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115TH CONGRESS, 1st Session | HOUSE OF REPRESENTATIVES | REPORT 115–160

BROADER OPTIONS FOR AMERICANS ACT

JUNE 2, 2017.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 2579]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2579) to amend the Internal Revenue Code of 1986 to allow the premium tax credit with respect to unsubsidized COBRA continuation coverage, 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 "Broader Options for Americans Act".

SEC. 2. PREMIUM TAX CREDIT ALLOWED WITH RESPECT TO UNSUBSIDIZED COBRA CONTINUATION COVERAGE.

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

(1) by inserting after "in section 9832(b))" the following: "offered in the individual health insurance market within a State (within the meaning of section 5000A(f)(1)(C)), or any unsubsidized COBRA continuation coverage,", and

(2) by striking paragraph (1) and by redesignating paragraphs (2), (3), (4), and (5) as paragraphs (1), (2), (3), and (4), respectively.

(b) CERTIFICATION OF UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—Section 36B(g) of such Code is amended by redesignating paragraph (9) as paragraph (10) and by inserting after paragraph (8) the following new paragraph:

"(9) SPECIAL RULE FOR UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—In the case of unsubsidized COBRA continuation coverage—

"(A) subsection (d)(1) shall be applied by substituting 'COBRA continuation coverage which is certified by the plan administrator (as defined in section 414(g)) of the group health plan' for 'health insurance coverage which is certified by the State in which such insurance is offered', and

"(B) the requirements of paragraph (8) shall be treated as satisfied if the certification meets such requirements as the Secretary may provide.".

(c) UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—Section 36B of such Code is amended by adding at the end the following new subsection:

"(h) UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'unsubsidized COBRA continuation coverage' means COBRA continuation coverage the payment of applicable premiums (as defined in section 4980B(f)(4)) for which is solely the obligation of the taxpayer.

"(2) COBRA CONTINUATION COVERAGE.—The term 'COBRA continuation coverage' means continuation coverage provided—

"(A) pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under sections 602(5) and 609), title XXII of the Public Health Service Act, section 4980B (other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines), or section 8905a of title 5, United States Code,

"(B) under a State law or program that provides coverage comparable to coverage described in subparagraph (A), or

"(C) under a group health plan that is a church plan (as defined in section 414(e)) and is comparable to coverage provided pursuant to section 4980B.

Such term shall not include coverage under a health flexible spending arrangement.".

(d) CONFORMING AMENDMENT.—

(1) Section 36B(d)(2)(A) is amended by inserting "COBRA continuation coverage or" after "other than".

(2) Section 36B(g)(6) of such Code is amended by striking "subsection (f)(5)" and inserting "subsection (f)(4)".

(e) AMENDMENT OF SECTION 36B AS AMENDED BY AMERICAN HEALTH CARE ACT OF 2017.—Whenever in this section an amendment is expressed in terms of an amendment to section 36B of the Internal Revenue Code of 1986, the reference shall be considered to be made to such section as amended by the American Health Care Act of 2017 and in effect for months beginning after December 31, 2019.

(f) EFFECTIVE DATE.—The amendments made by this section are contingent upon the enactment of the American Health Care Act of 2017 and shall apply (if at all)

to months beginning after December 31, 2019, in taxable years ending after such date.

I. SUMMARY AND BACKGROUND

A. Purpose and Summary

The bill, H.R. 2579, as reported by the Committee on Ways and Means, amends section 214 of H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017, which provides a tax credit under the Internal Revenue Code ("Code")[1] for the purchase of health insurance in the individual market, so that the credit is available also with respect to unsubsidized COBRA continuation coverage under an employer-sponsored health plan.

