Mr. BLACK. Mr. Speaker, pursuant to House Resolution 228, I call up the bill (H.R. 1628) to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017, and ask for its immediate consideration.

The Clerk read the title of the bill.

The result of the vote was announced as above recorded.

AMERICAN HEALTH CARE ACT OF 2017

Mrs. BLACK. The SPEAKER pro tempore announced the passage of the bill and announced the vote. The Speaker asked that the record be opened for any comments before he announced the vote. There were no comments.

The Speaker then announced the result of the vote, and the Journal was approved.
section 5009 of the 21st Century Cures Act, is amended—
(1) in paragraph (2), by adding “and” at the end;
(2) in paragraph (3)—
(A) by striking “each of fiscal years 2018 and 2019” and inserting “fiscal year 2018”; and
(B) by striking the semicolon at the end and inserting a period; and
(3) by striking paragraphs (4) through (8).
(b) RECISSION OF UNOBLIGATED FUNDS.—Of the funds made available by such section 4002, the unobligated balance at the end of fiscal year 2018 is rescinded.

SEC. 102. COMMUNITY HEALTH CENTER PROGRAM.
Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 176), paragraph (1) of section 221(a) of such Act is amended by inserting “and an additional $422,000,000 for fiscal year 2017 after “2017”.

SEC. 103. FEDERAL PAYMENTS TO STATES.
(a) IN GENERAL.—Notwithstanding section 501(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(1), and section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 704(a), 190(a)(23), 1906(a), 1906(f)(1), 1906(f)(2), 1907(a)(4), 1907(b)(a)(7), 1907(f)(1)), and the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1101 of the Social Security Act (42 U.S.C. 1315, 1316n), for the 1-year period beginning on the date of the enactment of this Act, no Federal funds provided from a program referred to in this subsection that is considered direct spending for any year may be made available to a State for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the State.
(b) DEFINITIONS.—In this section:
(1) PROHIBITED ENTITY.—The term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinicians, that—
(A) that, as of the date of enactment of this Act—
(i) is an organization described in sections 501(c)(3), 1902(a)(23), 1902(a)(4), 1902(a)(5), and 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 704(a), 190(a)(23), 1906(a), 1906(f)(1), 1906(f)(2), 1907(a)(4), 1907(b)(a)(7), 1907(f)(1)) and exempt from tax under section 501(a) of such Code;
(ii) is an essential community provider described in section 300 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health services, or related medical care; and
(iii) provides for abortions, other than an abortion—
(I) if the pregnancy is the result of an act of rape or incest; or
(II) in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself; and
(B) for which the total amount of Federal and State expenditures under the Medicare program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded $350,000,000.
(2) DIRECT SPENDING.—The term “direct spending” has the meaning given that term under section 1902(a)(15) of the Social Security Act (42 U.S.C. 1396a(c)).

Subtitle B—Medicaid Program Enhancement

SEC. 111. REPEAL OF MEDICAID PROVISIONS.
The Social Security Act is amended—
(1) in section 1902 (42 U.S.C. 1396a)—
(A) in subsection (a), by inserting “and provided that any such election shall cease to be effective on January 1, 2020, and no such election shall be made after that date before the semi-colon at the end; and
(B) in subsection (h)(2)(C), by inserting “and ending December 31, 2019,” after “January 1, 2014”; and
(2) in section 1915(k)(2) (42 U.S.C. 1396m(k)(2)), by striking “during the period described in paragraph (1)” and inserting “on or after the date referred to in paragraph (1) and before January 1, 2020.”

SEC. 112. REPEAL OF MEDICAID EXPANSION.
(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—
(1) in section 1902 (42 U.S.C. 1396a)—
(A) in subsection (a)(10)(A)—
(i) in clause (i)(VIII), by inserting “and’’ after the colon at the end; and
(ii) in clause (i)(IX), or clause (ii)(XX) of subsection (a)(10)(A) and inserting under clause (i)(VIII) or clause (ii)(XX) of section 1902(a)(10)(A) before January 1, 2020, section 1902(a)(10)(A)(i)(IX),
(b) RESCISSION OF UNOBLIGATED FUNDS.—Of the funds made available by such section 4002, the unobligated balance at the end of fiscal year 2018 is rescinded.

SEC. 113. ELIMINATION OF DISH CUTS.
Section 12293(b)(5) of the Social Security Act (42 U.S.C. 1396c–4(f)) is amended—
(1) in paragraph (7)—
(A) in subparagraph (A)—
(i) in clause (I), by striking “in the matter preceding subclause (I), by striking ‘2025’ and inserting ‘2019’; and
(ii) in clause (II), by striking “(aa) who are expansion enrollees (as defined in subsection (nn)(1)); or
(bb) who who are expansion enrollees (as defined in subsection (mn)(2));” and
(B) by adding at the end the following new subclause—
(’’(nn) EXPANSION ENROLLEES.—In this title:
’’’’(1) IN GENERAL.—The term ‘expansion enrollee’ means an individual—
(I) who is under 65 years of age;
(II) who is not pregnant;
(C) who is not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII;
(II) who is not described in any of subclauses (I) through (VII) of subsection (a)(10)(A); and
(E) whose income (as determined under subsection (a)(10)(A)(i));
(i) IN GENERAL.—In the case of an individual who is the recipient of qualified lottery winnings and income received as a lump sum income (received on or after such

SEC. 114. REDUCING STATE MEDICAID COSTS.
Subtitle C—Disenroll High Dollar Lottery Winners
(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396c–4(a)) is amended—
(1) in subsection (a)(17), by striking “(e)(14), (e)(14)” and inserting “(e)(14), (e)(15)”;
(B) in subsection (e)—
(i) in paragraph (10) (relating to modified adjusted gross income), by adding at the end the following new subparagraph—
(’’(J) TREATMENT OF CERTAIN LOTTERY Winnings and Income Received as a Lump SUM.—
(1) IN GENERAL.—In the case of an individual who is the recipient of qualified lottery winnings and income received as a lump sum income (received on or after such

SEC. 115. SUNSET OF ESSENTIAL HEALTH BENEFITS REQUIREMENT.—Section 1937(b)(5) of the Social Security Act (42 U.S.C. 1396c–4(f)) is amended by striking the end of the section and inserting the following:
“Section 1922(b)(5) of the Social Security Act (42 U.S.C. 1396c–4(f)) shall not apply to the DSH allotment for such State and fiscal year.”

SEC. 116. NO CHANGE IN REDUCTION FOR EXPANSION STATES.—In the case of a State that is an expansion State for a fiscal year, the DSH allotment for such State and fiscal year shall be determined as if clause (i) did not apply.

SEC. 117. NON-EXPANSION AND EXPANSION STATE DEFINED.—
(1) The term ‘expansion State’ means with respect to a fiscal year, a State that, as of July 1 of the preceding fiscal year, provides for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) for medical assistance under such State plan (or a waiver of such State plan approved under section 1115).
(2) The term ‘non-expansion State’ means, with respect to a fiscal year, a State that is not an expansion State.

SEC. 118. REDUCING STATE MEDICAID COSTS.
Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—
(1) in paragraph (7), by striking “fiscal year 2017” and inserting “fiscal year 2019”. 

March 24, 2017

CONGRESSIONAL RECORD — HOUSE
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(A) INTERCEPTION OF LOTTERY WINNINGS ALLOWED.—Nothing in the amendment made by paragraph (1)(B)(i) shall be construed as preventing a State from intercepting the State lottery winnings of an individual in the State to recover amounts paid by the State under the State Medicaid plan under title XIX of the Social Security Act for medical assistance to such individual.

(B) APPLICABILITY LIMITED TO ELIGIBILITY RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by paragraph (1)(B)(i) shall be construed, with respect to a determination of household income for purposes of a determination of medical assistance eligibility under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) made by applying modified adjusted gross income under subparagraph (A) of section 1902(e)(14) of such Act (42 U.S.C. 1396a(a)(14)), as limiting the eligibility for such medical assistance of any individual that is a member of the household other than the individual (or the individual’s spouse) who received qualified lottery winnings or qualified lump-sum income (as defined in section 1902(e)(14) of such Act (42 U.S.C. 1396a(a)(14)), as amended by paragraph (1)(B)(i) of this subsection).

(b) REPEAL OF RETROACTIVE ELIGIBILITY.—

(1) IN GENERAL.—

(A) STATE PLAN REQUIREMENTS.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) (as amended by striking “in or after the third month before the month in which he made application” and inserting “in or after the month in which the individual made application”)

(B) DEFINITION OF MEDICAL ASSISTANCE.—Section 1906(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by striking “in or after the month in which the recipient makes application for assistance” and inserting “in or after the month in which the recipient makes application for assistance”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to medical assistance furnished to the individual.

(c) UPDATE OF ALLOCABLE HOME EQUITY LIMITS IN MEDICAID.—

(1) IN GENERAL.—Section 1917(f)(1) of the Social Security Act (42 U.S.C. 1396p(f)(1)) is amended—

(A) in subparagraph (A), by striking “subparagraphs (B) and (C)” and inserting “subparagraphs (B), (C), and (D)”;

(B) by striking subparagraph (B);

(C) by redesignating subparagraph (C) as subparagraph (B); and

(D) by inserting after subparagraph (B), as so redesignated, by striking “dollar amounts specified in this paragraph” and inserting “dollar amount specified in subparagraph (A)”.

(2) EFFECTIVE DATE.—(A) IN GENERAL.—The amendments made by paragraph (1) shall apply with respect to eligibility determinations made after the date that is 180 days after the date of the enactment of this section.

(B) EXCEPTION FOR STATE LAW.—In the case of a State plan under title XIX of the Social Security Act that the Secretary of Health and Human Services determines requires State legislation in order for the respective plan to meet any requirement imposed by this section, the respective plan shall not be construed as failing to comply with the requirements of such title solely on the basis of its failure to meet the requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that holds an odd-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

SEC. 115. SAFETY NET FUNDING FOR NON-EXPANSION STATES.

Title XIX of the Social Security Act is amended by inserting after section 1923 (42 U.S.C. 1396n-4) the following new section:

‘‘SEC. 1923A. (a) IN GENERAL.—Subject to the limitations of this section for each fiscal year in the period beginning with fiscal year 2018 and ending with fiscal year 2022, each State that is one of the 50 States or the District of Columbia and that, as of July 1 of the preceding fiscal year, did not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10) for medical assistance furnished to the individual under this title or for a waiver of the State plan approved under section 1115 (each such State or District referred to in this section for each fiscal year as a ‘non-expansion State’) may adjust its payments otherwise provided under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396a) (or a waiver of such plan) to health care providers that provide health care to low-income, uninsured individuals who either are eligible for medical assistance under the State plan (or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

(b) INCREASE IN APPLICABLE FMAP.—Notwithstanding section 1905(b), the Federal medical assistance percentage applicable with respect to expenditures attributable to a payment adjustment under subsection (a) for any payment for medical assistance furnished to the individual under this title (in this section referred to as ‘eligible providers’) so long as the payment adjustment to such an eligible provider does not exceed the payment adjustment to the providing health care services (as determined by the Secretary and net of payments under this title to plans other than under this section, and by uninsured patients to individuals who either are eligible for medical assistance under the State plan or under a waiver of such plan) or have no health insurance or health plan coverage for such services.

(c) ALLOTMENT LIMITATION.—(1) PAYMENT.—Under section 1903(a)(1) no payment to a State with respect to any payment adjustment made under this section for all calendar quarters in a fiscal year in excess of the $2,000,000,000 multiplied by the ratio of—

(1) the population of the State with income below 138 percent of the poverty line in the 2017 (or most recently available) American Community Survey 1-Year Estimates, as published by the Bureau of the Census), to

(2) the sum of the populations of all States for which data for the fiscal year are available.

