

VERIFY FIRST 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. 2581]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2581) to amend the Internal Revenue Code of 1986 to require the provision of Social Security numbers as a condition of receiving the health insurance premium tax credit, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Verify First Act”.

SEC. 2. VERIFICATION OF STATUS IN UNITED STATES AS CONDITION OF RECEIVING ADVANCE PAYMENT OF HEALTH INSURANCE PREMIUM TAX CREDIT.

(a) APPLICATION TO CURRENT HEALTH INSURANCE PREMIUM TAX CREDIT.—Section 36B of the Internal Revenue Code of 1986, as in effect for months beginning before January 1, 2020, is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

“(g) VERIFICATION OF STATUS IN UNITED STATES FOR ADVANCE PAYMENT.—No advance payment of the credit allowed under this section with respect to any premium under subsection (b)(2)(A) with respect to any individual shall be made under section 1412 of the Patient Protection and Affordable Care Act unless the Secretary has received confirmation from the Secretary of Health and Human Services that the Commissioner of Social Security or the Secretary of Homeland Security has verified under section 1411(c)(2) of such Act the individual’s status as a citizen or national of the United States or an alien lawfully present in the United States using a process that includes the appropriate use of information related to citizenship or immigration status, such as social security account numbers (but not individual taxpayer identification numbers).”.

(b) APPLICATION TO NEW HEALTH INSURANCE PREMIUM TAX CREDIT.—Section 36B of the Internal Revenue Code of 1986, as amended by the American Health Care Act of 2017 and in effect for months beginning after December 31, 2019, is amended by adding at the end the following new subsection:

“(h) VERIFICATION OF STATUS IN UNITED STATES FOR ADVANCE PAYMENT.—No advance payment of the credit allowed under this section with respect to any amount under subparagraph (A) or (B) of subsection (b)(1) with respect to any individual shall be made under section 1412 of the Patient Protection and Affordable Care Act unless the Secretary has received confirmation from the Secretary of Health and Human Services that the Commissioner of Social Security or the Secretary of Homeland Security has verified under section 1411(c)(2) of such Act the individual’s status as a citizen or national of the United States or 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)) using a process that includes the appropriate use of information related to citizenship or immigration status, such as social security account numbers (but not individual taxpayer identification numbers).”.

(c) CONFORMING AMENDMENT ON CONTINUOUS HEALTH INSURANCE COVERAGE PROVISION.—Section 2710A(b)(1) of the Public Health Service Act, as added by section 133 of the American Health Care Act of 2017, is amended by adding after subparagraph (C) the following:

“In the case of an individual who applies for advance payment of a credit under section 1412 of the Patient Protection and Affordable Care Act and for whom a determination of eligibility for such advance payment is delayed by reason of the requirement for verification of the individual’s status in the United States under section 1411(c)(2) of such Act, the period of days beginning with the date of application for advance payment and ending with the date of such verification shall not be taken into account in applying subparagraph (B). The Secretary shall establish a procedure by which information relating to this period is provided to the individual.”.

(d) DELAY PERMITTED IN COVERAGE DATE IN CASE OF DELAY IN VERIFICATION OF STATUS FOR INDIVIDUALS APPLYING FOR ADVANCE PAYMENT OF CREDIT.—Section 1411(e) of the Patient Protection and Affordable Care Act (42 U.S.C. 18081(e)) is amended—

(1) in paragraph (3), by inserting after “applicant’s eligibility” the following: “other than eligibility for advance payment of a credit under section 1412”;

and

(2) by adding at the end the following new paragraph:

“(5) DELAY PERMITTED IN COVERAGE DATE IN CASE OF DELAY IN VERIFICATION OF STATUS FOR INDIVIDUALS APPLYING FOR ADVANCE PAYMENT OF CREDIT.—In the case of an individual whose eligibility for advance payments is delayed by reason of the requirement for verification under subsection (c)(2), if, for coverage to be effective as of the date requested in the individual’s application for enrollment, the individual would (but for this paragraph) be required to pay 2 or more months of retroactive premiums, the individual shall be provided the option to elect to postpone the effective date of coverage to the date that is not more than 1 month later than the date requested in the individual’s application for enrollment.”

(e) EFFECTIVE DATES.—

(1) APPLICATION TO CURRENT HEALTH INSURANCE PREMIUM TAX CREDIT.—The amendment made by subsection (a) is contingent upon the enactment of the American Health Care Act of 2017 and shall apply (if at all) to months beginning after December 31, 2017.

(2) APPLICATION TO NEW HEALTH INSURANCE PREMIUM TAX CREDIT.—The amendment made by subsection (b) is contingent upon the enactment of the American Health Care Act of 2017 and shall apply (if at all) to months beginning after December 31, 2019, in taxable years ending after such date.

