coverage,

(iii) an administrator, or

(iv) an employer.

(G) Coverage offered through a State arrangement with a private sector health care coverage purchasing pool.

(H) Coverage under a State-operated health plan that does not receive any Federal financial participation.

(I) Coverage under a group health plan that is available through the employment of the eligible individual's spouse.

(J) In the case of any eligible individual and such individual's qualifying family members, coverage under individual health insurance (other than coverage enrolled in through an Exchange established under the Patient Pro-

tection and Affordable Care Act). For purposes of this subparagraph, the term "individual health insurance" means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

(K) Coverage under an employee benefit plan funded by a voluntary employees' beneficiary association (as defined in section 501(c)(9)) established pursuant to an order of a bankruptcy court, or by agreement with an authorized representative, as provided in section 1114 of title 11, United States Code.

(2) REQUIREMENTS FOR STATE-BASED COVERAGE.—

(A) IN GENERAL.—The term "qualified health insurance" does not include any coverage described in subparagraphs (B) through (H) of paragraph (1) unless the State involved has elected to have such coverage treated as qualified health insurance under this section and such coverage meets the following requirements:

(i) GUARANTEED ISSUE.—Each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs credit eligibility certificate described in section 7527 and pays the remainder of such premium.

(ii) NO IMPOSITION OF PREEXISTING CONDITION EXCLUSION.—No pre-existing condition limitations are imposed with respect to any qualifying individual.

(iii) NONDISCRIMINATORY PREMIUM.—The total premium (as determined without regard to any subsidies) with respect to a qualifying individual may not be greater than the total premium (as so determined) for a similarly situated individual who is not a qualifying individual.

(iv) SAME BENEFITS.—Benefits under the coverage are the same as (or substantially similar to) the benefits provided to similarly situated individuals who are not qualifying individuals.

(B) QUALIFYING INDIVIDUAL.—For purposes of this paragraph, the term "qualifying individual" means—

(i) an eligible individual for whom, as of the date on which the individual seeks to enroll in the coverage described in subparagraphs (B) through (H) of paragraph (1), the aggregate of the periods of creditable coverage (as defined in section 9801(c)) is 3 months or longer and who, with respect to any month, meets the requirements of clauses (iii) and (iv) of subsection (b)(1)(A); and

(ii) the qualifying family members of such eligible individual.

(3) EXCEPTION.—The term "qualified health insurance" shall not include—

(A) a flexible spending or similar arrangement, and

(B) any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

(f) OTHER SPECIFIED COVERAGE.—For purposes of this section, an individual has other specified coverage for any month if, as of the first day of such month—

(1) SUBSIDIZED COVERAGE.—

(A) IN GENERAL.—Such individual is covered under any insurance which constitutes medical care (except insurance substantially all of the coverage of which is of excepted benefits described in section 9832(c)) under any health plan maintained by any employer (or former employer) of the taxpayer or the taxpayer's spouse and at least 50 percent of the cost of such coverage (determined under section 4980B) is paid or incurred by the employer.

(B) ELIGIBLE ALTERNATIVE TAA RECIPIENTS.—In the case of an eligible alternative TAA recipient, such individual is either—

(i) eligible for coverage under any qualified health insurance (other than insurance described in subparagraph (A), (B), or (F) of subsection (e)(1)) under which at least 50 percent of the cost of coverage (determined under section 4980B(f)(4)) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer's spouse, or

(ii) covered under any such qualified health insurance under which any portion of the cost of coverage (as so determined) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer's spouse.

(C) TREATMENT OF CAFETERIA PLANS.—For purposes of subparagraphs (A) and (B), the cost of coverage shall be treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d)).

(2) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP.—Such individual—

(A) is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

(3) CERTAIN OTHER COVERAGE.—Such individual—

(A) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, or

(B) is entitled to receive benefits under chapter 55 of title 10, United States Code.

(g) SPECIAL RULES.—

(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527 for months beginning in such taxable year.

(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into

account in determining any deduction allowed under section 162(l) or 213.

(3) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) or from a health savings account (as defined in section 223(d)) shall not be taken into account under subsection (a).