(2) DISQUALIFICATION IN CASE OF STATE COVERAGE EXPANSION.—If a State is a non-expansion State for a fiscal year and provides eligibility for medical assistance described in subsection (a) during the fiscal year, the State shall no longer be treated as a non-expansion State for the fiscal year for any subsequently fiscal years.

SEC. 116. PROVIDING INCENTIVES FOR INCREASED FREQUENCY OF ELIGIBILITY VERIFICATION.—

(a) IN GENERAL.—Section 1902(e)(14) of the Social Security Act (42 U.S.C. 1396a(e)(14))
(relating to modified adjusted gross income, as amended by section 114(a)(1), is further amended by adding at the end the following:

"(K) FREQUENCY OF ELIGIBILITY REDETERMINATION.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of an individual whose eligibility for medical assistance under the State plan under section 1902 of title XIX of the Social Security Act (42 U.S.C. 1396a) with respect to an individual, the individual's eligibility (as determined based on the application of modified adjusted gross income under subparagraph (a)) to be eligible on the basis of clause (i)(VIII) or clause (ii)(XX) of subsection (a)(10)(A) of this title shall be determined based on the modified adjusted gross income of such individual for the calendar quarter for which the State receives payment under such subsection, with respect to any medical assistance payments (as defined in paragraph (4)) for such administrative expenditure for such quarter, for the fiscal year otherwise included in such medical assistance expenditures; and

"(1) the amount of the medical assistance expenditures (as defined in paragraph (2)) for the State and fiscal year, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for such fiscal year otherwise included in such medical assistance expenditures; and

"(2) the number of 1903A FY16 enrollees, reduced by the number of any excluded expenditures (as defined in paragraph (3)) for such fiscal year otherwise included in such medical assistance expenditures and includes non-DSH supplemental payments (as defined in subsection (d)(4)(A)(iii)) and payments described in subsection (d)(4)(A)(iv) of such Act that are attributable to 1903A enrollees.

"(2) MEDICAL ASSISTANCE EXPENDITURES.—In this section, the term 'medical assistance expenditures' means, for a State and fiscal year, the medical assistance payments as reported by medical service category on the Form CMS-46 quarterly report for such fiscal year (including enrollment data and subsequent adjustments to such reports, in this section referred to collectively as a 'CMS-46 report') for which payment is (or may otherwise be) made pursuant to section 1903(a)(1).

"(3) EXCLUDED EXPENDITURES.—In this section, the term 'excluded expenditures' means, for a State and fiscal year, expenditures under the State plan (or under a waiver of such plan) that are attributable to any of the following:

"(A) DSH.—Payment adjustments made for disproportionate share hospitals under section 1902.

"(B) MEDICARE COST-SHARING.—Payment adjustments made for medicare cost-sharing (as defined in section 1905(b)(3)).

"(C) SAFETY NET PROVIDER PAYMENT ADJUSTMENTS IN NON-EXPANSION STATES.—Payment adjustments under subsection (a) of section 1921A for which payment is permitted under subsection (c) of such section.

"(D) the Federal average medical assistance expenditures for the State for the fiscal year otherwise included in such medical assistance expenditures, as reported by the State on the CMS-46 reports for calendar quarters in fiscal year 2016, that are attributable to 1903A enrollees (as defined in subsection (e)(2)) of:

"(1) the amount of the per capita medical assistance expenditures (as defined in paragraph (2)) for the enrollee category, State, and fiscal year, as reported to collectively as a 'CMS-46 report' for which payment is (or may otherwise be) made pursuant to section 1903(a)(1).
(A) for fiscal year 2020, an amount equal to—

(i) the provisional FY19 target per capita amount for such enrollee category (as calculated under subsection (d)(5) for the State; increased by

(ii) the applicable annual inflation factor (as defined in paragraph (3) for fiscal year 2020), and

(B) for each succeeding fiscal year, an amount equal to—

(i) the target per capita medical assistance expenditures (as defined in subparagraph (A) or this subparagraph) for the 1903A enrollee category and State for the preceding fiscal year, increased by

(ii) the applicable annual inflation factor for that succeeding fiscal year.

(3) APPLICABLE ANNUAL INFLATION FACTOR.—Except as provided in subparagraph (2), the term ‘applicable annual inflation factor’ means, for a fiscal year—

(A) for each of the 1903A enrollee categories described in subparagraphs (C), (D), and (E) of subsection (e)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from January 1 of the previous fiscal year to September of the fiscal year involved; and

(B) for each of the 1903A enrollee categories described in subparagraphs (A) and (B) of subsection (e)(2), the percentage increase described in subparagraph (A) plus 1 percentage point.

(4) DECREASE IN TARGET EXPENDITURES FOR REQUIRED EXPENDITURES BY CERTAIN POLITICAL SUBDIVISIONS.

(A) IN GENERAL.—In the case of a State that had a DSH allotment under section 1923(c) for fiscal year 2016 that was more than 6 times the national average of such allotments for all the States for such fiscal year and that requires political subdivisions within the State to contribute funds towards medical assistance or other expenditures under the State plan under this title or under a waiver of such plan for a fiscal year (beginning with fiscal year 2020), the target total medical assistance expenditures for such State and fiscal year shall be decreased by the amount that political subdivisions in the State are required to contribute under the plan (or waiver) without reimbursement from such fiscal year to September of the fiscal year following the fiscal year involved.

(B) EXCEPTIONS.—The contributions described in this subparagraph are the following:

(i) Contributions required by a State from a political subdivision that, as of the first day of the calendar year in which the fiscal year involved begins—

(I) has a population of more than 5,000,000, as estimated by the Bureau of the Census; and

(II) imposes a local income tax upon its residents.

(ii) Contributions required by a State from a political subdivision for administrable expenses if the State required such contributions from such subdivision without reimbursement from the State as of January 1, 2017.

(iii) CALCULATION OF FY19 PROVISIONAL TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—For each State the Secretary shall calculate and provide notice to the State not later than April 1, 2018, of the following:

(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2016.

(B) The number of 1903A enrollees for the State in fiscal year 2016 (as determined under subsection (e)(4)).

(C) The average per capita medical assistance expenditure (as defined in paragraph (2) for the State for fiscal year 2016 equal to—

(i) the amount calculated under subparagraph (A); divided by

(ii) the number calculated under subparagraph (B).

(D) FISCAL YEAR 2019 AVERAGE PER CAPITA AMOUNT BASED ON INFLATING THE FISCAL YEAR 2016 AMOUNT FOR MEDICAL ASSISTANCE EXPENDITURES FOR THE STATE.—The Secretary shall calculate a fiscal year 2019 average per capita amount for each State equal to—

(A) the average per capita medical assistance expenditures for the State for fiscal year 2016 (calculated under paragraph (1)(C)); increased by

(B) the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from September 2016 to September 2019.

(E) AGGREGATE AND AVERAGE EXPENDITURES FOR FISCAL YEAR 2019.—The Secretary shall calculate for each State the following:

(A) The amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019.

(B) The number of 1903A enrollees for the State in fiscal year 2019 (as determined under subsection (e)(2)).

(4) PER CAPITA EXPENDITURES FOR FISCAL YEAR 2019 FOR EACH 1903A ENROLLEE CATEGORY.—The Secretary shall calculate (and provide notice to each State not later than January 1, 2020, of) the following:

(A)(i) For each 1903A enrollee category, the amount of the adjusted total medical assistance expenditures (as defined in subsection (b)(1)) for the State for fiscal year 2019 for individuals in the enrollee category, calculated by excluding from medical assistance expenditures those expenditures attributable to expenditures described in clause (iii) or non-DSH supplemental expenditures (as defined in clause (ii)).

(ii) In this paragraph, the term ‘non-DSH supplemental expenditure’ means a payment to a provider under the State plan (or under a waiver of such plan) for a fiscal year for a DSH enrollee for any other similar expenditure (as defined by the Secretary) if such expenditure is not made with respect to a specific enrollee.

(iii) In addition to any payments made to the provider under the plan (or waiver) for any such item or service, and

(iv) to the limits for additional payments to providers under the plan (or waiver) imposed pursuant to section 1902(a)(30)(A), including the regulations specifying upper payment limits under the State plan in part 447 of title 42, Code of Federal Regulations (or any successor regulations).

(B)(i) An expenditure described in this clause is an expenditure that meets the criteria specified in subclauses (I), (II), and (III) of clause (ii) and is authorized under section 1115 for the purposes of funding a delivery system reform pool, uncompensated care pool, a designated state health agency, or any other similar expenditure (as defined by the Secretary).

(ii) For each 1903A enrollee category, the number of 1903A enrollees for the State in fiscal year 2019 in the enrollee category (as determined under section 1922(a)(10)(A)(i) or pursuant to a waiver that provides only comparable benefits).

(iii) For fiscal year 2016, the State’s non-DSH supplemental and pool payment percentage is equal to the ratio (expressed as a percentage) of—

(A) the total amount of non-DSH supplemental expenditures (as defined in subparagraph (A)(iii)) and payments described in subparagraph (A)(iii) for the State for fiscal year 2016 to

(B) the amount described in subsection (b)(1)(A) for the State for fiscal year 2016 for the enrollee category equal to

(C) For each 1903A enrollee category an average medical assistance expenditures per capita for the State for fiscal year 2019 for the enrollee category equal to

(D) For each 1903A enrollee category an average medical assistance expenditures per capita for the State for fiscal year 2019 or the enrollee category equal to

(E) For each 1903A enrollee category an average medical assistance expenditures per capita for the State for fiscal year 2019 or the enrollee category equal to

(F) For each 1903A enrollee category an average medical assistance expenditures per capita for the State for fiscal year 2019 or the enrollee category equal to

(5) PROVISIONAL FY19 PER CAPITA TARGET AMOUNT FOR EACH 1903A ENROLLEE CATEGORY.—Subject to subsection (g), the Secretary shall calculate for each State a provisional FY19 per capita target amount for each 1903A enrollee category equal to the average medical assistance expenditures per capita for the State for fiscal year 2019 (as calculated under paragraph (4)(D)) for such enrollee category multiplied by the ratio of—

(A) the fiscal year 2019 average per capita amount for the State, as calculated under paragraph (2); and

(B) the number of 1903A enrollees for the State in fiscal year 2019, as calculated under paragraph (3)(B); to

(6) 1903A ENROLLEE; 1903A ENROLLEE CATEGORY.—Subject to subsection (g), for purposes of this section, the following shall apply:

(A) 1903A ENROLLEE.—The term ‘1903A enrollee’ means, with respect to a State and a month and subject to subsection (i)(1)(B), any Medicaid enrollee (as defined in paragraph (3)) for the month, other than such an enrollee who for such month is in any of the following categories of excluded individuals:

(1)(i) CHIP.—An individual who is provided, under this title in the manner described in section 2101(a)(2), child health assistance under title XXI.

(ii) IHS.—An individual who receives any medical assistance under this title for services which is made under the third sentence of section 1905(b).

(II) BREAST AND CANCER SERVICES ELIGIBLE INDIVIDUAL.—An individual who is entitled to medical assistance under this title only pursuant to section 1902(a)(10)(A)(XII) or (XXI).

(iii) PARTIAL-BENEFIT ENROLLEES.—An individual who—

(1) is an alien who is entitled to medical assistance under this title only pursuant to section 1905(v)(2); and

(ii) is entitled to medical assistance under this title only pursuant to subclause (XXI) of section 1902(a)(10)(A)(ii) (or pursuant to a waiver that provides only comparable benefits);

(iii) is a dual eligible individual (as defined in section 1915(h)(2)(B)) and is entitled to medical assistance under this title (or under a waiver) only for some or all of medicare cost-sharing (as defined in section 1922(a)(30)(A)(i) or (XXVII).