(3) CONFORMING AMENDMENT ON CONTINUOUS HEALTH INSURANCE COVERAGE PROVISION.—The amendment made by subsection (c) is contingent upon the enactment of the American Health Care Act of 2017 and shall take effect (if at all) as if included in such Act.

(4) FLEXIBILITY IN COVERAGE DATE IN CASE OF DELAY IN VERIFICATION OF STATUS.—The amendment made by subsection (d) is contingent upon the enactment of the American Health Care Act of 2017 and shall apply (if at all) to applications for advance payments for months beginning after December 31, 2017.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 2581, as reported by the Committee on Ways and Means, amends the premium tax credit under section 36B of the Internal Revenue Code (“Code”),¹ to specify that advance payments of the credit are not to be made with respect to an individual unless the Secretary of the Treasury has confirmed with the Secretary of Health and Human Services that the individual’s status as a citizen or national of the United States, or as lawfully present in the United States, has been verified. In addition, H.R. 2581, as reported by the Committee on Ways and Means, amends H.R. 1628, the American Health Care Act of 2017, as passed by the House of Representatives on May 4, 2017, to provide a similar rule with respect to advance payments of a new credit for the purchase of health insurance (effective for months beginning after December 31, 2019, in taxable years ending after that date).

B. BACKGROUND AND NEED FOR LEGISLATION

Under present law and the American Health Care Act of 2017, an individual is not eligible for the premium assistance credit unless the individual is a citizen or national of the United States, or, in the case of the present law credit, lawfully present in the United States, or, in the case of the new credit under the American Health Care Act of 2017, a qualified alien. The procedures applicable with respect to advance payment of either credit require verification of the individual’s status by the Secretary of Health and Human Services before advance payments of the credit are made by the Department of the Treasury. However, existing procedures may not

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

be sufficient to ensure that proper verification has occurred. The bill therefore requires the Secretary of the Treasury to confirm such verification before making an advanced payment.

On March 8, 2017, in fulfillment of the reconciliation instructions included in section 2002 of the Concurrent Resolution on the Budget for Fiscal Year 2017 (S. Con. Res. 3), the Committee marked up Budget Reconciliation Legislative Recommendations Relating to Repeal and Replace of Health-Related Tax Policy. This submission included provisions modifying the determination and advanced payment of the refundable tax credit. However, that language was later changed at the Committee on Rules in order to comply with Senate guidance regarding the Reconciliation process.

C. LEGISLATIVE HISTORY

Background

H.R. 2581 was introduced on May 22, 2017, and was referred to the Committee on Ways and Means and the Committee on Energy and Commerce.

Committee action

The Committee on Ways and Means marked up H.R. 2581, the Verify First Act, on May 24, 2017, and ordered the bill, as amended, favorably reported (with a quorum being present).

Committee hearings

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

- March 2, 2011—Hearing on Improving Efforts to Combat Health Care Fraud
- September 11, 2012—Hearing on Internal Revenue Service’s Implementation and Administration of the Democrats’ Health Care Law
- September 12, 2012—Hearing on Implementation of Health Insurance Exchanges and Related Provisions
- December 4, 2013—Hearing on the Challenges of the Affordable Care Act
- June 10, 2014—Verification of Income and Insurance Information under 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. VERIFICATION OF STATUS IN UNITED STATES AS CONDITION OF RECEIVING ADVANCE PAYMENT OF HEALTH INSURANCE PREMIUM TAX CREDIT

PRESENT LAW

Premium assistance credit

In general

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, as discussed below, advance payments with respect to the premium assistance credit are made during the year directly to the insurer. 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.³ 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,⁴ (2) any tax-exempt interest received or accrued during the tax year, and (3) the portion of the individual’s social security benefits not included in gross income.⁵ 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.

In order to enroll in a qualified health plan through an Exchange and receive the premium assistance credit, an individual must be a citizen or national of the United States or an alien lawfully present in the United States.⁶

Advance payments and reconciliation on tax return

As part of the process of enrollment in a qualified health plan through an Exchange, an individual may apply and be approved for advance payments with respect to a premium assistance credit

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

³Federal 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>.

⁴Sec. 911.

⁵Under section 86, only a portion of an individual’s social security benefits are included in gross income.

⁶PPACA sec. 1312(f)(3) and sec. 36B(e)(2).

(“advance payments”).⁷ The individual must provide information on income, family size, changes in marital or family status or income, and U.S. citizen, national or lawfully present status. The Exchange process includes a system through which the Secretary of Health and Human Services (“HHS”) verifies information provided by the individual using information from certain Federal agencies and other sources. U.S. citizen, national or lawfully present status is verified by obtaining information from the Commissioner of Social Security and the Secretary of Homeland Security.⁸ If an individual is approved for advance payments, the Department of the Treasury pays the advance amount directly to the issuer of the health plan in which the individual is enrolled. The individual then pays to the issuer of the plan the difference, if any, between the advance payment amount and the total premium charged for the plan.