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

(5) BOTH SPOUSES ELIGIBLE INDIVIDUALS.—The spouse of the taxpayer shall not be treated as a qualifying family member for purposes of subsection (a), if—

(A) the taxpayer is married at the close of the taxable year,

(B) the taxpayer and the taxpayer's spouse are both eligible individuals during the taxable year, and

(C) the taxpayer files a separate return for the taxable year.

(6) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this section.

(7) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with respect to any contract for qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

(8) TREATMENT OF PAYMENTS.—For purposes of this section—

(A) PAYMENTS BY SECRETARY.—Payments made by the Secretary on behalf of any individual under section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals) shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

(B) PAYMENTS BY TAXPAYER.—Payments made by the taxpayer for eligible coverage months shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

(9) COBRA PREMIUM ASSISTANCE.—In the case of an assistance eligible individual who receives premium reduction for COBRA continuation coverage under section 3001(a) of title III of division B of the American Recovery and Reinvestment Act of 2009 for any month during the taxable year, such individual shall not be treated as an eligible individual, a certified individual, or a qualifying family member for purposes of this section or section 7527 with respect to such month.

(10) CONTINUED QUALIFICATION OF FAMILY MEMBERS AFTER CERTAIN EVENTS.—

(A) MEDICARE ELIGIBILITY.—In the case of any month which would be an eligible coverage month with respect to an eligible individual but for subsection (f)(2)(A), such month shall be treated as an eligible coverage month with respect to such eligible individual solely for purposes of de-

termining the amount of the credit under this section with respect to any qualifying family members of such individual (and any advance payment of such credit under section 7527). This subparagraph shall only apply with respect to the first 24 months after such eligible individual is first entitled to the benefits described in subsection (f)(2)(A).

(B) DIVORCE.—In the case of the finalization of a divorce between an eligible individual and such individual's spouse, such spouse shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such finalization, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such finalization.

(C) DEATH.—In the case of the death of an eligible individual—

(i) any spouse of such individual (determined at the time of such death) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such death, and

(ii) any individual who was a qualifying family member of the decedent immediately before such death (or, in the case of an individual to whom paragraph (4) applies, the taxpayer to whom the deduction under section 151 is allowable) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that in determining the amount of such credit only such qualifying family member may be taken into account.

(11) ELECTION.—

(A) IN GENERAL.—This section shall not apply to any taxpayer for any eligible coverage month unless such taxpayer elects the application of this section for such month.

(B) TIMING AND APPLICABILITY OF ELECTION.—Except as the Secretary may provide—

(i) an election to have this section apply for any eligible coverage month in a taxable year shall be made not later than the due date (including extensions) for the return of tax for the taxable year; and

(ii) any election for this section to apply for an eligible coverage month shall apply for all subsequent eligible coverage months in the taxable year and, once made, shall be irrevocable with respect to such months.

(12) COORDINATION WITH PREMIUM TAX CREDIT.—

(A) IN GENERAL.—An eligible coverage month to which the election under paragraph (11) applies shall not be treated as a coverage month (as defined in section

36B(c)(2)) for purposes of section 36B with respect to the taxpayer.

(B) COORDINATION WITH ADVANCE PAYMENTS OF PREMIUM TAX CREDIT.—In the case of a taxpayer who makes the election under paragraph (11) with respect to any eligible coverage month in a taxable year or on behalf of whom any advance payment is made under section 7527 with respect to any month in such taxable year—

(i) the tax imposed by this chapter for the taxable year shall be increased by the excess, if any, of—

(I) the sum of any advance payments made on behalf of the taxpayer under section 1412 of the Patient Protection and Affordable Care Act and section 7527 for months during such taxable year, over

(II) the sum of the credits allowed under this section (determined without regard to paragraph (1)) and section 36B (determined without regard to subsection (f)(1) thereof) for such taxable year; and

(ii) section 36B(f)(2) shall not apply with respect to such taxpayer for such taxable year, except that if such taxpayer received any advance payments under section 7527 for any month in such taxable year and is later allowed a credit under section 36B for such taxable year, then section 36B(f)(2)(B) shall be applied by substituting the amount determined under clause (i) for the amount determined under section 36B(f)(2)(A).