B. Background and Need for Legislation

Under section 214 of the American Health Care Act of 2017, effective for months beginning after December 31, 2019, in taxable years ending after that date, individuals who purchase health insurance in a State individual insurance market may receive a refundable tax credit. Under the rules for COBRA continuation coverage, an individual may continue to receive coverage under an employer-sponsored health plan after an event that would otherwise end coverage, such as a termination of employment. Although employers generally subsidize the cost of health coverage for active employees, employer subsidies generally are not provided to individuals receiving COBRA continuation coverage. Instead, the individual must pay the full cost of the COBRA coverage. The bill amends the American Health Care Act of 2017 to allow such an individual to receive the refundable tax credit with respect to unsubsidized COBRA continuation coverage.

On March 8, 2017, in fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee marked up Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy. This submission allowed eligible individuals to receive the refundable tax credit with respect to unsubsidized COBRA continuation coverage. However, that language was later removed at the Committee on Rules in order to comply with Senate guidance regarding the Reconciliation process.

C. Legislative History

Background

H.R. 2579 was introduced on May 19, 2017, and was referred to the Committee on Ways and Means.

Committee action

The Committee on Ways and Means marked up H.R. 2579, the Broader Options for Americans Act, on May 24, 2017, and ordered

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

the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

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

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

II. EXPLANATION OF THE BILL

A. Premium Tax Credit Allowed With Respect to Unsubsidized COBRA Continuation Coverage

PRESENT LAW

Premium assistance credit

A refundable tax credit ("premium assistance credit") is provided for eligible individuals and families to subsidize the purchase of health insurance plans through an American Health Benefit Exchange ("Exchange"), referred to as "qualified health plans."[2] In general, advance payments with respect to the premium assistance credit are made during the year directly to the insurer.[3] However, eligible individuals may choose to pay their total health insurance premiums without advance payments and claim the credit at the end of the taxable year.

The premium assistance credit is generally available for individuals (single or joint filers) with household incomes between 100 and 400 percent of the Federal poverty level ("FPL") for the family size involved.[4] Household income is defined as the sum of: (1) the individual's modified adjusted gross income, plus (2) the aggregate modified adjusted gross incomes of all other individuals taken into account in determining the individual's family size (but only if the other individuals are required to file a tax return for the taxable year). Modified adjusted gross income is defined as adjusted gross income increased by: (1) any amount excluded from gross income for citizens or residents living abroad,[5] (2) any tax-exempt interest

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

[3] PPACA sections 1411–1412 provide rules relating to eligibility for and receipt of advance payments.

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

[5] Sec. 911.

received or accrued during the tax year, and (3) the portion of the individual's social security benefits not included in gross income.[6] To be eligible for the premium assistance credit, individuals who are married must file a joint return. Individuals who are listed as dependents on a return are not eligible for the premium assistance credit.

COBRA continuation coverage requirements

Employer-sponsored health plans (referred to as "group health plans"[7]) generally are required to offer an employee, spouse or dependent child covered by the plan the opportunity to continue coverage under the plan for a specified period of time after the occurrence of certain events that otherwise would have terminated the coverage ("qualifying events").[8] These continuation coverage requirements are often referred to as "COBRA continuation coverage" or "COBRA" requirements.[9] The premium charged an individual for COBRA continuation coverage cannot exceed 102 percent of the "applicable premium," that is, it cannot exceed 102 percent of the cost to the plan of providing coverage to a similarly situated individual who has not experienced a qualifying event. In the case of a failure to comply with the COBRA continuation coverage requirements under the Code, an excise tax may apply to the employer maintaining the group health plan or, in the case of a multiemployer group health plan, to the plan.

COBRA continuation requirements generally apply also under the Employee Retirement Income Security Act of 1974 ("ERISA") to group health plans covering employees of private employers, other than church plans, and under the Public Health Service Act ("PHSA") to group health plans covering State or local government employees. Similar requirements (referred to as "temporary continuation coverage" or "TCC") apply with respect to coverage under the Federal Employees Health Benefit Program ("FEHBP").[10] In addition, some State laws apply similar continuation coverage requirements with respect to employer-sponsored health plans. In some cases, church plans provide for similar continuation coverage, regardless of whether legally required.