An individual 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 individual is entitled for the taxable year.

If the advance payments of the premium assistance credit exceed the amount of credit to which the individual is entitled, the excess (“excess advance payments”) is treated as an additional tax liability on the individual’s income tax return for the taxable year (referred to as “recapture”), subject to a limit on the amount of additional liability in some cases. For an individual with household income below 400 percent of FPL, liability for the excess advance payments for a taxable year is limited to a specific dollar amount (the “applicable dollar amount”) as shown in the table below. One-half of the applicable dollar amount shown in the table below applies to an unmarried individual who is not a surviving spouse or filing as a head of household.

RECONCILIATION LIMIT ON ADDITIONAL TAX LIABILITY (FOR 2017)⁹

| 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 |

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

SSNs and ITINs

An individual filing a U.S. tax return is required to state his or her taxpayer identification number on the return. Generally, a taxpayer identification number is the individual’s Social Security number (“SSN”).¹⁰ However, in the case of an individual who is not eligible to be issued an SSN, but who has a tax filing obligation, the

⁷ PPACA secs. 1411–1412. The Department of Health and Human Services is responsible for rules relating to Exchanges and the eligibility determination process.

⁸ PPACA sec. 1411(c)(2).

⁹ Rev. Proc. 2016–55, 2015–45 I.R.B. 707. 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.

¹⁰ Sec. 6109(a).

Internal Revenue Service issues an individual taxpayer identification number (“ITIN”) for use in connection with the individual’s tax filing requirements.¹¹ An individual who is eligible to receive an SSN may not obtain an ITIN for purposes of his or her tax filing obligations.¹² An ITIN does not provide eligibility to work in the United States or to claim Social Security benefits.

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.¹³ 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.¹⁴ Under the AHCA, an individual is eligible for the new premium assistance credit only if the individual is a citizen or national of the United States or a qualified alien.¹⁵ In connection with the new premium assistance credit, the AHCA amends the provisions relating to advance payment of the credit to direct the Secretary of the Treasury and the Secretary of HHS to prescribe such regulations as each Secretary may deem necessary to establish and operate the advance payment program in a manner that protects taxpayer information, provides robust verification of all information necessary to establish eligibility for advance payments, ensures proper and timely payments to appropriate health providers, and protects program integrity to the maximum extent feasible.¹⁶

REASONS FOR CHANGE

The Committee is concerned that the existing verification procedures that apply with respect to citizen, national or immigration status before advance payments may be made do not adequately ensure that only eligible individuals are approved for advance payments. Erroneous advance payments represent a misuse of taxpayer funds and contribute to Federal deficits, particularly when erroneous amounts cannot be fully recovered. The Committee therefore wishes to strengthen the procedures that must be followed before advance payments can be made.

¹¹Treas. Reg. Sec. 301.6109–1(d)(3)(i).

¹²Treas. Reg. Sec. 301.6109–1(d)(3)(ii).

¹³H.R. 1628, as passed by the House of Representatives on May 4, 2017. The AHCA also amends certain provisions of the Public Health Service Act (the “PHSA”). Under present-law PHSA section 2701, premiums charged for health insurance purchased in the individual market are permitted to vary only by certain factors, such as the number of individuals covered by the insurance and, within limits, the age of the insured. This limit on premium variation is referred to as community rating. AHCA section 133 amends the PHSA to require an increase of 30 percent in the otherwise applicable premium in certain cases where an individual enrolling in health insurance coverage did not have health insurance for 63 or more consecutive days during the preceding 12-month period (sometimes referred to as the “continuous coverage” requirement). Under AHCA section 136, in certain cases where the continuous coverage requirement is not met, premiums may be based on the health status of the individual in lieu of the 30 percent premium increase.

¹⁴AHCA section 214. AHCA section 201 amends the present-law premium assistance credit to repeal the limits on recapture of excess advance payments, effective for taxable years beginning after December 31, 2017. AHCA section 202 makes other changes to the present-law premium assistance credit for periods before the new credit becomes effective.

¹⁵Qualified alien is defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. sec. 1641).

¹⁶AHCA section 214(b), adding a new PPACA section 1412(f).