(2) 1903A ENROLLEE CATEGORY.—The term ‘1903A enrollee category’ means each of the following:

(A) the number of 1903A enrollees for the State in fiscal year 2016 (as determined under subsection (e)(4)).

(B) The average per capita medical assistance expenditure (as defined in paragraph (2) for the State for fiscal year 2016) equal to—

(i) the amount calculated under subparagraph (A); divided by

(ii) the number calculated under subparagraph (B).
“(A) ELDERLY.—A category of 1903A enrollees who are 65 years of age or older.

“(B) BLIND AND DISABLED.—A category of 1903A enrollees (not described in the previous subparagraph) who are eligible for medical assistance under this title on the basis of being blind or disabled.

“(C) CHILDREN.—A category of 1903A enrollees (not described in a previous subparagraph) who are children under 19 years of age.

“(D) EXPANSION ENROLLEES.—A category of 1903A enrollees (not described in a previous subparagraph) for whom the amounts expended for medical assistance are subject to an adjustment set forth in section 1902(a)(7).

“(E) OTHER NONELDERLY, NONDISABLED, NON-1903A.—A category of 1903A enrollees who are not described in any previous subparagraph.

“(F) MEDICAID ENROLLEE.—The term ‘Medicaid enrollee’ means, with respect to a State for a month, an individual who is eligible for medical assistance for items or services under this title and enrolled under the State plan (or a waiver of such plan) under this title for the month.

“(G) DETERMINATION OF NUMBER OF 1903A ENROLLEES.—The number of 1903A enrollees for a State for the month (and, if applicable, for each succeeding fiscal year for which 1903A enrollees were determined) is the sum of the number of Medicaid enrollees for such State and fiscal year (and, if applicable, for each succeeding fiscal year for which 1903A enrollees were determined) plus 1 percentage point.

“(H) EXPANSION ENROLLEE FEDERAL MATCHING PERCENTAGE.—The amounts paid under subsection (e)(4)(A) for a State for fiscal year 2016, fiscal year 2017, and any subsequent fiscal year for which the State elects to apply this subsection; and

“(I) (B) block grant individuals within the applicable block grant category for the State that elected the applicable block grant category for block grant health care assistance under the option that which shall be instead of other conditions for eligibility under this title that in the case of a State that has elected the applicable block grant category described in—

“(ii) the conditions for eligibility of block grant individuals within such applicable block grant category for block grant health care assistance under the option that which shall be instead of other conditions for eligibility under this title that in the case of a State that has elected the applicable block grant category described in—

“(I) subparagraph (A) of paragraph (6), the plan must provide for eligibility for pregnant women and children required to be provided medical assistance under subsections (a)(10)(A)(i) and (e)(4) of section 1902; or

“(II) subparagraph (B) of paragraph (6), the plan must provide for eligibility for pregnant women required to be provided medical assistance under subsection (a)(10)(A)(i); and

“(III) the types of items and services, the amount, duration, and scope of such services, the cost-sharing with respect to such services, and the means by which medical assistance otherwise required under this title, except that the plan must provide for assistance for—

“(I) hospital care;

“(II) surgical care and treatment;

“(III) medical care and treatment;

“(IV) obstetrical and prenatal care and treatment;

“(V) prescribed drugs, medicines, and prosthetic devices;

“(VI) other medical supplies and services; and

“(VII) health care for children under 18 years of age.

“(B) REVIEW AND APPROVAL.—A plan described in subparagraph (A) shall be deemed approved by the Secretary unless the Secretary determines, within 30 days after the date of the Secretary’s receipt of the plan, that the plan is incomplete or unreasonably unsound and, with respect to such plan and its implementation under this subsection, the requirements of paragraphs (1), (10)(B), and (20) of section 1902(a) shall not apply.

“(C) AMOUNT OF BLOCK GRANT FUNDS.—
“(A) FOR INITIAL FISCAL YEAR.—The block grant amount under this paragraph for a State for the initial fiscal year in the first 10-fiscal-year period is equal to the sum of the products for each applicable block grant category for such State and period of—

(i) the target per capita medical assistance expenditure for such State for such fiscal year (c)(2); and

(ii) the number of 1903A enrollees for such category and State for fiscal year 2019, as determined under subsection (e)(4); and

(2) the average medical assistance matching percentage (as defined in subsection (a)(4)) for the State for fiscal year 2019.

(B) FOR ANY SUBSEQUENT FISCAL YEAR.—The block grant amount under this paragraph for a State for each succeeding fiscal year (in any 10-fiscal-year period) is equal to the block grant amount under subparagraph (A) or this subparagraph for the State for the previous fiscal year increased by the annual increase in the consumer price index for all urban consumers (all items; U.S. city average) for the fiscal year involved.

(C) AVAILABILITY OF ROLLOVER FUNDS.—The block grant amount under this paragraph for a State for a fiscal year shall remain available to the State for expenditures under this subsection for the succeeding fiscal year unless the election in the balance of such fiscal year (under subsection (c)(2)) for plan years beginning after December 31, 2025, and ending on December 31, 2026, for the purposes described in section 2202.

(4) FEDERAL PAYMENT AND STATE RESPONSIBILITY.—The Secretary shall pay to each State that has elected under this subsection, a payment, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.

(5) Block Grant Individual Defined.—In this subsection, the term ‘block grant category’ means with respect to a State for a 10-fiscal-year period, each of the purposes described in paragraphs (6) and (7) of this subsection.

(6) Applicable Block Grant Category Defined.—In this subsection, the term ‘applicable block grant category’ means with respect to a State for a 10-fiscal-year period, all of the applicable block grant categories for such State for such period in its plan under paragraph (3).

(A) 2 ENROLLMENT CATEGORIES.—Both of the following 1903A enrollee categories:

(i) CHILDREN.—The 1903A enrollee category specified in subparagraph (C) of subsection (e)(2).

(ii) OTHER NONELDERLY, NONDISABLED, NONEXPANSION ADULTS.—Only the 1903A enrollee category specified in subparagraph (E) of such subsection.

(B) OTHER NONELDERLY, NONDISABLED, NONEXPANSION ADULTS.—Only the 1903A enrollee category specified in subparagraph (E) of such subsection.

(7) Block Grant Health Care Assistance.—In this subsection, the term ‘block grant health care assistance’ means assistance for health-care-related items and medical services for block grant individuals within the applicable block grant category for such State for such 10-fiscal-year period involved who are low-income individuals (as defined by the State).

(B) AUDITING.—As a condition of receiving funds under this section, a State shall enter into a contract with an independent entity to conduct audits of its expenditures made with respect to activities funded under this subsection for each fiscal year for which the State elects to apply this subsection to ensure that such funds are used consistent with all relevant requirements.

Subtitle D—Patient Relief and Health Insurance Market Stability

SEC. 131. REPEALING SUBSIDY.

(a) IN GENERAL.—Section 1402 of the Patient Protection and Affordable Care Act is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing reductions (and payments to issuers for such reductions) for plan years beginning after December 31, 2015.

SEC. 132. PATIENT AND STATE STABILITY FUND.

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following new title:

"TITLE XIX—PATIENT AND STATE STABILITY FUND

"SEC. 2101. ESTABLISHMENT OF PROGRAM.

"There is hereby established the ‘Patient and State Stability Fund’ to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the ‘Administrator’), to establish a stabilization fund with respect to such health care services as are specified by the title, to the 50 States and the District of Columbia (each referred to in this section as a ‘State’) during the period, subject to section 2204(c), beginning on January 1, 2018, and ending on December 31, 2026, for the purposes described in section 2202.

"SEC. 2102. USE OF FUNDS.

"(a) IN GENERAL.—Subject to subsection (b), a State may use the funds allocated to the State under this title for any of the following purposes:

(1) Providing, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer, who enroll in health insurance coverage in the individual market in the State, as such market is defined by the State (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose).

(2) Providing incentives to appropriate entities to enter into arrangements with the State to increase the availability of health insurance coverage in the individual market, as such markets are defined by the State.

(3) Reducing the cost for providing health insurance coverage for small group, as such markets are defined by the State, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost) and to individuals who have high costs of health insurance coverage due to the low density population of the State in which they reside.

(4) Promoting participation in the individual market and small group market in the State and increasing health insurance options available through such market.

(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); or any combination of such services.

(6) Maternity coverage and newborn care. In the case of a year beginning during the period described in section 2201, subject to subsection (b), to such extent as respects services for individuals with mental or substance use disorders, focused on either of the following:

(A) Directing funds to outpatient clinical care for treatment of addiction and mental illness.

(B) Early identification and intervention for children and young adults with serious mental illness.

(6) Providing payments, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.

(7) Providing assistance to reduce out-of-pocket costs, such as premiums, co-payments, deductibles, and other costs.

(8) Providing payments for activities to reduce the number of adverse selection and market stability.

(b) EFFECTIVE DATE.—Subsection (a) shall take effect for plan years beginning after December 31, 2018. For purposes of this subsection, such plan years shall be treated as if they were in the 10-fiscal-year period described in section 2201.

SEC. 2203. STATE ELIGIBILITY AND APPROVAL; DEFaulT SAFEGUARD.

(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

(1) IN GENERAL.—To be eligible for an allocation of funds under this title for a year during the period described in section 2201 for use for one or more purposes described in section 2202, a State must submit to the Administrator an application at such time (but, in the case of allocations for 2018, not later than 45 days after the date of the enactment of this Act) for each fiscal year after that for which the State is eligible.

(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator determines that the State has failed to comply with any applicable requirement of this title and of the reason for such denial.

(3) ONE-TIME APPLICATION.—If an application submitted to the Administrator is approved, subject to section 2204(b) for each year only for the purposes described in section 2202, such application shall be treated as approved, with respect to such purpose, for each subsequent year only, that is, not later than March 31 of the previous year and in such form and manner as specified by the Administrator and contained in such application.

(4) TREATMENT AS A STATE HEALTH CARE PROGRAM.—Any program receiving funds from an allocation for a State under this title, including pursuant to subsection (b), shall be considered to be a ‘State health care program’ for purposes of sections 1128, 1128A, and 1128B.

(b) DEFAULT FEDERAL SAFEGUARD.—

(1) IN GENERAL.—

(2) TREATMENT AS A STATE HEALTH CARE PROGRAM.—Any program receiving funds from an allocation for a State under this title, including pursuant to subsection (b), shall be considered to be a ‘State health care program’ for purposes of sections 1128, 1128A, and 1128B.
section 2204(e), the Administrator, in consultation with the State insurance commissioner, shall use the allocation that would otherwise be provided to the State under this title for such purpose to the extent your purpose in accordance with paragraph (2), for such State.

SEC. 2204. ALLOCATIONS.

(a) Appropriation.—For the purpose of providing allocations for States (including pursuant to section 2203(b)) under this title there shall be appropriated out of any money in the Treasury of the United States appropriated—

(1) for 2018, $15,000,000,000; (2) for 2019, $15,000,000,000; (3) for 2020, $10,000,000,000; (4) for 2021, $10,000,000,000; (5) for 2022, $10,000,000,000; (6) for 2023, $10,000,000,000; (7) for 2024, $10,000,000,000; (8) for 2025, $10,000,000,000; and

(9) for 2026, $10,000,000,000.

The amount otherwise appropriated under the purpose for which such an allocation was made pursuant to section 2203(b) under this title shall be increased by $15,000,000,000, to be used and available under subsection (d) only for the purposes described in paragraphs (6) and (7) of section 2203(a).