Responsibility for the administration of an employee benefit plan, including a group health plan, generally lies with the plan administrator. Plan administrator is defined as the person specifically designated as plan administrator by the terms of the plan, or, in the absence of a designation, (1) in the case of a plan maintained by a single employer, the employer, (2) in the case of a plan maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representa-

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

[7] A group health plan may include a health flexible spending arrangement, under which medical care expenses of an employee (and family members, if applicable) that are not covered by insurance may be paid or reimbursed.

[8] Sec. 4980B. Section 4980B(d) provides exceptions for plans maintained by employers with fewer than 20 employees, plans of governmental employers, and church plans.

[9] The COBRA requirements were originally enacted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99–272.

[10] 5 U.S.C. sec. 8905a.

tives of the parties who maintained the plan, or (3) in any other case, the person prescribed by regulations.[11]

THE AMERICAN HEALTH CARE ACT OF 2017

The American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017 (the "AHCA"), amends various health-related provisions of the Code.[12] Effective for months beginning after December 31, 2019, in taxable years ending after that date, the AHCA replaces the present-law premium assistance credit with a new credit and provides a new definition of "qualified health plan" to which the new credit applies.[13] Under the AHCA, qualified health plan means health insurance coverage [14] that is offered in the individual health insurance market within a State and that meets certain other requirements.[15] In order for an individual to be eligible for the new credit, the health insurance coverage must be certified by the State in which the insurance is offered as meeting the qualified health plan requirements.[16] A State certification will not be taken into account for this purpose unless the certification is made available to the public and meets such other requirements as the Secretary of the Treasury ("Secretary") may provide.[17]

REASONS FOR CHANGE

COBRA continuation coverage provides a transition period during which an individual can continue, under an employer's health plan, to receive the same coverage and care from the same providers, rather than immediately having to research and enroll in coverage available from another source. However, individuals enrolled in COBRA coverage generally do not receive an employer subsidy for the cost of the coverage and must instead pay the entire cost themselves. Such cost may make it difficult for the individual to afford COBRA continuation coverage. The Committee therefore wishes to facilitate the purchase of COBRA continuation coverage by expanding the AHCA credit to apply with respect to unsubsidized COBRA coverage.

EXPLANATION OF PROVISION

The provision amends the definition of qualified health plan under the provision of the AHCA relating to the new premium assistance credit to include unsubsidized COBRA continuation coverage. For this purpose, COBRA continuation coverage generally

[11] Sec. 414(g). In some cases, a plan sponsor or plan administrator may contract for administrative services by a separate service provider, often referred to as a third-party administrator or "TPA." However, a TPA does not necessarily assume the legal status of plan administrator.

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

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

[14] Health insurance coverage is defined in section 9832(b) and means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer. Health insurance issuer means an insurance company, insurance service, or insurance organization (including a health maintenance organization) that is licensed to engage in the business of insurance in a State and which is subject to State law regulating insurance. A group health plan is not a health insurance issuer.

[15] Section 36B(f) as amended by AHCA section 214.

[16] Section 36B(d)(1) as amended by AHCA section 214.

[17] Section 36B(g)(8) as amended by AHCA section 214.

means continuation coverage provided under the Code, ERISA, the PHSA, or the FEHBP. It also includes coverage under a State law or program that provides comparable continuation coverage and continuation coverage under a church plan that is comparable to COBRA coverage. It does not include coverage under a health flexible spending arrangement. Unsubsidized COBRA continuation coverage means COBRA continuation coverage, the payment of the applicable premiums for which is solely the obligation of the taxpayer. In the case of COBRA continuation coverage, the plan administrator of the group health plan must certify that the coverage meets the qualified health plan requirements, and the certification must meet requirements provided by the Secretary.

EFFECTIVE DATE

The provision is contingent on enactment of the AHCA and will apply (if at all) to months beginning after December 31, 2019, in taxable years ending after that date.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the vote of the Committee on Ways and Means in its consideration of H.R. 2579, the "Broader Options for Americans Act," on May 24, 2017.