EXPLANATION OF PROVISION

The provision amends the present-law premium assistance credit to specify that no advance payments are to be made with respect to an individual unless the Secretary of the Treasury has received confirmation from the Secretary of HHS that the Commissioner of Social Security or the Secretary of Homeland Security has verified the individual's status as a citizen or national of the United States or an alien lawfully present in the United States using a process that includes the appropriate use of information related to citizenship or immigration status, such as SSNs.¹⁷ The provision also amends the provision of the AHCA relating to the new premium assistance credit to add a similar requirement of confirmation that an individual's status as a citizen or national of the United States or a qualified alien has been verified.¹⁸

EFFECTIVE DATE

The provision relating to the present-law premium assistance credit is contingent on the enactment of the AHCA and will apply (if at all) to months beginning after December 31, 2017. The provision relating to the new premium assistance credit under the AHCA is contingent on the enactment of the AHCA and will apply (if at all) to months beginning after December 31, 2019, in taxable years ending after that date.¹⁹

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. 2581, the "Verify First Act," on May 24, 2017.

The vote on the amendment by Ms. Sanchez to the amendment in the nature of a substitute to H.R. 2581, which would limit the applicability of the underlying provision, was not agreed to by a roll call vote of 21 nays to 16 yeas (with a quorum being present). The vote was as follows:

¹⁷An SSN is not the sole means by which citizenship or immigration status can be verified. However, under the provision, an ITIN cannot be used to verify citizenship or immigration status.

¹⁸The bill also contains a provision that amends the continuous coverage requirement under AHCA section 133 so that, in the case of an individual for whom a determination of eligibility for advance payments is delayed by reason of the requirement to verify the individual's status under PPACA section 1411(c)(2), the period from the date of application for advance payments to the date of verification is disregarded in determining whether the individual meets the continuous coverage requirement (including for purposes of whether, under AHCA section 136, premiums can be based on the individual's health status). The bill further contains a provision that amends PPACA section 1411 to require with respect to such an individual that, if, in order for the individual's health coverage to be effective as of the date requested in the individual's application for enrollment, the individual would be required to pay retroactive premiums for two or more months, the individual must be provided the option of postponing the effective date of coverage for up to one month.

¹⁹The provision amending the continuous coverage requirement under AHCA section 133 is contingent on enactment of the AHCA and will take effect (if at all) as if included in the AHCA. The provision relating to the postponement of health coverage by an individual, for whom a determination of eligibility for advance payments is delayed by reason of the requirement to verify the individual's status under PPACA section 1411(c)(2), is contingent on enactment of the AHCA and will apply (if at all) to applications for advance payments for months beginning after December 31, 2017.

| 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 | | | | Mr. Larson | X | | |
| Mr. Buchanan | | X | | Mr. Blumenauer | X | | |
| Mr. Smith (NE) | | X | | Mr. Kind | X | | |
| Ms. Jenkins | | X | | Mr. Pascrell | X | | |
| Mr. Paulsen | | X | | Mr. Crowley | X | | |
| Mr. Marchant | | X | | Mr. Davis | X | | |
| Ms. Black | | | | Ms. Sanchez | X | | |
| Mr. Reed | | X | | Mr. Higgins | X | | |
| Mr. Kelly | | X | | Ms. Sewell | X | | |
| Mr. Renacci | | X | | Ms. DelBene | X | | |
| Mr. Meehan | | X | | Ms. Chu | X | | |
| Ms. Noem | | X | | | | | |
| Mr. Holding | | X | | | | | |
| Mr. Smith (MO) | | X | | | | | |
| Mr. Rice | | X | | | | | |
| Mr. Schweikert | | X | | | | | |
| Ms. Walorski | | X | | | | | |
| Mr. Curbelo | | X | | | | | |
| Mr. Bishop | | X | | | | | |

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

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

The legislation was ordered favorably transmitted to the House of Representatives as amended by a roll call vote of 22 yeas and 16 nays (with a quorum being present). The vote was as follows:

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

| Representative | Yea | Nay | Present | Representative | Yea | Nay | Present |
|----------------------|-------|-------|---------|----------------------|-------|-----|---------|
| Mr. Reichert | X | ..... | ..... | Mr. Thompson ..... | ..... | X | ..... |
| Mr. Roskam | X | ..... | ..... | Mr. Larson ..... | ..... | X | ..... |
| Mr. Buchanan | X | ..... | ..... | Mr. Blumenauer ..... | ..... | 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. 2581, 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. 2581, the Verify First 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. 2581—Verify First Act

H.R. 2581 would amend the Internal Revenue Code related to advance payments of health-related tax credits, contingent upon enactment of the American Health Care Act of 2017. Under that contingency, H.R. 2581 would add additional verification procedures before the Department of Treasury could make payments of certain tax credits in advance to health insurers on behalf of enrollees. Specifically, the bill would require that no advance payments could be made unless the Secretary of the Treasury has received confirmation from the Secretary of Health and Human Services that either the Commissioner of Social Security or the Secretary of Homeland Security has verified the individual's status either as a U.S. citizen or national or as an alien lawfully present in the country. The verification process would need to include information related to citizenship or immigration status, such as Social Security numbers. The requirements would apply through 2017 to the premium assistance credits that exist under current law and after 2017 to the new credits that would be established by enactment of the American Health Care Act of 2017.