(b) Allocations.—

(1) Payment.—

(A) in general.—From amounts appropriated for a year, the Administrator shall, with respect to a State and not later than the date specified under subparagraph (B) for such year, allocate, subject to paragraphs (3) and (4) for such State (including pursuant to section 2203(b)) the amount determined for such State and year under paragraph (2).

(B) for a State.—For purposes of subparagraph (A), the date specified in this subparagraph is—

(i) for 2018, the date that is 45 days after the date of the enactment of this title; and

(ii) for 2019 and subsequent years, January 1 of the respective year.

(2) Allocation amount determinations.—

(A) for 2018 and 2019.—

(i) in general.—For purposes of paragraph (1), the amount determined under this paragraph for 2018 and 2019 for a State is an amount equal to the sum of—

(I) the relative incurred losses amount described in clause (ii) for such State and year;

(II) the relative uninsured and issuer participation amount described in clause (iv) for such State and year.

(B) for purposes of clause (i), the relative incurred claims amount described in this clause for a State for 2018 and 2019 is the product of—

(i) 85 percent of the amount appropriated under subsection (a) for the year; and

(ii) the relative State incurred claims proportion described in clause (iii) for such State and year.

(III) relative State incurred claims proportion described in this clause for a State and year is the amount equal to the ratio of—

(A) the adjusted incurred claims by the State, as reported through the medical loss ratio annual reporting under section 2718 of the Public Health Service Act for the third previous year; and

(B) the sum of such adjusted incurred claims for all States, as so reported, for such third previous year.

(IV) relative uninsured and issuer participation amount.—For purposes of clause (i), the relative uninsured and issuer participation amount described in this clause for a State for 2018 and 2019 is the product of—

(I) 15 percent of the amount appropriated under subsection (a) for the year; and

(II) the relative State uninsured and issuer participation proportion described in clause (v) for such State and year.

(V) relative State uninsured and issuer participation proportion.—For relative State uninsured and issuer participation proportion described in this clause for a State and year.

(1) in the case of a State not described in clause (vi) for such year; and

(ii) in the case of a State described in clause (vi) for such year, the amount equal to—

(aa) the number of individuals residing in such State who for the third preceding year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved; to

(bb) the sum of the number of such individuals for all States described in clause (vi) for the third preceding year.

(VI) states described.—For purposes of clause (v) a State is described in this clause, with respect to 2018 and 2019, if the State satisfies either of the following criterion:

(I) the ratio described in subclause (II) of clause (v) that would be determined for such State by substituting ‘2018’ for each reference in such ratio to the third preceding year and by substituting ‘all States’ for the reference in item (bb) of such subclause to ‘all States’ described in clause (vi) is greater than the ratio described in such subclause that would be determined for such State by substituting ‘2013’ for each reference in such ratio to the third preceding year and by substituting ‘all States’ for the reference in item (bb) of such subclause to ‘all States’ described in clause (vi).

(II) The State has fewer than three health insurance issuers offering qualified health plans through the Exchange for 2017.

(B) for purposes of paragraph (1), the amount determined under this paragraph for a year (beginning with 2020) during the period described in section 2201 for a State is an amount determined in accordance with an allocation methodology specified by the Administrator which—

(i) takes into consideration the adjusted incurred claims of such State, the number of residents of such State who for the previous year were not enrolled in a health plan or otherwise did not have health insurance coverage (including through a Federal or State health program) and whose income is below 100 percent of the poverty line applicable to a family of the size involved, and the number of health care consumers, health insurance issuers, and other stakeholders and after taking into consideration additional factors that may inhibit health care consumer and health insurance issuer participation; and

(ii) reflects the goals of improving the health insurance risk pool, promoting a more competitive health insurance market, and increasing choice for health care consumers.

(1) annual distribution of previous year’s remaining funds.—In carrying out subsection (b), the Administrator shall, with respect to a State (beginning in fiscal year 2018 and ending with 2027), not later than March 31 of each year—

(A) determine the amount of funds, if any, from amounts appropriated under subsection (a) for the previous year but not allocated for such previous year; and

(B) if the Administrator determines that any such funds were not so allocated for such previous year, allocate such remaining funds, in accordance with the allocation methodology specified pursuant to subsection (b)(2)(B) for States for which an application approved under section 2203(a) for such previous year for any purpose for which such an application was approved; and

(C) for States for which an application were made pursuant to section 2203(b) for such previous year, to be used by the Administrator for such States, to carry out the purpose described in section 2202(e), for States by providing payments to appropriate entities described in such section with respect to claims that exceed $1,000,000,000, in any year, to a State, any remaining funds being made available for allocations to States for the subsequent year.

(VII) availability.—Any amount appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2027.

(e) conditions for and limitations on receipt of funds.—The Secretary may not make an allocation under this title for a State, with respect to a purpose described in section 2202—

(1) in the case of an allocation that would be made to a State pursuant to section 2203(a), if the State does not agree that the State will make available non-Federal contributions towards such purpose in an amount equal to—

(A) for 2020, 7 percent of the amount allocated under this subsection to such State for such year and purpose;

(B) for 2021, 21 percent of the amount allocated under this subsection to such State for such year and purpose;

(C) for 2022, 38 percent of the amount allocated under this subsection to such State for such year and purpose;

(D) for 2023, 38 percent of the amount allocated under this subsection to such State for such year and purpose;

(E) for 2024, 35 percent of the amount allocated under this subsection to such State for such year and purpose;

(F) for 2025, 30 percent of the amount allocated under this subsection to such State for such year and purpose;

(G) for 2026, 25 percent of the amount allocated under this subsection to such State for such year and purpose;

(H) for 2027, 20 percent of the amount allocated under this subsection to such State for such year and purpose;

(2) in the case of an allocation that would be made for a State pursuant to section 2203, if the State does not agree that the State will make available non-Federal contributions towards such purpose in an amount equal to—

(A) for 2020, 10 percent of the amount allocated under this subsection to such State for such year and purpose;
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.

1. Notwithstanding section 2714, such enrollees under section 2714 are subject to the first open enrollment period following the date on which such coverage so ceased.

2. (LOOK-BACK PERIOD)—The term ‘look-back period’ means—

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

3. (ENFORCEMENT PERIOD)—The term ‘enforcement period’ means—

(A) with respect to enrollees during a special enrollment period for plan year 2018, the period beginning with the first month that is during such plan year and that begins subsequent to such date of enrollment, and ending with the last month of such plan year; and

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

II. —CONFORMING AMENDMENTS

Subtitle E—Implementation Funding

SEC. 141. AMERICAN HEALTH CARE IMPLEMENTATION FUND.

(a) IN GENERAL.—There is hereby established the American Health Care Implementation Fund (referred to in this section as the ‘‘Fund’’) within the Department of Health and Human Services to carry out sections 201 to 212, and 214 (including the amendments made by such sections).

(b) FUNDING.—There is appropriated to the Fund, out of any funds in the Treasury not otherwise appropriated, $1,000,000,000 for Federal administrative expenses to carry out the sections described in subsection (a) (including the amendments made by such sections).

II. —CONFORMING AMENDMENTS

Subtitle II—CONFORMING AMENDMENTS

Title V—Approval of State Plans

Subtitle A—Repeal and Replace of Health Related Tax Policy

SEC. 201. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

Subparagraph (B) of section 36B(f)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

‘‘(iii) NONAPPLICABILITY OF LIMITATION.—This subparagraph shall not apply to taxable years beginning after December 31, 2017, and before January 1, 2020.’’

SEC. 202. ADDITIONAL MODIFICATIONS TO PREMIUM TAX CREDIT.

(a) MODIFICATION OF DEFINITION OF QUALIFIED PLANS.—

(1) IN GENERAL.—Section 36B(c)(5)(A) of the Internal Revenue Code of 1986 is amended—

(A) by inserting ‘‘(determined without regard to subparagraphs (A), (C), (D), and (E) of paragraph (1) thereof and without regard to whether the plan is offered on an Exchange’’ after ‘‘130(a) of the Patient Protection and Affordable Care Act’’;

(B) by striking ‘‘shall not include all that follows and inserting ‘‘shall not include any health plan that—’’;

‘‘(i) is a grandfathered health plan or a grandmothered health plan, or

‘‘(ii) includes 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).’’

(2) DEFINITION OF GRANDMOTHERED HEALTH PLAN.—Section 36B(c)(5)(B) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

‘‘(C) GRANDMOTHERED HEALTH PLAN.—In any calendar year, the term ‘grandmothered health plan’ means health insurance coverage which is offered in the individual health insurance market as of October 1, 2013, and is pervaded by the Department of Labor in such market after January 1, 2014, as a result of CCIO guidance.’’

‘‘(ii) CCIO GUIDANCE DEFINED.—The term ‘CCIO guidance’ means the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for non-grandfathered coverage in the individual health insurance market, as subsequently extended and modified (including by a communication entitled ‘Insurance Standards Bulletin in Section 102 Extension of Transitional Policy through Calendar Year 2017’ issued on February 29, 2016, by the Director of the Center for Consumer Information & Insurance Oversight of such Centers).

‘‘(iii) INDIVIDUAL HEALTH INSURANCE MARKET.—The term ‘individual health insurance market’ means the market as defined in section 380gg(a)(1)(A)(iii), as inserted by section 1201(a) of the Patient Protection and Affordable Care Act, or as section 380gg(a)(1)(A)(iii) is further modified (including by a communication entitled ‘Insurance Standards Bulletin in Section 102 Extension of Transitional Policy through Calendar Year 2017’ issued on February 29, 2016, by the Director of the Center for Consumer Information & Insurance Oversight of such Centers).

(3) CONFORMING AMENDMENT RELATED TO ABBORTION COVERAGE.—Section 36B(c)(3) of
such Code, as amended by paragraph (2), is amended by adding at the end the following new subparagraph:

"(D) CERTAIN RULES RELATED TO ABBORTION.—

"(1) OPTION TO PURCHASE SEPARATE COVERAGE OR PLAN.—Nothing in subparagraph (A) shall be construed as prohibiting any individual from purchasing separate coverage for abortions described in such subparagraph, or a health plan that includes such abortions, so long as no credit is allowed under this section with respect to the premiums for such coverage or plan.

"(ii) OPTION TO OFFER COVERAGE OR PLAN.—Nothing in paragraph (A) shall restrict any health insurance issuer offering a health plan from offering separate coverage for abortions described in such subparagraph, or a plan that includes such abortions, so long as premiums for such separate coverage or plan are not paid for with any amount attributable to the credit allowed under this section or the amount of any advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act.

(iii) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).

(4) CONFORMING AMENDMENTS RELATED TO OFF-EXCHANGE COVERAGE.—

"(A) ADVANCE PAYMENT NOT APPLICABLE.—Section 1412 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

"(i) EXCLUSION OF OFF-EXCHANGE COVERAGE.—Advance payments under this section, and advance determinations under section 1411, with respect to any credit allowed under section 36B shall not be made with respect to any health plan which is not enrolled in through an Exchange.

"(B) REPORTING.—Section 6055(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(I) INFORMATION RELATING TO OFF-EXCHANGE PREMIUM ELIGIBLE COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) so consists of a qualified health plan (as defined in section 36B(c)(3)), which is not enrolled in through an Exchange established under title I of the Patient Protection and Affordable Care Act, a return described in this subsection shall include—

"(i) a statement that such plan is a qualified health plan (as defined in section 36B(c)(3)),

"(ii) the premiums paid with respect to such coverage,

"(iii) the months during which such coverage is provided,

"(iv) the issuer of such coverage,

"(B) the applicable percentage.