(13) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050T, and section 7527.

* * * * * * *

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

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

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

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

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

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange

established by the State under 1311 of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of—

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

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

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

(A) APPLICABLE PERCENTAGE.—

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

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

(ii) INDEXING.—

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

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

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

to 0.504 percent of the gross domestic product for the preceding calendar year.

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

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides—

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

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

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

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

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

(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) ADDITIONAL BENEFITS.—If—

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

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

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

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

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

(1) APPLICABLE TAXPAYER.—

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

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

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

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

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

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

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

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

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

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

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

(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

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

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

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

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

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

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

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

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

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

(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same

manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

(3) DEFINITIONS AND OTHER RULES.—

(A) QUALIFIED HEALTH PLAN.—The term "qualified health plan" has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

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

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

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

(2) HOUSEHOLD INCOME.—

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

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

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

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

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

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

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

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

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

(3) POVERTY LINE.—

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

(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

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

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

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

(i) A method under which—

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

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

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

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

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

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

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

(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

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

(2) EXCESS ADVANCE PAYMENTS.—

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

(B) LIMITATION ON INCREASE.—

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

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

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

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2013" for "calendar year 1992" in subparagraph (B) thereof.

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

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

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

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

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

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

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

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

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

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under sec-

tion 1412 of the Patient Protection and Affordable Care Act, and

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

* * * * * * *

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

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

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

**INTERNAL REVENUE CODE OF 1986**

# Subtitle A—Income Taxes

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## CHAPTER 1—NORMAL TAXES AND SURTAXES

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## Subchapter A—Determination of Tax Liability

* * * * * * *

### PART IV—CREDITS AGAINST TAX

* * * * * * *

#### Subpart C—Refundable Credits

* * * * * * *

**SEC. 35. HEALTH INSURANCE COSTS OF ELIGIBLE INDIVIDUALS.**

(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by subtitle A an amount equal to 72.5 percent of the amount paid by the taxpayer for coverage of the taxpayer and qualifying family members under qualified health insurance for eligible coverage months beginning in the taxable year.

(b) ELIGIBLE COVERAGE MONTH.—For purposes of this section—

(1) IN GENERAL.—The term "eligible coverage month" means any month if—

(A) as of the first day of such month, the taxpayer—

(i) is an eligible individual,

(ii) is covered by qualified health insurance, the premium for which is paid by the taxpayer,

(iii) does not have other specified coverage, and

(iv) is not imprisoned under Federal, State, or local authority, and

(B) such month begins more than 90 days after the date of the enactment of the Trade Act of 2002, and before January 1, 2020.

(2) JOINT RETURNS.—In the case of a joint return, the requirements of paragraph (1)(A) shall be treated as met with respect to any month if at least 1 spouse satisfies such requirements.

(c) ELIGIBLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term "eligible individual" means—

(A) an eligible TAA recipient,

(B) an eligible alternative TAA recipient, and

(C) an eligible PBGC pension recipient.

(2) ELIGIBLE TAA RECIPIENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "eligible TAA recipient" means, with respect to any month, any individual who is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974 or who would be eligible to receive such allowance if section 231 of such Act were applied without regard to subsection (a)(3)(B) of such section. An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(B) SPECIAL RULE.—In the case of any eligible coverage month beginning after the date of the enactment of this paragraph, the term "eligible TAA recipient" means, with respect to any month, any individual who—

(i) is receiving for any day of such month a trade readjustment allowance under chapter 2 of title II of the Trade Act of 1974,

(ii) would be eligible to receive such allowance except that such individual is in a break in training provided under a training program approved under section 236 of such Act that exceeds the period specified in section 233(e) of such Act, but is within the period for receiving such allowances provided under section 233(a) of such Act, or

(iii) is receiving unemployment compensation (as defined in section 85(b)) for any day of such month and who would be eligible to receive such allowance for such month if section 231 of such Act were applied without regard to subsections (a)(3)(B) and (a)(5) thereof.

An individual shall continue to be treated as an eligible TAA recipient during the first month that such individual would otherwise cease to be an eligible TAA recipient by reason of the preceding sentence.