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. As a result, 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

* * * * *

Subchapter A—Determination of Tax Liability

* * * * *

PART IV—CREDITS AGAINST TAX

* * * * *

Subpart C—Refundable Credits

* * * * *

【The following shows proposed changes to 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 al-

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

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

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

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

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

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

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

(2) HOUSEHOLD INCOME.—

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

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

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

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

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

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

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

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

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

(3) POVERTY LINE.—

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

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

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

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

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

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

(i) A method under which—

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

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

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

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

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

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

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

(f) **RECONCILIATION OF CREDIT AND ADVANCE CREDIT.**—

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

(2) **EXCESS ADVANCE PAYMENTS.**—

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

(B) **LIMITATION ON INCREASE.**—

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

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

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

(I) such dollar amount, multiplied by

(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, deter-

mined 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) VERIFICATION OF STATUS IN UNITED STATES FOR ADVANCE PAYMENT.—*No advance payment of the credit allowed under this section with respect to any premium under subsection (b)(2)(A) with respect to any individual shall be made under section 1412 of the Patient Protection and Affordable Care Act unless the Secretary has received confirmation from the Secretary of Health and Human Services that the Commissioner of Social Security or the Secretary of Homeland Security has verified under section 1411(c)(2) of such Act the individual’s status as a citizen or national of the United States or an alien lawfully present in the United States using a process that includes the appropriate use of information related to citizenship or immigration status, such as social security account numbers (but not individual taxpayer identification numbers).*

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

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

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

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

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

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

(b) MONTHLY CREDIT AMOUNTS.—

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

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

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

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

(c) MONTHLY LIMITATION AMOUNTS.—

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

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

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

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

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

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

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

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

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

(3) OTHER LIMITATIONS.—

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

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

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

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

(2) The individual is not eligible for—

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

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

(3) The individual is either—

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

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

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

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

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

(2) any dependent of the taxpayer, and

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

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

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

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

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

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

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

(g) SPECIAL RULES.—

(1) MARRIED COUPLES MUST FILE JOINT RETURN.—

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

(B) EXCEPTION FOR CERTAIN TAXPAYERS.—Subparagraph

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

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

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

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

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

(2) DENIAL OF CREDIT TO DEPENDENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) INFLATION ADJUSTMENT.—

(A) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2020, each dollar amount in subsection (c)(1), the \$75,000 amount in subsection (c)(2)(B), and the dollar amount in subsection (c)(3)(A), shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

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

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

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

(B) TERMS RELATED TO CPI.—

(i) ANNUAL PERCENTAGE INCREASE.—For purposes of subparagraph (A)(ii)(II), the term “annual percentage

increase” means the percentage (if any) by which CPI for any year exceeds CPI for the prior year.

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

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

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

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

(h) VERIFICATION OF STATUS IN UNITED STATES FOR ADVANCE PAYMENT.—*No advance payment of the credit allowed under this section with respect to any amount under subparagraph (A) or (B) of subsection (b)(1) with respect to any individual shall be made under section 1412 of the Patient Protection and Affordable Care Act unless the Secretary has received confirmation from the Secretary of Health and Human Services that the Commissioner of Social Security or the Secretary of Homeland Security has verified under section 1411(c)(2) of such Act the individual’s status as a citizen or national of the United States or 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)) using a process that includes the appropriate use of information related to citizenship or immigration status, such as social security account numbers (but not individual taxpayer identification numbers).*

* * * * *

SECTION 2710A OF THE PUBLIC HEALTH SERVICE ACT

【The following shows proposed changes to section 2710A of the Public Health Service Act as such section is proposed to read after amendment by section 133 of the American Health Care Act of 2017 (H.R. 1628, as engrossed in the House):】

SEC. 2710A. ENCOURAGING CONTINUOUS HEALTH INSURANCE COVERAGE.

(a) PENALTY APPLIED.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, a health insurance issuer offering health insurance coverage in the individual market shall, in the case of an individual who is an applicable policyholder of such coverage with respect to an enforcement period applicable to enrollments for a plan year beginning with plan year 2019 (or, in the case of enrollments during a special enrollment period, beginning with plan year 2018), increase the monthly premium rate otherwise applicable to such individual for such coverage during each month of such period, by an amount determined under paragraph (2).

(2) AMOUNT OF PENALTY.—The amount determined under this paragraph for an applicable policyholder enrolling in health insurance coverage described in paragraph (1) for a plan year, with respect to each month during the enforcement period applicable to enrollments for such plan year, is the amount that is equal to 30 percent of the monthly premium rate otherwise applicable to such applicable policyholder for such coverage during such month.