"(C) OTHER TREATMENTS.—The treatment of any infection, injury, disease, or disorder that has been caused by or exacerbated by the performance of an abortion shall not be treated as an abortion for purposes of subparagraph (A).

(5) MODIFICATION OF APPLICABLE PERCENTAGE.—Section 36B(b)(3)(A) of such Code is amended to read as follows:

"(A) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—The applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any year in which 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 percentage to the final percentage specified in such table for such income tier with respect to a taxpayer of the age involved:

<table>
<thead>
<tr>
<th>Income Tier</th>
<th>Initial Percentage</th>
<th>Final Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133%</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>133%-150%</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>150%-200%</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>200%-250%</td>
<td>4.3</td>
<td>6.3</td>
</tr>
<tr>
<td>250%-300%</td>
<td>4.3</td>
<td>8.05</td>
</tr>
<tr>
<td>300%-400%</td>
<td>4.3</td>
<td>10.5</td>
</tr>
</tbody>
</table>

"(ii) DETERMINATION OF APPLICABLE PERCENTAGE.—The applicable percentage is determined as the percentage that bears the same relationship to the initial percentage as the final percentage bears to the initial percentage.

(iii) COMPUTATION OF APPLICABLE PERCENTAGE.—The applicable percentage for any taxable year is determined by subtracting the applicable percentage specified for the prior taxable year from the applicable percentage specified for the current taxable year.

(iv) DEFINITIONS.—For purposes of this paragraph:

"(I) ASSUMPTIONS.—The applicable percentage for any taxable year shall be determined as if the following assumptions were in effect:

"(i) the applicable percentage for the prior taxable year is 2% for all income tiers,

"(ii) the applicable percentage for the current taxable year is 10.5% for all income tiers,

"(v) ADJUSTMENT.—The applicable percentage for any taxable year shall be adjusted to reflect—

"(A) the rate of growth in the consumer price index for the period beginning with calendar year 2013 and ending with calendar year 2018,

"(B) the rate of growth in the consumer price index for the period beginning with calendar year 2018 and ending with calendar year 2022.

"(C) NON-APPLICABILITY OF INCREASE IN PERCENTAGE.—The applicable percentage for any taxable year shall not be increased by an amount that is greater than the increase in the applicable percentage for the prior taxable year.

(iv) ADJUSTMENT.—The applicable percentage for any taxable year shall be adjusted to reflect—

"(A) the rate of growth in the consumer price index for the period beginning with calendar year 2013 and ending with calendar year 2018,

"(B) the rate of growth in the consumer price index for the period beginning with calendar year 2018 and ending with calendar year 2022.

"(C) NON-APPLICABILITY OF INCREASE IN PERCENTAGE.—The applicable percentage for any taxable year shall not be increased by an amount that is greater than the increase in the applicable percentage for the prior taxable year.

In the case of household income (expressed as a percent of the poverty line within the following income tier):

<table>
<thead>
<tr>
<th>Income Tier</th>
<th>Initial</th>
<th>Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133%</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>133%-150%</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>150%-200%</td>
<td>4</td>
<td>4</td>
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<td>200%-250%</td>
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<td>6.3</td>
</tr>
<tr>
<td>250%-300%</td>
<td>4.3</td>
<td>8.05</td>
</tr>
<tr>
<td>300%-400%</td>
<td>4.3</td>
<td>10.5</td>
</tr>
</tbody>
</table>

(vii) AGE DETERMINATIONS.—

"(1) IN GENERAL.—For purposes of clause (1), the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

"(2) IN GENERAL.—The age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

"(3) IN GENERAL.—The age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

"(4) IN GENERAL.—The age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

"(5) IN GENERAL.—The age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained by such taxpayer before the close of such taxable year.

"(vi) INDEXING.—In the case of any taxable year beginning in calendar year 2018, the initial and final percentages contained in clause (i) shall be adjusted to reflect—

"(1) the excess (if any) of the rate of premium growth for the period beginning with calendar year 2013 and ending with calendar year 2018, over the rate of income growth for such period, and

"(2) in addition to any adjustment under subparagraph (a)(1), the excess (if any) of the rate of premium growth for calendar year 2018, over the rate of growth in the consumer price index for calendar year 2018.

"(vii) FAILSAFE.—Clause (ii)(1) shall apply only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 162(f) of the Patient Protection and Affordable Care Act for calendar year 2018 exceeds an amount equal to 0.504 percent of the gross domestic product for such calendar year.

(c) EFFECTIVE DATE.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 2017.

(2) ADVANCE PAYMENT NOT APPLICABLE.—Section 1412 of the Patient Protection and Affordable Care Act is amended by adding at the end the following new subsection:

"(i) SHALL NOT APPLY.—This section shall not apply with respect to amounts paid or incurred in taxable years beginning after December 31, 2019.

"(b) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE EXPENSE CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABRONTION.—Subsection (h) of section 45R of the Internal Revenue Code of 1986 is amended—

"(1) by striking ‘‘Any term’’ and inserting the following:

"(i) IN GENERAL.—Any term; and

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

"(A) IN GENERAL.—The term ‘qualified health plan’ does not include any health plan that includes 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).

"(E) OTHER CONFORMING AMENDMENTS.—

"(1) Section 36B(b)(3)(A) of such Code is amended by striking ‘‘and which were enrolled’’ and all that follows and inserting ‘‘or’’. (2) Section 36B(b)(3)(B)(i) of such Code is amended by striking ‘‘the same Exchange’’ and all that follows and inserting ‘‘the Exchange through which such taxpayer is permitted to obtain coverage’’. (3) Section 36B(c)(2)(A)(i) of such Code is amended by striking ‘‘that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act’’.

"(b) MODIFICATION OF APPLICABLE PERCENTAGE.—Section 36B(b)(3)(A) of such Code is amended to read as follows:

"(A) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—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 percentage to the final percentage specified in such table for such income tier with respect to a taxpayer of the age involved:

"(ii) INDEXING.—In the case of any taxable year beginning in calendar year 2018, the initial and final percentages contained in clause (i) shall be adjusted to reflect—

"(1) the excess (if any) of the rate of premium growth for the period beginning with calendar year 2013 and ending with calendar year 2018, over the rate of income growth for such period, and

"(2) in addition to any adjustment under subparagraph (a)(1), the excess (if any) of the rate of premium growth for calendar year 2018, over the rate of growth in the consumer price index for calendar year 2018.

"(iv) FAILSAFE.—Clause (ii)(1) shall apply only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 162(f) of the Patient Protection and Affordable Care Act for calendar year 2018 exceeds an amount equal to 0.504 percent of the gross domestic product for such calendar year.

(c) EFFECTIVE DATE.—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to taxable years beginning after December 31, 2017.
shall apply to taxable years beginning after December 31, 2017.

SEC. 204. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 5000A(c) of the Internal Revenue Code of 1986 is amended by striking—

(1) after subsection (ii), by striking "2.5 percent" and inserting "Zero percent", and

(2) in paragraph (3)—

(A) by striking "$695" in subparagraph (A) and inserting "$0", and

(B) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 205. EMPLOYER MANDATE.

(a) IN GENERAL.—

(1) Paragraph (1) of section 4980B(c) of the Internal Revenue Code of 1986 is amended by inserting "(A) in the case of months beginning after December 31, 2015," after "$2,000.

(2) Paragraph (1) of section 4980B(b) of the Internal Revenue Code of 1986 is amended by inserting "(A) in the case of months beginning after December 31, 2015," after "$3,000.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2015.

SEC. 206. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS FOR FLEXIBLE SPENDING PLAN BENEFITS.

Section 4980(f) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(h) SHALL NOT APPLY.—No tax shall be imposed for a taxable year with respect to any taxable period beginning after December 31, 2019, and before January 1, 2026.

SEC. 207. REPEAL OF TAX ON OVER-THE-COUNTER DRUGS.

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking "Such term" and all that follows through the period.

(b) MSA.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking "Such term" and all that follows through the period.

SEC. 208. REPEAL OF INCOME TAX ON HEALTH SAVINGS ACCOUNTS.

(a) HSAS.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking "20 percent" and inserting "10 percent".

(b) MSA.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking "20 percent" and inserting "15 percent".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to distributions made after December 31, 2016.

SEC. 209. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING ACCOUNTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended by striking subsection (i).

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

SEC. 210. REPEAL OF MEDICAL DEVICE EXCISE TAX.

Section 4191 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"(d) APPLICABILITY.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2016.

SEC. 211. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 233A of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence:

"This section shall not be taken into account for purposes of determining whether any deduction is allowable with respect to any cost taken into account in determining such payment.

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

SEC. 212. REDUCTION OF INCOME THRESHOLD ELIGIBLE FOR MEDICARE CARE DEDUCTION.

(a) IN GENERAL.—Subsection (a) of section 231 of the Internal Revenue Code of 1986 is amended by inserting "10 percent" and inserting: "5.8 percent.

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

SEC. 213. REPEAL OF MEDICARE TAX INCREASE.

(a) IN GENERAL.—Subsection (b) of section 3101 of the Internal Revenue Code of 1986 is amended to read as follows:

"(b) HOSPITAL INSURANCE.—In addition to the tax imposed by the preceding subsection, there is hereby imposed on the income of every individual a tax equal to 1.45 percent of the wage base (as defined in section 3121(a)) received by such individual with respect to employment (as defined in section 3121(b))

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

SEC. 214. REPEAL OF MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 36B of the Internal Revenue Code of 1986 is amended to read as follows:

"(b) ELIGIBLE PREMIUM CREDIT.—(1) ALLOCATION OF PREMIUM TAX CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by the preceding subsection, a credit equal to 1.45 percent of the amount of the self-employment income for such taxable year.

"(2) ELIGIBLE COVERAGE MONTH REQUIREMENTS.—The credit allowed under subsection (a) with respect to any taxpayer for any taxable year shall be reduced (if any) by 10 percent of the excess (if any) of—

"(A) the taxpayer's modified adjusted gross income (as defined in section 36B(b)(2)(B), as in effect for taxable years beginning after 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.

"(4) ELIGIBLE COVERAGE MONTH.—For purposes of this section, the term 'eligible coverage month' means, with respect to any individual, any month in which the individual meets the following requirements:

"(A) 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).

"(B) 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)(B).

"(C) The individual is either—

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


"(D) 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—

"(i) 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 such 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 in 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 1521(b)(5) of the Patient Protection and Affordable Care Act) or a small group 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 is not a grandfathered health plan (as defined in section 36B(c)(3)(C) as in effect for taxable years beginning before January 1, 2020), and

"(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 7704) at the close of any 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.

(2) EXCEPTION FOR CERTAIN TAXPAYERS.—''(A) IN GENERAL.—Except as provided in this paragraph, any married taxpayer who—
(1) is living apart from the taxpayer's spouse at any time during the calendar year in which such individual's taxable year begins,
(2) is unable to file a joint return because such taxpayer is incurring any of domestic abuse or spousal abandonment,
(3) certifies on the tax return that such taxpayer meets the requirements of clauses (i) and (ii), and
(4) has not met the requirements of clauses (i), (ii), and (iii) for each of the 3 preceding taxable years.

(B) COORDINATION WITH RULES FOR EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—''(1) CREDIT FOR EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—For purposes of this paragraph, the term 'qualified small employer health reimbursement arrangement' means any reimbursement arrangement under which each employee or such employee's qualifying family member is provided with a credit to the extent that such arrangement is provided to such employee or such employee's qualifying family member.