(3) ELIGIBLE ALTERNATIVE TAA RECIPIENT.—The term "eligible alternative TAA recipient" means, with respect to any month, any individual who—

(A) is a worker described in section 246(a)(3)(B) of the Trade Act of 1974 who is participating in the program established under section 246(a)(1) of such Act, and

(B) is receiving a benefit for such month under section 246(a)(2) of such Act.

An individual shall continue to be treated as an eligible alternative TAA recipient during the first month that such individual would otherwise cease to be an eligible alternative TAA recipient by reason of the preceding sentence.

(4) ELIGIBLE PBGC PENSION RECIPIENT.—The term "eligible PBGC pension recipient" means, with respect to any month, any individual who—

(A) has attained age 55 as of the first day of such month, and

(B) is receiving a benefit for such month any portion of which is paid by the Pension Benefit Guaranty Corporation under title IV of the Employee Retirement Income Security Act of 1974.

(d) QUALIFYING FAMILY MEMBER.—For purposes of this section—

(1) IN GENERAL.—The term "qualifying family member" means—

(A) the taxpayer's spouse, and

(B) any dependent of the taxpayer with respect to whom the taxpayer is entitled to a deduction under section 151(c).

Such term does not include any individual who has other specified coverage.

(2) SPECIAL DEPENDENCY TEST IN CASE OF DIVORCED PARENTS, ETC..—If section 152(e) applies to any child with respect to any calendar year, in the case of any taxable year beginning in such calendar year, such child shall be treated as described in paragraph (1)(B) with respect to the custodial parent (as defined in section 152(e)(4)(A)) and not with respect to the noncustodial parent.

(e) QUALIFIED HEALTH INSURANCE.—For purposes of this section—

(1) IN GENERAL.—The term "qualified health insurance" means any of the following:

(A) Coverage under a COBRA continuation provision (as defined in section 9832(d)(1)).

(B) State-based continuation coverage provided by the State under a State law that requires such coverage.

(C) Coverage offered through a qualified State high risk pool (as defined in section 2744(c)(2) of the Public Health Service Act).

(D) Coverage under a health insurance program offered for State employees.

(E) Coverage under a State-based health insurance program that is comparable to the health insurance program offered for State employees.

(F) Coverage through an arrangement entered into by a State and—

(i) a group health plan (including such a plan which is a multiemployer plan as defined in section 3(37) of the Employee Retirement Income Security Act of 1974),

(ii) an issuer of health insurance coverage,

(iii) an administrator, or

(iv) an employer.

(G) Coverage offered through a State arrangement with a private sector health care coverage purchasing pool.

(H) Coverage under a State-operated health plan that does not receive any Federal financial participation.

(I) Coverage under a group health plan that is available through the employment of the eligible individual's spouse.

(J) In the case of any eligible individual and such individual's qualifying family members, coverage under individual health insurance (other than coverage enrolled in through an Exchange established under the Patient Protection and Affordable Care Act). For purposes of this subparagraph, the term "individual health insurance" means any insurance which constitutes medical care offered to individuals other than in connection with a group health plan and does not include Federal- or State-based health insurance coverage.

(K) Coverage under an employee benefit plan funded by a voluntary employees' beneficiary association (as defined in section 501(c)(9)) established pursuant to an order of a bankruptcy court, or by agreement with an authorized representative, as provided in section 1114 of title 11, United States Code.

(2) REQUIREMENTS FOR STATE-BASED COVERAGE.—

(A) IN GENERAL.—The term "qualified health insurance" does not include any coverage described in subparagraphs (B) through (H) of paragraph (1) unless the State involved has elected to have such coverage treated as qualified health insurance under this section and such coverage meets the following requirements:

(i) GUARANTEED ISSUE.—Each qualifying individual is guaranteed enrollment if the individual pays the premium for enrollment or provides a qualified health insurance costs credit eligibility certificate described in section 7527 and pays the remainder of such premium.

(ii) NO IMPOSITION OF PREEXISTING CONDITION EXCLUSION.—No pre-existing condition limitations are imposed with respect to any qualifying individual.

(iii) NONDISCRIMINATORY PREMIUM.—The total premium (as determined without regard to any subsidies) with respect to a qualifying individual may not be greater than the total premium (as so determined) for a similarly situated individual who is not a qualifying individual.