(b) DEFINITIONS.—For purposes of this section:

(1) APPLICABLE POLICYHOLDER.—The term “applicable policyholder” means, with respect to months of an enforcement period and health insurance coverage, an individual who—

(A) is a policyholder of such coverage for such months;

(B) cannot demonstrate that (through presentation of certifications described in section 2704(e) or in such other manner as may be specified in regulations, such as a return or statement made under section 6055(d) or 36B of the Internal Revenue Code of 1986), during the look-back period that is with respect to such enforcement period, there was not a period of at least 63 continuous days during which the individual did not have creditable coverage (as defined in paragraph (1) of section 2704(c) and credited in accordance with paragraphs (2) and (3) of such section); and

(C) in the case of an individual who had been enrolled under dependent coverage under a group health plan or health insurance coverage by reason of section 2714 and such dependent coverage of such individual ceased because of the age of such individual, is not enrolling during the first open enrollment period following the date on which such coverage so ceased.

In the case of an individual who applies for advance payment of a credit under section 1412 of the Patient Protection and Affordable Care Act and for whom a determination of eligibility for such advance payment is delayed by reason of the requirement for verification of the individual’s status in the United States under section 1411(c)(2) of such Act, the period of days beginning with the date of application for advance payment and ending with the date of such verification shall not be taken into account in applying subparagraph (B). The Secretary shall establish a procedure by which information relating to this period is provided to the individual.

(2) LOOK-BACK PERIOD.—The term “look-back period” means, with respect to an enforcement period applicable to an enrollment of an individual for a plan year beginning with plan year 2019 (or, in the case of an enrollment of an individual during a special enrollment period, beginning with plan year 2018) in health insurance coverage described in subsection (a)(1), the 12-month period ending on the date the individual enrolls in such coverage for such plan year.

(3) ENFORCEMENT PERIOD.—The term “enforcement period” means—

(A) with respect to enrollments during a special enrollment period for plan year 2018, the period beginning with the first month that is during such plan year and that be-

gins subsequent to such date of enrollment, and ending with the last month of such plan year; and

(B) with respect to enrollments for plan year 2019 or a subsequent plan year, the 12-month period beginning on the first day of the respective plan year.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * *

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

* * * * *

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

* * * * *

Subpart B—Eligibility Determinations

[The following shows proposed changes to current law section 1411 of the Patient Protection and Affordable Care Act:]

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) **ESTABLISHMENT OF PROGRAM.**—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual’s coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an “enrollee”); and

(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:

(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee’s social security number.

(B) In the case of an individual whose eligibility is based on an attestation of the enrollee’s immigration status, the enrollee’s social security number (if applicable) and such identifying information with respect to the enrollee’s immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:

(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

(B) CERTAIN INDIVIDUAL HEALTH INSURANCE POLICIES OBTAINED THROUGH SMALL EMPLOYERS.—The amount of the enrollee’s permitted benefit (as defined in section 9831(d)(3)(C) of the Internal Revenue Code of 1986) under a qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of such Code).

(C) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee’s (or related individual’s) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential

coverage or affordable minimum essential coverage, the following information:

(A) The name, address, and employer identification number (if available) of the employer.

(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.

(C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.

(D) If an enrollee claims an employer's minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 1311(d)(4)(H) from any requirement or penalty imposed by section 5000A, the following information:

(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

(2) CITIZENSHIP OR IMMIGRATION STATUS.—

(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

(ii) The attestation of an individual that the individual is a citizen.

(B) SECRETARY OF HOMELAND SECURITY.—

(i) IN GENERAL.—In the case of an individual—

(I) who attests that the individual is an alien lawfully present in the United States; or

(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

(ii) INFORMATION.—The information described in clause (ii) is the following:

(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

(II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

(3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

(4) METHODS.—

(A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done—

(i) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

(ii) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

(B) FLEXIBILITY.—The Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant, including allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary. The

Secretary shall not make any such modification unless the Secretary determines that any applicable requirements under this section and section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.

(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not required under subsection (c) to be submitted to another person for verification, the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the Exchange.

(e) ACTIONS RELATING TO VERIFICATION.—

(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

(2) VERIFICATION.—

(A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

(i) the individual's eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and

(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 1412(c) of the amount of any advance payment to be made.

(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(3) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant's eligibility (*other than eligibility for advance payment of a credit under section 1412*) will be determined in the same manner as an individual's eligibility under the medicaid program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(4) INCONSISTENCIES INVOLVING OTHER INFORMATION.—

(A) IN GENERAL.—If the information provided by an applicant under subsection (b) (other than subsection (b)(2)) is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the Exchange and the Exchange shall take the following actions:

(i) REASONABLE EFFORT.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

(ii) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) SPECIFIC ACTIONS NOT INVOLVING CITIZENSHIP OR LAWFUL PRESENCE.—

(i) IN GENERAL.—Except as provided in paragraph (3), the Exchange shall, during any period before the close of the period under subparagraph (A)(ii)(II), make any determination under paragraphs (2), (3), and (4) of subsection (a) on the basis of the information contained on the application.