(2) QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENT.—''(A) IN GENERAL.—If the taxpayer or any qualifying family member of the taxpayer is provided a qualified small employer health reimbursement arrangement for any month, the amount shall be determined under section 36Al(c)(3)(A), and
(3) the tax imposed by section 1 for such taxable year shall be increased by the excess, if any, of—
(i) the amount which would be paid by such employee or such employee's qualifying family member under such section 1412 for such month and
(ii) the amount which would be paid under such section 1412 for such month if such employee or such employee's qualifying family member were not covered under a qualified health plan which is not a grandfathered health plan (as defined in section 1521(b)(5) of the Patient Protection and Affordable Care Act) for such month.

(4) INFLATION ADJUSTMENT.—''(A) IN GENERAL.—In the case of any applicable month, the amount which would be paid under section 1412 of the Patient Protection and Affordable Care Act for such month shall be increased by the excess, if any, of—
(i) the amount which would be paid under section 1412 of the Patient Protection and Affordable Care Act for such month if such employee or such employee's qualifying family member were not covered under a qualified health plan which is not a grandfathered health plan (as defined in section 1521(b)(5) of the Patient Protection and Affordable Care Act) for such month, and
(ii) the amount which would be paid under section 1412 of the Patient Protection and Affordable Care Act for such month if such employee or such employee's qualifying family member were covered under a qualified health plan which is not a grandfathered health plan (as defined in section 1521(b)(5) of the Patient Protection and Affordable Care Act) for such month.

(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 with a qualified small employer health reimbursement arrangement for any month, the amount shall be determined under section 36Al(c)(3)(A), and
(3) the tax imposed by section 1 for such taxable year shall be increased by the excess, if any, of—
(i) the amount which would be paid by such employee or such employee's qualifying family member under such section 1412 for such month and
(ii) the amount which would be paid under such section 1412 for such month if such employee or such employee's qualifying family member were not covered under a qualified health plan which is not a grandfathered health plan (as defined in section 1521(b)(5) of the Patient Protection and Affordable Care Act) for such month.

"(h) INCREASED PENALTY ON ERRONEOUS CLAIMS OF CREDIT.—Section 6662(a) of the Internal Revenue Code of 1986 is amended by inserting '(25 percent in the case of a claim for refund or credit relating to the health insurance coverage credit under section 36B)' after subsection (a).

"(i) REPORTING BY EMPLOYERS.—Section 6662(a) of such Code is amended by striking 'and' at the end of paragraph (14), by striking the period at the end of paragraph (15) and inserting ', and', and by inserting after paragraph (15) the following new paragraph:

(16) each month with respect to which the employee is eligible for coverage described in section 36B(b)(2) in connection with employment with the employer.

"(j) COORDINATION WITH OTHER TAX BENEFITS.—Section 36B(d) of such Code is amended by adding at the end the following new paragraph:

(1) the term 'Coordinated With Health Insurance Coverage Credit' means—
(2) an eligible coverage month to which the election under paragraph (11) applies shall not be treated as an eligible coverage month (as defined in section 36B(d)) for purposes of section 36B with respect to the taxpayer or any tax payer or any tax payer for whom the election under paragraph (11) was made (as defined in section 36B(e)).

"(k) COORDINATION WITH ADVANCE PAYMENTS OF HEALTH INSURANCE COVERAGE CREDIT.—In the case of a taxpayer who makes the election under paragraph (11) with respect to any eligible coverage month in a taxable year on or before whom any advance pay- ment is made under section 7257 and section 1412 of the Patient Protection and Affordable Care Act, and

(1) the sum of the credits allowed under this section (determined without regard to...
paragraph (1) and section 36B (determined without regard to subsection (g)(4)(A) thereof) for such taxable year, and

(ii) section 36B(g)(4)(B) shall not apply with respect to such taxpayer for such taxable year.

(2) Trade or business deduction.—Section 162(i) of such Code is amended by adding at the end the following new paragraph:

“(g) Coordination with health insurance coverage credit.—The deduction otherwise allowable to a taxpayer under paragraph (1) for any taxable year shall be reduced (but not below zero) by the amount of the credit allowable to such taxpayer under section 36B (determined without regard to subsection (g)(4)(A) thereof) for such taxable year.

(f) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 217. Special rule for certain medical expenses incurred before establishment of health savings account.

(a) In general.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

“(d) Treatment of certain medical expenses incurred before establishment of health savings account.—If a health savings account is established during the 60-day period beginning on the date that coverage of the account beneficiary under a high deductible health plan begins, then, solely for purposes of determining whether an amount paid is used for a qualified medical expense, such account shall be treated as having been established on the date that such coverage begins.

(b) Effective date.—The amendment made by this section shall apply with respect to coverage beginning after December 31, 2017.

Subtitle B—Repeal of Certain Consumer Taxes

SEC. 221. Repeal of excise tax on prescription medications.

Subsection (j) of section 9008 of the Patient Protection and Affordable Care Act is amended to read as follows:

“(j) Repeal.—This section shall apply to calendar years beginning after December 31, 2010, and ending before January 1, 2017.

SEC. 222. Repeal of health insurance tax.

Subsection (j) of section 9019 of the Patient Protection and Affordable Care Act is amended to read as follows:

“(j) Repeal.—This section shall apply to calendar years beginning after December 31, 2013, and ending before January 1, 2017.

Subtitle C—Repeal of Tanning Tax

SEC. 223. Repeal of tanning tax.

(a) In general.—The Internal Revenue Code of 1986 is amended by striking chapter 49.

(b) Effective date.—The amendment made by this section shall apply to services performed after June 30, 2017.

Subtitle D—Remuneration From Certain Insurers

SEC. 241. Remuneration from certain insurers.

Paragraph (e) of section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

“(d) Termination.—This paragraph shall not apply to taxable years beginning after December 31, 2016.

Subtitle E—Repeal of Net Investment Income Tax

SEC. 251. Repeal of net investment income tax.

(a) In general.—Subtitle A of the Internal Revenue Code of 1986 is amended by striking chapter 2A.

(b) Effective date.—The amendment made by this section shall apply to taxable years beginning after December 31, 2017.

The Chair recognizes the gentlewoman from Tennessee.

Mrs. BLACK. Mr. Speaker, I ask unanimous consent that all Members have 7 legislative days in which to revise and extend their remarks on H.R. 1, the American Health Care Act of 2017.

The Speaker pro tempore. Is there objection to the request of the gentlewoman from Tennessee?

There was no objection.

Mrs. BLACK. Mr. Speaker, I yield myself such time as I may consume.

I rise today to speak in favor of the American Health Care Act, a bill that repeals many of the worst aspects of ObamaCare, and begins to repair the damage caused by the law by bringing choice, competition, and patient-centered solutions back into our healthcare system.

Standing here today in the House debating this bill is a proud moment for me. I was working as a nurse in Nashville in the 1990s when, fresh off of the failure of HillaryCare, the Clinton administration pushed out a single-payer pilot program in Tennessee.

As the story goes, Vice President Gore and the Democratic Governor sketched out a program on a napkin while sitting in a local bar. I saw firsthand the negative impact of government-run health care on patient care. I saw the costs rise, and the quality of care fall. I saw the burdens being placed on doctors, patients, hospitals, and care providers. I saw patients faced with fewer choices and more regulation. And I saw the devastating impact that TennCare was having on our State’s budget, gobbling up so much State spending that other priorities like education and infrastructure were getting squeezed.

I couldn’t sit idly by while this was happening in my State, so I decided to get involved in public service, and it is what inspired me to run for office at the very beginning. And when, in 2009 and 2010, I saw the same principles being debated and eventually implemented on the national level, I thought my experience in Tennessee would be valuable to the national debate. I told the people in my district that, if elected to Congress, I would fight to repeal and replace ObamaCare.

In 2011, I sponsored the first piece of legislation that replaced a part of ObamaCare. And today, we take the largest step yet in rescuing the American people from the damage that has been done by ObamaCare.

We are united in our goal to repeal ObamaCare and advance it with patient-centered health care. Right now, ObamaCare is imploding. We were promised premiums that would decrease by $2,500; instead, average family premiums in the employer market have increased by $3,000.

We were promised healthcare costs would go down; instead, deductibles have skyrocketed.
We were promised we could keep our doctor, and keep our health insurance plans; instead, millions of Americans have lost their insurance and the doctors that they liked.

In short, the Affordable Care Act was neither affordable, nor did it provide the quality of care that the American people deserve.

The American Health Care Act is a first step in our efforts to deliver patient-centered care reform. This bill returns to the American people freedom and choice in their healthcare decisions. It gets government out of the relationship between patients and their doctors—where it has never belonged—and puts people back in charge of their own health care. It brings the free market principle of competition to an industry that has long been dominated by government intervention.

Today we are faced with a stark choice. Do we continue the damage ObamaCare is doing to our health care system with no congressional hearings, not a single one, on a bill that impacts the health care of nearly every American.

That is a potential health crisis for millions of Americans. It nearly doubles the amount of uninsured people in this country, guts Medicaid, giving $1 trillion in tax cuts to corporations and millionaires, and corporate welfare, saving care is being stolen.

Mr. Speaker, I reserve the balance of my time.

Mr. YARMUTH. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, after 7 years of campaigning against the Affordable Care Act, congressional Republicans have finally produced a cynically described as a replacement plan.

Sadly, however, this bill will unravel all of the progress we made under the ACA, including expanding access to health insurance to 22 million Americans and improving the quality of coverage and care for tens of millions more.

It nearly doubles the amount of uninsured people in this country, guts Medicaid by almost $900 billion, and weakens the Medicare trust fund.

That was bad enough. But the last-minute changes to this bill are astonishing and appalling. This legislation now allows insurers to end coverage for prescription drugs, mental health, maternity and newborn care, preventive care, emergency room visits, hospitalizations, outpatient care, rehab visits, lab services, and pediatric care. That is not progress. That is not a fix.

That is a potential health crisis for every American.

My Republican colleagues are well aware of this. Why else would they have drafted this bill and these last-minute changes in secret? Why else would complicated legislation affecting the lives of millions be sent to the floor just 2 weeks after it was introduced with no congressional hearings, not a single one, on a bill that impacts the health care of nearly every American family? Why else would they rush the bill to the floor without an updated Congressional Budget Office estimate of how much coverage and care will be lost by their backroom deal that ends consumer protections?

I get it. I wouldn’t want to, nor would I know how to justify giving nearly $1 trillion in tax cuts to corporations and the wealthy paid for by the health and the health care of the wellbeing of millions of American families.

Who is getting these huge windfalls? Companies like Amgen, with annual profits of more than $3 million; Medtronic, with annual profits of more than $6 billion; and Gilead Sciences, with $13 billion in profits in 2016 alone.

When the CBO released its report last week showing that 24 million hard-working Americans will be left without healthcare coverage by 2026 if we pass this bill, that premiums will rise 15 to 20 percent next year, that people will pay thousands of dollars more in deductibles and out-of-pocket costs, and that older Americans will be priced out of the market by an age tax, I thought for sure it would mean that there was no way my Republican colleagues would walk this plank. But here they are, and they are trying to take millions of American families with them.

Fourteen million Americans will lose health coverage next year if this bill is approved. Twenty-one million Americans will lose coverage in the next 3 years alone, wiping out all of the coverage gains from the ACA in just 3 years. For pretty much everyone else in the individual market, deductibles and other costs will be higher. And for lower-income individuals, out-of-pocket costs will be much higher.

Insurance companies will again be able to sell plans that offer much less financial protection, and we will return to the days when millions of people in this country will live in fear that they are always one serious illness or accident away from bankruptcy.

This bill will result in the largest transfer of wealth from struggling families to the well-off in our Nation’s history, giving $1 trillion in tax breaks to millionaires, billionaires, and corporations. It is Robin Hood in reverse, but this is far worse because access to lifesaving care is being stolen.