(iv) SAME BENEFITS.—Benefits under the coverage are the same as (or substantially similar to) the benefits provided to similarly situated individuals who are not qualifying individuals.

(B) QUALIFYING INDIVIDUAL.—For purposes of this paragraph, the term "qualifying individual" means—

(i) an eligible individual for whom, as of the date on which the individual seeks to enroll in the coverage described in subparagraphs (B) through (H) of paragraph (1), the aggregate of the periods of creditable coverage (as defined in section 9801(c)) is 3 months or longer and who, with respect to any month, meets the requirements of clauses (iii) and (iv) of subsection (b)(1)(A); and

(ii) the qualifying family members of such eligible individual.

(3) EXCEPTION.—The term "qualified health insurance" shall not include—

(A) a flexible spending or similar arrangement, and

(B) any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

(f) OTHER SPECIFIED COVERAGE.—For purposes of this section, an individual has other specified coverage for any month if, as of the first day of such month—

(1) SUBSIDIZED COVERAGE.—

(A) IN GENERAL.—Such individual is covered under any insurance which constitutes medical care (except insurance substantially all of the coverage of which is of excepted benefits described in section 9832(c)) under any health plan maintained by any employer (or former employer) of the taxpayer or the taxpayer's spouse and at least 50 percent of the cost of such coverage (determined under section 4980B) is paid or incurred by the employer.

(B) ELIGIBLE ALTERNATIVE TAA RECIPIENTS.—In the case of an eligible alternative TAA recipient, such individual is either—

(i) eligible for coverage under any qualified health insurance (other than insurance described in subparagraph (A), (B), or (F) of subsection (e)(1)) under which at least 50 percent of the cost of coverage (determined under section 4980B(f)(4)) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer's spouse, or

(ii) covered under any such qualified health insurance under which any portion of the cost of coverage (as so determined) is paid or incurred by an employer (or former employer) of the taxpayer or the taxpayer's spouse.

(C) TREATMENT OF CAFETERIA PLANS.—For purposes of subparagraphs (A) and (B), the cost of coverage shall be treated as paid or incurred by an employer to the extent the coverage is in lieu of a right to receive cash or other qualified benefits under a cafeteria plan (as defined in section 125(d)).

(2) COVERAGE UNDER MEDICARE, MEDICAID, OR SCHIP.—Such individual—

(A) is entitled to benefits under part A of title XVIII of the Social Security Act or is enrolled under part B of such title, or

(B) is enrolled in the program under title XIX or XXI of such Act (other than under section 1928 of such Act).

(3) CERTAIN OTHER COVERAGE.—Such individual—

(A) is enrolled in a health benefits plan under chapter 89 of title 5, United States Code, or

(B) is entitled to receive benefits under chapter 55 of title 10, United States Code.

(g) SPECIAL RULES.—

(1) COORDINATION WITH ADVANCE PAYMENTS OF CREDIT.—With respect to any taxable year, the amount which would (but for this subsection) be allowed as a credit to the taxpayer under subsection (a) shall be reduced (but not below zero) by the aggregate amount paid on behalf of such taxpayer under section 7527 for months beginning in such taxable year.

(2) COORDINATION WITH OTHER DEDUCTIONS.—Amounts taken into account under subsection (a) shall not be taken into account in determining any deduction allowed under section 162(l) or 213.

(3) MEDICAL AND HEALTH SAVINGS ACCOUNTS.—Amounts distributed from an Archer MSA (as defined in section 220(d)) or from a health savings account (as defined in section 223(d)) shall not be taken into account under subsection (a).

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

(5) BOTH SPOUSES ELIGIBLE INDIVIDUALS.—The spouse of the taxpayer shall not be treated as a qualifying family member for purposes of subsection (a), if—

(A) the taxpayer is married at the close of the taxable year,

(B) the taxpayer and the taxpayer's spouse are both eligible individuals during the taxable year, and

(C) the taxpayer files a separate return for the taxable year.

(6) MARITAL STATUS; CERTAIN MARRIED INDIVIDUALS LIVING APART.—Rules similar to the rules of paragraphs (3) and (4) of section 21(e) shall apply for purposes of this section.