(ii) ELIGIBILITY OR AMOUNT OF CREDIT OR REDUCTION.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) EMPLOYER AFFORDABILITY.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage, the Exchange shall notify the employer of such fact and that the employer may be liable for the payment assessed under section 4980H of such Code.

(iv) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved as of the close of the period under subparagraph (A)(ii)(II), the Exchange shall notify an applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(C) APPEALS PROCESS.—The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(5) *DELAY PERMITTED IN COVERAGE DATE IN CASE OF DELAY IN VERIFICATION OF STATUS FOR INDIVIDUALS APPLYING FOR ADVANCE PAYMENT OF CREDIT.*—*In the case of an individual whose eligibility for advance payments is delayed by reason of the requirement for verification under subsection (c)(2), if, for coverage to be effective as of the date requested in the individual's application for enrollment, the individual would (but for this paragraph) be required to pay 2 or more months of retroactive premiums, the individual shall be provided the option to elect to postpone the effective date of coverage to the date that is not more than 1 month later than the date requested in the individual's application for enrollment.*

(f) APPEALS AND REDETERMINATIONS.—

(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

(A) hears and makes decisions with respect to appeals of any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(2) EMPLOYER LIABILITY.—

(A) IN GENERAL.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(i) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(ii) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of such Code.

(B) CONFIDENTIALITY.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not be entitled to any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of such Code with respect to the employee, except that—

(i) the employer may be notified as to the name of an employee and whether or not the employee's in-

come is above or below the threshold by which the affordability of an employer's health insurance coverage is measured; and

(ii) this subparagraph shall not apply to an employee who provides a waiver (at such time and in such manner as the Secretary may prescribe) authorizing an employer to have access to the employee's taxpayer return information.

(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—

(1) IN GENERAL.—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of the credit or reduction.

(2) RECEIPT OF INFORMATION.—Any person who receives information provided by an applicant under subsection (b) (whether directly or by another person at the request of the applicant), or receives information from a Federal agency under subsection (c), (d), or (e), shall—

(A) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction or the amount of the credit or reduction; and

(B) not disclose the information to any other person except as provided in this section.

(h) PENALTIES.—

(1) FALSE OR FRAUDULENT INFORMATION.—

(A) CIVIL PENALTY.—

(i) IN GENERAL.—If—

(I) any person fails to provide correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms "negligence" and "disregard" shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) REASONABLE CAUSE EXCEPTION.—No penalty shall be imposed under clause (i) if the Secretary determines that there was a reasonable cause for the failure and that the person acted in good faith.

(B) KNOWING AND WILLFUL VIOLATIONS.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$250,000.

(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses informa-

tion in violation of subsection (g) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than \$25,000.

(3) LIMITATIONS ON LIENS AND LEVIES.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person by reason of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(i) STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) REPORT.—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

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VII. DISSENTING VIEWS

H.R. 2581 (Barletta, R-PA) amends H.R. 1628, the American Health Care Act (AHCA), to require individuals to complete identity authentication by providing a Social Security number (SSN) (and disallowing the use of an Individual Taxpayer Identification number (ITIN)) before receiving any advanceable tax credit established by the AHCA, as well as advanced premium tax credits (APTC) provided under current law, and on any tax return claiming health insurance premium tax credits. The Barletta bill amends AHCA, which has not passed the Senate or been enacted into law.

The Barletta bill fails to address the major, underlying flaws in the bill it amends. According to the nonpartisan, independent Congressional Budget Office (CBO), the AHCA would cause 23 million Americans to lose health insurance coverage, erode important consumer protections, and raise out-of-pocket health care costs for countless more Americans. H.R. 2581 does not address any of the problems that would undermine the health security for millions of working families.

Instead, the Barletta bill could exacerbate the ability to access affordable coverage that would be created by the AHCA for working families by increasing administrative barriers, requiring more government paperwork, and reducing access to affordable coverage. Ultimately, for someone who is ill, delayed care could mean the difference between accessing life-saving treatment and going without much needed care.

The Barletta bill fails to recognize unique circumstances of American families, forcing a one-size-fits-all approach to accessing financial help. Not all individuals who are eligible for tax credits have an SSN or are eligible to obtain an SSN that can be verified at the time of application. Some people, like newborns, may not have an SSN at the time their family applies on their behalf. Other individuals, like domestic violence survivors and survivors of human trafficking, may have no need to have an SSN related to work and would experience delays in accessing health coverage as a result of this requirement.