I don’t say that casually. I have met people, constituents of mine, whose lives have been saved because of the Affordable Care Act.

This is from one of my constituents: “My name is Kevin Schweitzer. I am 62 years old and I’m a lifelong resident of Louisville, Kentucky. “I worked hard, took risks and built a successful small business that I sold at age 59. My wife and I were excited about our prospects as we headed into early retirement. As a retiree too young for Medicare, I purchased health insurance on the open market. Less than a year later, I was diagnosed with lymphoma. I have undergone multiple therapies, which has been winning the battle so far, but since this disease is in my blood I will be fighting it for the rest of my life.”
"A cancer diagnosis is a life-changing event that not only attacks the body, but the mental stress is just as tough to deal with. Thanks to ObamaCare, I've been able to rest easier knowing that my illness wouldn't bankrupt my family and that I'll be able to provide for my 12-year-old daughter."

I also heard from a young woman named Sarah Adkins. She suffers from chronic kidney disease. Sarah was able to get health insurance because of the ACA. On January 9, 2011, it saved her life. Her doctors shut down and almost went septic. If she didn't have coverage, she would have waited or not gone to the hospital at all. The doctor told her that if she had arrived at the ER an hour later, she would have died.

Mr. Speaker, the health of my constituents Kevin Schweitzer and Sarah Adkins is at stake in this debate. They, and the hundreds of other constituents I have heard from who have serious and chronic health conditions, will need high-quality, affordable health care for the rest of their lives. Under this bill, they will get less coverage, it will cost more, and eventually they will be priced out of the market, leaving them nowhere to turn for the care they need.

And that is not all. Because of the last-minute changes to this bill, insurers will be able to sell stripped-down coverage to weed out people with pre-existing conditions. They will be able to refuse, for example, to offer coverage for chemotherapy drugs and cancer treatments, insulin pumps, hospital stays, and prescription drugs that treat chronic conditions across the board. Basically, if you have a serious health problem, the care you need may not be available to you at all.

When the American people were promised by President Trump and Republican congressional leadership that their existing coverage would be preserved, nobody would buy insurance and it would be less expensive and much better, they, understandably, believed they would be treated much better than this. None of those promises are in this bill. In fact, the opposite of every one of those promises is what is in this bill. Those were promises made to every family in our congressional districts, and this bill fails them at every turn.

Mr. Speaker, I urge my colleagues to oppose this legislation, and I reserve the balance of my time.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. McClintock).

Mr. MCCLINTOCK. Mr. Speaker, I remind the gentleman from Kentucky that everyone, for example, to our American people in support of ObamaCare was rapidly broken. We are now, at this moment in time, watching the death throes of ObamaCare.

More people are paying the State tax penalty on the claiming hardship exemptions than are buying ObamaCare policies. In a third of our counties, there is no choice left at all. You get one provider. Soon, we are warned, some regions will have no providers at all. Premiums soared an average of 25 percent last year, and this year we are warned it could be 40 percent or more.

Critics cite the CBO estimate that 24 million Americans will lose their coverage under this bill. I understand their reasoning there. The CBO believes that people won't buy health insurance unless we force them to buy health insurance. In fact, people won't buy health insurance that is not a good value to them, and, clearly, ObamaCare isn't.

We replace it with a vigorous buyer's market where plans across the country will compete to offer consumers better services at lower prices tailored to their own needs and wants. And we assure these plans are within their financial reach with $90 billion of additional support that the CBO simply ignores.

The AHCA's biggest achievement is to replace coercion with choice for families and individuals. It requires employers to mandate that forces Americans to buy products they don't want. It ends the employer mandate that has trapped low-income workers in part-time jobs. It begins to restore consumers' freedom of choice, the best guarantee of quality and value in any market. It allows Americans to meet more of their healthcare needs with pre-tax dollars. It relieves the premium base of the enormous cost of preexisting conditions, mandating them to a block-granted assigned risk pool.

Mr. Speaker, ObamaCare is collapsing, premiums are skyrocketing, and providers are fleeing. This may well be our last off-ramp on this road to ruin.

Mr. YARMUTH. Mr. Speaker, I remind my colleagues that his vote for this bill will result in 38,200 people from his congressional district in California losing health care and coverage. Please, Mr. Speaker, tell me your constituents from the gentlewoman from California (Ms. Lee), a distinguished member of the Budget Committee.

Ms. LEE. Mr. Speaker, I rise in strong opposition to H.R. 1628, which is a bill to take away health care from 24 million Americans.

Whether you believe it or not, health care is a basic right. This shameful bill steals from those who can least afford it, including seniors, veterans, people living with HIV, children, and the disabled. It would, yes, rip away health care from 24 million people. It would reduce benefits, make families pay more for less, and transfer $600 billion in tax cuts to the very wealthy. This is outrageous. It is important to understand the economic reach with $90 billion of additional support.

Access to women's health is denied by defunding Planned Parenthood. Medicaid, as we know it, will end. Healthcare costs for working families and seniors will skyrocket. And now it eliminates essential health benefits like maternity, mental health, and emergency care.

This is not a health bill. It is a tax giveaway to the wealthy.

Let me tell you, as a woman of faith, I am appalled and I am saddened by the hypocrisy displayed in this bill by people who say they are religious. I want to remind you—in the Scriptures, the Book of Mark, chapter 12:31, we are reminded to love your neighbor as your self.

This bill shows disdain for the most vulnerable and would lead to death and destruction and disease for millions of Americans. I hope Republicans remember to love their neighbor as themselves today and vote "no" on this mean-spirited bill. Let's defeat this harmful and morally bankrupt bill. This is a matter of life and death, and the American people deserve better.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. Johnson), a member of the Budget Committee.

Mr. JOHNSON of Ohio. Mr. Speaker, the American people spoke loudly and clearly last November. They said that they have been speaking loudly and clearly ever since this fatally flawed bill called ObamaCare was signed into law. And now we are hours away from the vote that the American people have been waiting years for.

This vote can be distilled down to simply this, and each Member of this body must ask themselves this simple question: Are they willing to allow ObamaCare to remain the law of the land? Are we going to begin to restore healthcare decisions to the American people and their doctors?

Those who choose to vote against the American Health Care Act, regardless of how they attempt to justify it, will be voting to keep ObamaCare in place. This is an inexplicable fact that will remain long after the smoke and spin and handwringing from political pundits following this vote has gone and disappeared, regardless of how the votes go.

There is no such thing as perfect legislation in a body of 435 men and women representing 435 different parts of the Nation.

There is consensus among the American people that this law should be repealed and replaced, and today the people's House will either acknowledge the will of the people or we will defy it.

Mr. YARMUTH. Mr. Speaker, I remind my colleagues that his vote for this bill will result in 40,500 people from his congressional district in Ohio losing health coverage and care.

Mr. Speaker, I yield 1½ minutes to the gentleman from Massachusetts (Mr.oulton), a distinguished member of the Budget Committee.

Mr. Moulton. Mr. Speaker, I would also like to remind the gentleman from Ohio that the latest poll put the will of the American people at 17 percent in favor of this bill.

I would like to read a message from my Republican constituent:

"The American Health Care Act would strain the fiscal resources necessary to support the Commonwealth's
This constituent is the Republican Governor of Massachusetts, who knows that TrumpCare destroys our ability to ensure access to quality, affordable healthcare coverage.

Another Republican in my State, Governor Mitt Romney, worked with the Democratic legislature to create the Nation’s first system to provide affordable health care. RomneyCare wasn’t perfect, but Republicans and Democrats worked together to improve it, and they created a system with higher approval ratings than TrumpCare or even ObamaCare.

We can do this. Health care should not be partisan. It should be about investing in our people, in our families, and in our future so that Americans can live healthy, productive lives. But that is not what this Republican TrumpCare bill does.

Michael is a constituent from Gloucester, the old fishing city. He was prescribed OxyContin by his doctors, and then became addicted. But he was able to get treatment through Medicaid, the kind of program that will be cut by TrumpCare. He is now back at work as an electrician, and he says that the Affordable Care Act saved his life.

I am a veteran, and I get my health care at the VA. Sometimes it takes me months to get an appointment. If this Republican bill passes, it will throw 8 million veterans off private health care, integral to them into the VA, and creating even longer wait times. That is no way to treat those who have put their lives on the line for our country.

Perhaps it’s no surprise that this bill is being jammed down the throats of Congress and the American people like a dead fish.

Nobody wants it and it will make a lot of people sick.

What we should be doing here in Washington is coming together as Republicans and Democrats—open, honest debate, and improve the health care system.

Everyone says Congress doesn’t work—don’t prove them right.

I urge my colleagues to vote no on this terrible bill and instead come to the table like we did in Massachusetts.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Minnesota (Mr. LEWIS), who is a distinguished member of the Budget Committee.

Mr. LEWIS of Minnesota. Mr. Speaker, I rise today in support of the American Health Care Act, and I ask the other side: Just what is it you are trying to preserve by voting “no”?

Premiums rising double digits for years for the last 7 years? In my home State of Minnesota, back-to-back premium increases of 50 to 67 percent?

Young, healthy people being priced out of the insurance market, 8 million in 2014, choosing to pay the penalty instead of buying insurance?

That is the genesis of the death spiral in the insurance markets. That is what this bill is trying to correct.

Deductibles, copays—I had a deductible on my own individual policy, a skyrocketing deductible. There are deductibles of $13,000. That is not health care. That is not even access.

Drug formularies being tightened to save money, so people are denied prescriptions. The opioid drug tax; thousands of Minnesotans losing their plans, 100,000 when a big insurer dropped out; 1,000 counties with one insurer—that is what you are trying to preserve on the other side, people voting “no” on this bill.

Emergency State legislation trying to prop up MNsure in my home State because it is failing, and $1 trillion in taxes and spending that is bankrupting the country—that is what the other side is trying to preserve.

Those voting “no” on this bill, we have a choice today. You can embrace the status quo and see the markets spiral out of control completely, or you can vote for change and do the right thing.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 50,200 people from his congressional district in Minnesota losing health coverage and care.

I yield 2 minutes to the gentleman from New York (Mr. JEFFRIES), a distinguished member of the Budget Committee.

Mr. JEFFRIES. Mr. Speaker, the Trump Presidency has been characterized by a lack of consensus, and this Republican healthcare debacle has been no different.

The American people clearly understand that TrumpCare will be an unmitigated disaster. Under TrumpCare, working families will pay more and get less. Under TrumpCare, premiums will increase. Under TrumpCare, copays will increase. Under TrumpCare, deductibles will increase. Under TrumpCare, out-of-pocket expenses will increase.

Under TrumpCare, 24 million hardworking Americans will lose their health coverage. Under TrumpCare, individuals between the age of 50 and 64 will pay a regressive age tax.

Health care is a matter of life and death; that is why we take it so seriously. TrumpCare will lead to increased death, disease, and destitution, and that is why we oppose this horrible piece of legislation.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. ARRINGTON) who is a member of the Budget Committee.

Mr. ARRINGTON. Mr. Speaker, Obamacare’s disastrous effects over the last seven years have wreaked havoc on our small businesses, broken the backs of middle and working class families, and have had a disproportionately negative impact on rural America. Those are the folks who I represent in west Texas.

While the current bill before us is far from perfect—and let’s be honest, there is no such thing as perfect legislation—it reverses course and takes us in the right direction. It repeals the mandates and restores freedom to individuals and markets.

It repeals about $1 trillion of taxes. It reduces deficit spending by over $100 billion, making it the largest entitlement reform since Medicare. It rolls back regulations, gives maximum flexibility to States, and begins to defederalize health care.