The legislation was ordered favorably transmitted to the House of Representatives as amended by a roll call vote of 23 yeas and 15 nays (with a quorum being present). The vote was as follows:

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

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. 2579, as reported.

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

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

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

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee states that the bill involves no new or increased budget authority. The Committee further states that the revenue provisions of the bill do not increase or decrease tax expenditures.

C. Cost Estimate Prepared by the Congressional Budget Office

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

U.S. Congress,
Congressional Budget Office,
Washington, DC, June 1, 2017.

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

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2579, the Broader Options for Americans Act.

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

Sincerely,

Keith Hall, *Director.*

Enclosure.

H.R. 2579—Broader Options for Americans Act

H.R. 2579 would amend certain health-related provisions of the Internal Revenue Code, contingent upon enactment of the American Health Care Act of 2017 (AHCA). Under current law, employment-based health plans are generally required to offer employees and their families the option to continue coverage, without any sub-

sidy from the employer, for a period of time following certain events that would have terminated the coverage, such as the employee no longer working for the employer. Under AHCA, the premium assistance tax credit allowed under current law would be replaced by a new credit and a new definition of qualified health plans to which the new credit would apply. H.R. 2579 would amend provisions of AHCA to include unsubsidized continuation coverage under the new definition of qualified health plans, allowing people covered by such a plan to receive the new credits.

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

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

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

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

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

A. Committee Oversight Findings and Recommendations

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

B. Statement of General Performance Goals and Objectives

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

C. Information Relating to Unfunded Mandates

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

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

D. Applicability of House Rule XXI 5(b)

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

E. Tax Complexity Analysis

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

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

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

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

G. Duplication of Federal Programs

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

H. Disclosure of Directed Rule Makings

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

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

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

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

INTERNAL REVENUE CODE OF 1986

* * * * * * *

Subtitle A—Income Taxes

* * * * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter A—Determination of Tax Liability

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PART IV—CREDITS AGAINST TAX

* * * * * * *

Subpart C—Refundable Credits

* * * * * * *

[The following shows current law section 36B of the Internal Revenue Code of 1986:**]**

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

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

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

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

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

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

(B) the excess (if any) of—

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

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

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

(A) APPLICABLE PERCENTAGE.—

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

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

(ii) INDEXING.—

(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any 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.

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

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

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

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

(i) the excess of—

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

(II) 1/12 of the employee's permitted benefit (as defined in section 9831(d)(3)(C)) under such arrangement, does not exceed—

(ii) 1/12 of 9.5 percent of the employee's household income.

(D) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—For purposes of this paragraph, the

term "qualified small employer health reimbursement arrangement" has the meaning given such term by section 9831(d)(2).

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

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

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

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

(2) HOUSEHOLD INCOME.—

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

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

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

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

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

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

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

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

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

(3) POVERTY LINE.—

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

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

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

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

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

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

(i) A method under which—

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

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

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

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

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

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

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

(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

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

(2) EXCESS ADVANCE PAYMENTS.—

(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph

(1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

(B) LIMITATION ON INCREASE.—

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

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

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

(I) such dollar amount, multiplied by

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) MONTHLY CREDIT AMOUNTS.—

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

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

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

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

(c) MONTHLY LIMITATION AMOUNTS.—

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

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

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

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

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

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

(2) LIMITATION BASED ON MODIFIED ADJUSTED GROSS INCOME.—The credit allowed under subsection (a) with respect to

any taxpayer for any taxable year shall be reduced (but not below zero) by 10 percent of the excess (if any) of—

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

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

(3) OTHER LIMITATIONS.—

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

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

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

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

(2) The individual is not eligible for—

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

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

(3) The individual is either—

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

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

(4) The individual is not incarcerated, other than incarceration pending the disposition of charges.