(7) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—For purposes of this section, rules similar to the rules of section 213(d)(6) shall apply with respect to any contract for qualified health insurance under which amounts are payable for coverage of an individual other than the taxpayer and qualifying family members.

(8) TREATMENT OF PAYMENTS.—For purposes of this section—

(A) PAYMENTS BY SECRETARY.—Payments made by the Secretary on behalf of any individual under section 7527 (relating to advance payment of credit for health insurance costs of eligible individuals) shall be treated as having been made by the taxpayer on the first day of the month for which such payment was made.

(B) PAYMENTS BY TAXPAYER.—Payments made by the taxpayer for eligible coverage months shall be treated as

having been made by the taxpayer on the first day of the month for which such payment was made.

(9) COBRA PREMIUM ASSISTANCE.—In the case of an assistance eligible individual who receives premium reduction for COBRA continuation coverage under section 3001(a) of title III of division B of the American Recovery and Reinvestment Act of 2009 for any month during the taxable year, such individual shall not be treated as an eligible individual, a certified individual, or a qualifying family member for purposes of this section or section 7527 with respect to such month.

(10) CONTINUED QUALIFICATION OF FAMILY MEMBERS AFTER CERTAIN EVENTS.—

(A) MEDICARE ELIGIBILITY.—In the case of any month which would be an eligible coverage month with respect to an eligible individual but for subsection (f)(2)(A), such month shall be treated as an eligible coverage month with respect to such eligible individual solely for purposes of determining the amount of the credit under this section with respect to any qualifying family members of such individual (and any advance payment of such credit under section 7527). This subparagraph shall only apply with respect to the first 24 months after such eligible individual is first entitled to the benefits described in subsection (f)(2)(A).

(B) DIVORCE.—In the case of the finalization of a divorce between an eligible individual and such individual's spouse, such spouse shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such finalization, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such finalization.

(C) DEATH.—In the case of the death of an eligible individual—

(i) any spouse of such individual (determined at the time of such death) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that the only qualifying family members who may be taken into account with respect to such spouse are those individuals who were qualifying family members immediately before such death, and

(ii) any individual who was a qualifying family member of the decedent immediately before such death (or, in the case of an individual to whom paragraph (4) applies, the taxpayer to whom the deduction under section 151 is allowable) shall be treated as an eligible individual for purposes of this section and section 7527 for a period of 24 months beginning with the date of such death, except that in determining the amount of such credit only such qualifying family member may be taken into account.

(11) ELECTION.—

(A) IN GENERAL.—This section shall not apply to any taxpayer for any eligible coverage month unless such taxpayer elects the application of this section for such month.

(B) TIMING AND APPLICABILITY OF ELECTION.—Except as the Secretary may provide—

(i) an election to have this section apply for any eligible coverage month in a taxable year shall be made not later than the due date (including extensions) for the return of tax for the taxable year; and

(ii) any election for this section to apply for an eligible coverage month shall apply for all subsequent eligible coverage months in the taxable year and, once made, shall be irrevocable with respect to such months.

(12) COORDINATION WITH PREMIUM TAX CREDIT.—

(A) IN GENERAL.—An eligible coverage month to which the election under paragraph (11) applies shall not be treated as a coverage month (as defined in section 36B(c)(2)) for purposes of section 36B with respect to the taxpayer.

(B) COORDINATION WITH ADVANCE PAYMENTS OF PREMIUM TAX CREDIT.—In the case of a taxpayer who makes the election under paragraph (11) with respect to any eligible coverage month in a taxable year or on behalf of whom any advance payment is made under section 7527 with respect to any month in such taxable year—

(i) the tax imposed by this chapter for the taxable year shall be increased by the excess, if any, of—

(I) the sum of any advance payments made on behalf of the taxpayer under section 1412 of the Patient Protection and Affordable Care Act and section 7527 for months during such taxable year, over

(II) the sum of the credits allowed under this section (determined without regard to paragraph (1)) and section 36B (determined without regard to subsection (f)(1) thereof) for such taxable year; and

(ii) section 36B(f)(2) shall not apply with respect to such taxpayer for such taxable year**[**, except that if such taxpayer received any advance payments under section 7527 for any month in such taxable year and is later allowed a credit under section 36B for such taxable year, then section 36B(f)(2)(B) shall be applied by substituting the amount determined under clause (i) for the amount determined under section 36B(f)(2)(A).**]**.