Delays in the eligibility process would be significant because people must enroll during open enrollment or within a special enrollment period. People can enroll without premium tax credits (PTCs) but even one or two months of enrollment without PTCs could result in significant financial hardship. For some people, like newborn babies, the delay in obtaining an SSN will be modest (on average, four weeks). Other groups may experience far longer delays if they must take steps like getting a work authorization prior to being able to obtain an SSN. In fact, the legislation itself acknowledges that this new bureaucratic barrier could cause delays in accessing credits of more than two months.

Under current law, initial verification of eligibility for APTCs occurs at the time an individual applies for coverage through the Marketplace. If an individual does not have an SSN, or if there is a problem verifying the SSN, a secondary verification process occurs. Under the law, the agency needs to notify the consumer of the problem verifying eligibility, and the applicant has 90 days to provide documentation or otherwise address the issues. During this verification process, individuals are presumed eligible to enroll in Marketplace coverage and, if appropriate, also provided financial assistance. If the individual is unable to provide documentation of eligibility, coverage and financial assistance is terminated. Under current law, individuals are not left in the position of needing coverage but having to wait potentially months to receive verification of eligibility for tax credits to afford that coverage.

This legislation would simply make it harder for individuals in need of financial assistance to purchase insurance coverage. Some people would forgo coverage due to the bureaucratic complications, and others would experience delays in accessing that coverage.

No evidence exists that says the current process isn't working or ineligible individuals fraudulently are claiming the APTCs. Rep. Barletta claims that 500,000 undocumented immigrants received \$750 million in premium tax credits. These claims are false and there is no evidence that supports these allegations.

As the source of information to support his claim, Rep. Barletta has pointed to a February 2016 majority staff report from the United States Senate Committee on Homeland Security and Governmental Affairs. However, this report does not make this claim, rather the report claims that "as of September 30, 2015, CMS awarded approximately \$750 million in APTCs to individuals enrolled in FFMs who CMS later determined to be ineligible because the individuals failed to verify their citizenship, status as a national, or legal presence."

The report does not make the leap that these individuals are undocumented immigrants, rather it focuses on their termination being linked to failure to verify their status. There is no evidence that suggests these individuals were undocumented immigrants—only that they never got around to providing the remaining documentation to keep coverage. This could have happened for any number of reasons, for example, they could have abandoned the process because of securing a job with coverage or moving out of state.

The number of people whose coverage was terminated for failure to provide necessary documentation continues to decline. Efforts have become more refined as the program matures, meaning fewer individuals are experiencing documentation problems, especially as electronic interfaces have improved.

Democrats offered two amendments to highlight serious shortcomings with H.R. 2581 and the continued issue that President Trump has not released his tax returns. Both amendments were ruled non-germane by Chairman Kevin Brady (R-TX) and appealed by Democratic Members. The appeals were then defeated by party-line votes.

Congresswoman Sanchez (D-CA) offered an amendment to stop the provisions of H.R. 2581 from taking effect if the Inspector Gen-

eral of the Department of Health and Human Services determines that more than three percent (3%) of American citizens eligible for APTCs experience a disbursement delay. By having an impartial organization certify this threshold, the amendment would protect American citizens from suffering a delay in the disbursement of their APTCs as a result of this bill. Specifically, this amendment would protect the many APTC-eligible American citizens most likely to suffer the unintended consequences of this bill. Low-income American citizens, particularly naturalized Americans from immigrant families, have a more difficult time producing the documentation needed to verify their citizenship. These Americans are also more likely to have errors in their records because of the spelling of their surnames or the number of people who share the same name. This common sense fix would ensure that those who need coverage the most, including newborn children, will not have to wait for our system to “verify” their status.

Congressman Doggett (D-TX) offered an amendment to require President Trump to provide his tax returns under the Committee’s oversight authority. The Committee considered this matter previously. Congress, the Legislative Branch, has the responsibility and the authority to check the Executive Branch. As we have discussed, Section 6103 of the tax code allows for an examination of the President’s tax returns—authority put in place following the Teapot Dome scandal specifically so Congress could examine conflicts of interest in the Executive Branch. This is a genuine “Verify First” amendment. Before Congress assumes fraud and delays Americans’ access to health care, we need to verify first how much President Trump and his family would be enriched by changes made by the AHCA and how the many corporate entities over which he exercises control would be enriched. Moreover, we also need to know whether this is about personal enrichment of President Trump or if it is about the enrichment of our nation’s economy. We also should take this opportunity to verify that there is no other conflicts of interest as we move forward in legislation impacting the tax code.

For the reasons stated above, Democrats opposed this legislation as it imposes additional and unnecessary bureaucratic paperwork on working families that are in need of financial assistance to afford their health insurance premiums.

RICHARD E. NEAL,
Ranking Member.