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

(1) in the case of a joint return, the taxpayer's spouse,

(2) any dependent of the taxpayer, and

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

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

surance market within a State (within the meaning of section 5000A(f)(1)(C)), or any unsubsidized COBRA continuation coverage, if—

[(1) such coverage is offered in the individual health insurance market within a State (within the meaning of section 5000A(f)(1)(C)),]

[(2)] *(1)* substantially all of such coverage is not of excepted benefits described in section 9832(c),

[(3)] *(2)* such coverage does not consist of short-term limited duration insurance (within the meaning of section 2791(b)(5) of the Public Health Service Act),

[(4)] *(3)* such coverage is not a grandfathered health plan (as defined in section 1251 of the Patient Protection and Affordable Care Act) or a grandmothered health plan (as defined in section 36B(c)(3)(C) as in effect for taxable years beginning before January 1, 2020), and

[(5)] *(4)* such coverage does not include coverage for abortions (other than any abortion necessary to save the life of the mother or any abortion with respect to a pregnancy that is the result of an act of rape or incest).

(g) SPECIAL RULES.—

(1) MARRIED COUPLES MUST FILE JOINT RETURN.—

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

(B) EXCEPTION FOR CERTAIN TAXPAYERS.—Subparagraph (A) shall not apply to any married taxpayer who—

(i) is living apart from the taxpayer's spouse at the time the taxpayer files the tax return,

(ii) is unable to file a joint return because such taxpayer is a victim of domestic abuse or spousal abandonment,

(iii) certifies on the tax return that such taxpayer meets the requirements of clauses (i) and (ii), and

(iv) has not met the requirements of clauses (i), (ii), and (iii) for each of the 3 preceding taxable years.

(2) DENIAL OF CREDIT TO DEPENDENTS.—

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

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

such individual for such month shall be taken into account.

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

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

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

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

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

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

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

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

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

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

(6) CERTAIN RULES RELATED TO NONQUALIFIED HEALTH PLANS.—The rules of section 36B(c)(3)(D), as in effect for taxable years beginning before January 1, 2020, shall apply with respect to subsection [(f)(5)] *(f)(4)*.

(7) INFLATION ADJUSTMENT.—

(A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2020, each dollar amount in subsection (c)(1), the $75,000 amount in subsection

(c)(2)(B), and the dollar amount in subsection (c)(3)(A), shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined—

(I) by substituting "calendar year 2019" for "calendar year 1992" in subparagraph (B) thereof, and

(II) by substituting for the CPI referred to section 1(f)(3)(A) the amount that such CPI would have been if the annual percentage increase in CPI with respect to each year after 2019 had been one percentage point greater.

(B) TERMS RELATED TO CPI.—

(i) ANNUAL PERCENTAGE INCREASE.—For purposes of subparagraph (A)(ii)(II), the term "annual percentage increase" means the percentage (if any) by which CPI for any year exceeds CPI for the prior year.

(ii) OTHER TERMS.—Terms used in this paragraph which are also used in section 1(f)(3) shall have the same meanings as when used in such section.

(C) ROUNDING.—Any increase determined under subparagraph (A) shall be rounded to the nearest multiple of $50.

(8) RULES RELATED TO STATE CERTIFICATION OF QUALIFIED HEALTH PLANS.—A certification shall not be taken into account under subsection (d)(1) unless such certification is made available to the public and meets such other requirements as the Secretary may provide.

(9) SPECIAL RULE FOR UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—In the case of unsubsidized COBRA continuation coverage—

(A) subsection (d)(1) shall be applied by substituting "COBRA continuation coverage which is certified by the plan administrator (as defined in section 414(g)) of the group health plan" for "health insurance coverage which is certified by the State in which such insurance is offered", and

(B) the requirements of paragraph (8) shall be treated as satisfied if the certification meets such requirements as the Secretary may provide.

[(9)**]** *(10)* REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be necessary or appropriate to carry out this section and section 1412 of the Patient Protection and Affordable Care Act.

(h) UNSUBSIDIZED COBRA CONTINUATION COVERAGE.—For purposes of this section—

(1) IN GENERAL.—The term "unsubsidized COBRA continuation coverage" means COBRA continuation coverage the payment of applicable premiums (as defined in section 4980B(f)(4)) for which is solely the obligation of the taxpayer.