(13) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section, section 6050T, and section 7527.

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

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

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

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

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

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

(B) the excess (if any) of—

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

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

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

(A) APPLICABLE PERCENTAGE.—

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

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

(ii) INDEXING.—

(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for

the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

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

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

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

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides—

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

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

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

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

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

(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if

each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

(D) ADDITIONAL BENEFITS.—If—

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

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

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

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

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

(1) APPLICABLE TAXPAYER.—

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

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

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

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

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

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

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

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

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

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

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

(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

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

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

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

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

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

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

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

(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

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

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

(3) DEFINITIONS AND OTHER RULES.—

(A) QUALIFIED HEALTH PLAN.—The term "qualified health plan" has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

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

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

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

(2) HOUSEHOLD INCOME.—

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

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

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

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

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

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

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

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

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

(3) POVERTY LINE.—

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

(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

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

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

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

(i) A method under which—

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

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

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

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

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

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

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

(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

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

[(2) EXCESS ADVANCE PAYMENTS.—]

[(A) IN GENERAL.—If the]

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

[(B) LIMITATION ON INCREASE.—

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

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

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

[(I) such dollar amount, multiplied by

[(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2013" for "calendar year 1992" in subparagraph (B) thereof.

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

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

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

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

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

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

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

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

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

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

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

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## VII. DISSENTING VIEWS

With the economy still recovering and hardworking Americans feeling left behind, we should be focusing in our Committee on proposals to grow the economy, create good-paying jobs, and strengthen the programs that reduce poverty and protect children and seniors, not tearing those very programs apart. This bill was part of a misguided effort to win support from extreme, right-wing Republicans for their party's budget resolution. Committee Democrats strongly oppose both this specific bill and the general tactic of appeasing hardliners by offering legislation that harms seniors, children, and Americans trying to work their way out of poverty and obtain health coverage for their families.

We oppose H.R. 4723—the Protecting Taxpayers by Recovering Obamacare Subsidy Overpayments Act. Rather than protecting taxpayers, this bill really serves to scare families away from obtaining coverage under the Affordable Care Act (ACA).

The ACA provides advanceable tax credits, payable directly to health insurance companies, so that families receive real-time assistance in purchasing health coverage. This is a critical component of the health care reform law because a credit available several months after the close of the coverage and tax year is far too late to help most families afford coverage. In fact, 83 percent of people (10.5 million) who selected coverage through the ACA Marketplaces for 2016 receive advanced premium tax credits.

The credits are advanced based on a family's estimated income and family size, since the actual income and family size for a tax and coverage year is not known until the end of that year. Sensibly, the ACA requires families to report changes in status during the tax and coverage year so that increases and decreases in income and family size are reflected in the credit that is advanced.

The ACA also requires reconciliation of the advanced credits with the credit that a family is entitled to, based on the actual income and family size for the tax and coverage year. If too much credit has been advanced, families must pay back some or all of the advanced credit, depending on income; if too little credit has been advanced, families will receive additional credit on their tax return.

Sensibly, the ACA places limits on the amount of repayment that families face so that they are not discouraged from applying for the advanceable credits that are crucial to coverage affordability. Families cannot predict the future—tellingly, for the 2014 tax and coverage year, only 8% of taxpayers were able to accurately predict their family size and income for the year ahead such that their advanced credits were equal to the actual credits to which they were entitled.

H.R. 4723 would completely repeal the ACA's protections that limit the repayment burden for advanced premium tax credits if a person's circumstances change.

The Joint Committee on Taxation estimates that H.R. 4723 will result in 220,000 to 250,000 Americans losing health coverage. This is because they would rather forgo coverage than be faced with a large year-end tax bill.

H.R. 4723 is not a sensible change to the ACA. This is moving reform backward—not forward.

SANDER M. LEVIN,
*Ranking Member.*

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