(2) COBRA CONTINUATION COVERAGE.—The term "COBRA continuation coverage" means continuation coverage provided—

(A) pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than

under sections 602(5) and 609), title XXII of the Public Health Service Act, section 4980B (other than subsection (f)(1) thereof insofar as it relates to pediatric vaccines), or section 8905a of title 5, United States Code,

(B) under a State law or program that provides coverage comparable to coverage described in subparagraph (A), or

(C) under a group health plan that is a church plan (as defined in section 414(e)) and is comparable to coverage provided pursuant to section 4980B.

Such term shall not include coverage under a health flexible spending arrangement.

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VII. DISSENTING VIEWS

H.R. 2579 (Tiberi, R–OH) amends H.R. 1628, the American Health Care Act (AHCA), to allow people to receive tax credits for Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage if they have elected their COBRA coverage upon separation from employment and are paying the entire premium out of pocket. H.R. 2579 amends a bill that has not yet passed the Senate or become law.

COBRA requires employers to offer eligible employees who lose their health benefits due to a qualifying event (e.g., loss of a job) to continue group health insurance benefits for up to 18 months at the employee's own cost. Under COBRA, an individual pays the full cost of the premiums plus a two percent (2%) administrative fee. Most individuals eligible for COBRA do not select this coverage option because of the high, unsubsidized cost at a time when income is often declining. Prior to the Affordable Care Act (ACA) market reforms, COBRA was important for individuals leaving a job who were often unable to access affordable individual market health insurance because of pre-existing conditions and underwriting. While COBRA remains important for some families, because individuals separating from their employers have had access to coverage in the individual market without concerns about underwriting, pre-existing condition discrimination or outright denial of coverage, coupled with the availability of premium subsidies, COBRA coverage has declined in importance.

Under current law, individuals separating from their employer may be eligible for financial assistance to purchase coverage through the ACA exchanges. The advanced premium tax credits are adjusted for the cost of the insurance, as well as income. Individuals who separate from their employer and are eligible for unsubsidized COBRA are eligible for premium tax credits for marketplace plans as they no longer have an offer of employer-sponsored coverage.

H.R. 2579 does not address the underlying harm and inadequacies in the AHCA. H.R. 2579 does nothing to improve the inadequate tax credits under AHCA, which are unlikely to provide meaningful assistance for the individual market or for COBRA plans. AHCA also repeals the cost-sharing assistance that helps Americans afford the out-of-pocket costs associated with medical visits. AHCA allows insurance companies to discriminate against older workers by charging five times or more what they charge younger people; the result is lower quality coverage and higher out of pocket costs for older Americans by nearly 70 percent. Middle-class families could be particularly hard hit by this bill, while millionaires and billionaires would get a tax cut.

Potential for harm of employer group health insurance risk pools. The underlying Republican bill, AHCA, passed without a hearing

or any opportunity for public comment. Employer and their current employees and retirees could be negatively impacted by this proposal as it could encourage older sicker workers to remain in the risk pool for longer periods of time. For a large employer this might not present a burden, but for a smaller employer, retaining former employees on the insurance plan could increase premiums. However, the Committee does not know whether this is the case because the proposal was not examined prior to Committee action.

H.R. 2579 is another Republican attempt to distract from the underlying problems with the AHCA. The AHCA would cause 23 million Americans to lose health insurance coverage, erode important consumer protections and raise costs for countless more Americans. Higher costs and less coverage. All the while the AHCA provides a huge tax giveaway to the wealthiest. In fact, the 400 wealthiest Americans would get a $7 million tax cut every year. The Republicans put billionaires ahead of working families, and H.R. 2579 does nothing to fix the underlying bill's significant problems. For these reasons we oppose the AHCA, H.R. 2579, and any amendments that do not address the underlying problems with the legislation.

RICHARD E. NEAL,
Ranking Member.

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