For 7 years now, Republicans have promised the American people that if we give control of the Presidency and the House and the Senate, then we would replace and replace ObamaCare. And now that we are given the opportunity to govern and to keep our promises and to deliver results for the American people, we can’t let perfection be the enemy of good.

The debate is now closing. We have two choices. We either pass a good but imperfect bill, or we leave ObamaCare in place. That is an unacceptable alternative.

As leaders, we have a moral obligation to do something, to not stand idly by while the people suffer under a system that is failing them.

If we are going to restore the greatness of America and transfer power back to the people, we need more than policy solutions, even perfect policy solutions. We need the political will and the courage to lead.

This is a rescue mission, Mr. Speaker, and it isn’t without risk; but I have faith in the President and his team. I have faith in our States and the free markets, and, above all, Mr. Speaker, I have faith in the American people.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 60,400 people from his congressional district in Texas losing health coverage and care.

I yield 2 minutes to the gentleman from New York (Mr. HIGGINS), a distinguished member of the Budget Committee and the Ways and Means Committee.

Mr. HIGGINS of New York. Mr. Speaker, this never needed to be an ideological fist fight. Democrats were always willing to take into account serious and constructive alternatives to the law that we have today that make it better, to make it affordable, more affordable for the American people.

But this bill is a blatant takeaway from the American people of money back protection. If you are 50 to 64 years old, you get clobbered. If you are 64 years old, you make $26,000 a year, according to the Republican-led Congressional Budget Office, your premiums go from $1,700 a year to $14,000 a year.

Fact: UnitedHealthcare is one of the largest private health insurers in America.

Fact: UnitedHealthcare will have $200 billion in revenues this year, and they paid their chief executive officer $66 million in compensation in 2014.

Fact: UnitedHealthcare is under investigation today by the Department of Justice for stealing billions of dollars from the Medicare program.
Fact: The Republican health bill, on page 67, in 7 words, gives UnitedHealthcare, their high-paid executives, and all of their cronies, a massive tax cut to continue to screw the American people.

Mr. Speaker, we can do much better. We are prepared to do much better. But this is a financial assault on good, hardworking Americans who want to do one thing at the end of the day, after paying too much money for health care throughout the year, and that is, we are, for the first time, equalizing something. Make no mistake; people who do not have employer-provided health care.

Those of us who have employer-provided health care, 170 million Americans, that is not a taxable event for them; yet, if you are the person who have to pay tax at the end of the year on the value of that employer-provided health care.

And yet, if you are the person who does not have employer-provided health care, you and your husband and wife with two kids making 45 or $50,000, and your employer does not provide health care, you receive absolutely no tax subsidy through the Tax Code.

This bill, through the advance refundable tax credits, will, for the first time, give someone the choice to buy health care and give them the opportunity and the means to buy health care that they previously have not had. It is not a markedly important distinction, frankly, from the Affordable Care Act, where you only could buy the health care through an exchange-approved policy.

This policy, under this legislation today, will allow someone the flexibility and the freedom to buy a policy of their choosing, not one dictated by Washington. So that is a fundamental important distinction between the status quo and what this legislation would offer.

Mr. Speaker, and my colleagues, I urge support for the bill. It is not perfect, as we all know, but it is something that is long overdue.

I would also point out that the numbers that my colleague from Kentucky uses are really based upon fantasy. Those numbers are simply incorrect, and the people of our State and our country will have health care under the provisions of this bill, and we will work hard to ensure that they do.

Mr. YARMUTH. Mr. Speaker, I remind my colleagues that his vote for this bill will result in 65,800 people from his congressional district in New York losing health coverage and care.

I yield 2 minutes to the gentlewoman from Washington (Ms. DELBENE), a distinguished member of the Budget Committee.

Ms. DELBENE. Mr. Speaker, if Republicans published a book that lived up to the promise of insurance for everybody, they would have broad bipartisan support. But that is not what they did.

This bill threatens massive disruption and costs to our healthcare system, but to middle class families, families who sit at their kitchen table trying to figure out how to pay their mortgage, buy groceries, and also get health coverage for their kids. This Republican bill does nothing to help them.

In their rush to check a political box, Republicans have crafted legislation that does nothing but hurt working Americans, and, in the last 24 hours, it has gone from bad to worse. Make no mistake; the changes made in the 11th hour to appease the most extreme Members of Congress have put lifesaving care even further out of reach.

Some may use alternative facts, but this is reality, and the reality is that their bill robs $75 billion from Medicare, forces older Americans to pay five times more than others, and shifts $312 billion in out-of-pocket costs onto middle class families.

But this is about more than numbers. It is about people like Rachel, from Kirkland, Washington, who suffered a heart attack and blood clot at the age of 35. She now depends on frequent tests, medications and doctors’ visits to stay healthy. Thankfully, it is all covered by her insurance.

Rachel told me: “I’m horrified by the talking point that equates repealing the Affordable Care Act with getting freedom back. For me, the loss of the ACA means nothing but the freedom to die sooner and worry more.”

I am not voting against this bill because it is a Republican bill. I am voting “no” for families like Rachel’s.

Health care doesn’t need to be a partisan issue, and I stand ready and willing to work on commonsense solutions that expand coverage and reduce costs. But I was sent here to make my constituents’ lives better. This bill does not do that. I encourage my colleagues to vote “no”.

Mr. Speaker, and my colleagues, I urge support for the bill. It is not perfect, as we all know, but it is something that is long overdue.

I would also point out that the numbers that my colleague from Kentucky uses are really based upon fantasy. Those numbers are simply incorrect, and the people of our State and our country will have health care under the provisions of this bill, and we will work hard to ensure that they do.

Mr. GAETZ. Mr. Speaker, I specifically implore my conservative colleagues to vote for this bill and give us a chance to get out from under this disasterous law. This legislation represents $1 trillion in tax cuts, $1.15 trillion in spending cuts, $1.5 trillion in deficit reduction; defunding Planned Parenthood.

How long have we been fighting to defund Planned Parenthood?

Close the illegal alien loophole that allows people to enroll in ObamaCare, only to check their status in this country subsequently.

We install work requirements. I don’t think people that are able to work but not to choose to go life of leisure in China to pay for their health care. Installing those work requirements is fundamental to bold conservative reform.

Block grants for States so that finally they can be liberated from the oppressive hand of the Federal Government, and also blocking States from additional Medicaid expansion.

We have been engaging in these conservative fights for years, and finally, today, we have got the chance to put a win on the board; and so I am joining our President, our Speaker, and many conservatives in this Congress in voting for the American Health Care Act. Choose, in the end, do this, not only do we enhance our economy, not only do we free up opportunities for broader prosperity in America, but we allow people to be in charge of health care, and we move from a government-centered system to a patient-centered system. That was the promise we made in the elections, and that is the promise I intend to keep by voting for this bill.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 50,000 people from his congressional district in Florida losing health coverage and care.

I yield 1 3⁄4 minutes to the gentlewoman from Florida (Ms. WASSERMAN SCHULTZ), a distinguished member of the Budget Committee.
Mr. Speaker, I urge all my colleagues to vote “yes,” because this bill is not about freedom or choice. This bill is a travesty, and the American people will pay the price.

This is not a healthcare bill. The only people who benefit are millionaires, billionaires, and insurance companies, who will get $1 trillion in tax benefits while working Americans pay more and get nothing. Mr. Speaker, this bill is pure greed, and real people will suffer and die from it. Vote “no,” and protect our care.

Mr. BLACK. Mr. Speaker, I yield myself such time as I may consume. I want to recognize that our Members on the other side of the aisle are sharing some data on the coverage of per congressional district based on a study that was conducted by the Center for American Progress, which is a left-leaning organization to begin with. The Center for American Progress employs a flawed methodology for estimating this coverage. In
Mr. Speaker. I yield 1 ½ minutes to the gentleman from California (Mr. McCLINTOCK), who is a member of our committee.

Mr. McCLINTOCK. Mr. Speaker, I simply want to underscore what the chairwoman of the Budget Committee has so clearly laid out.

When my friend from Kentucky says that his constituents will lose coverage, he is basing it on two premises. He is ignoring the $90 billion of additional funds that we freed up in the Budget Committee to assure that nobody will face sticker shock as we make this transition.

Second, he assumes that the only reason that people buy insurance is if we force them to buy it. The reality is many are driven by Obamacare policies even when they are faced with these crushing tax policies. The AHCA replaces this heavyhanded and failing bureaucratic nightmare.

Ultimately, we are going to be judged not on polls or fairy tales, but on whether the vast majority of Americans have a better experience with this new consumer-driven market than they had with the bureaucratized, one-size-fits-all Obamacare system. That system was weighed in the balance and found wanting by the American people, and I am here to stake my reputation on the prediction that they will find better policies with better services at lower costs when they are restored the freedom to be consumers in a marketplace with a supportive tax structure that assures that these policies are within the financial reach of every American family.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 38,200 people from his congressional district in California losing health coverage and care.

Mr. Speaker, I yield 1 ½ minutes to the gentleman from California (Mr. CARBAJAL), who is a distinguished member of the Budget Committee.

Mr. CARBAJAL. Mr. Speaker, before I came to Congress, I worked in local government as a county supervisor. One of my proudest achievements during that time was working in a bipartisan way to create a program that reduced the rate of uninsured children in our county by over 90 percent—all because the Affordable Care Act was signed into law. Since the Affordable Care Act, I saw firsthand the direct and positive impact of this legislation over the past 7 years to communities and families across the central coast.

The AHCA means Sarah, from Lompoc, could open her small business and afford insurance coverage for her two children. It meant that Kathleen, in San Luis Obispo, who was diagnosed with ovarian and breast cancer, that her $500,000 medical bill was covered by her healthcare plan. It meant that Adrienne, from Buellton, now could afford to pay for her husband’s nursing facility, as his debilitating disease prevents her from being able to physically care for him.

Repealing legislation that has improved the quality of life not only for Sarah, Kathleen, and Adrienne, but for the over 20 million Americans who have gained since under the Affordable Care Act, would be callous, cruel, and irresponsible.

Instead of taking away health care from 24 million Americans, let’s work together to create a more equitable, affordable, and accessible healthcare system for all.

Mrs. BLACK. Mr. Speaker, I yield 1 minute to the gentleman from South Carolina (Mr. SANFORD).

Mr. SANFORD. Mr. Speaker, I want to make clear that I agree with what every Republican speaker has said thus far on the need to repeal and replace the Affordable Care Act. I want to say how much I admire the Speaker and the leadership team, President Trump and his team, Chairwoman BLACK, and others on the Budget Committee for what they have brought to bear.

My simple question is one of timing. What I tell my boys consistently is: If you don’t know, you don’t go.

One of the things that I think we have to realize is this bill is one of process. It does a lot of good things, as has been pointed out by the Republican speakers, but it still leaves in place community rating. It leaves in place the architecture, I think, of a flawed bill that came with the Affordable Care Act.

The question is: Can we build on top of that to do the very good things that are talked about in this bill, or do we take just a little bit more time to make certain it is right?

I think that when you look at this notion of lowering premiums, look at it like rent control in New York. Rent control in New York has done a lot of good for some folks, but it has hurt a lot of others.

The question we fundamentally have to ask ourselves is: At this juncture, can we make the changes necessary?

Mr. YARMUTH. Mr. Speaker, I mention to my colleague that his vote against this bill will result in 56,600 people from his congressional district in South Carolina losing health coverage and care.

Mr. Speaker, I yield ⅓ minutes to the gentlewoman from Texas (Ms. JACKSON LEE).

Ms. JACKSON LEE. Mr. Speaker, I thank the distinguished gentleman of the Budget Committee for his leadership.

Our mothers and our doctors have warned us about poison pills. Well, let me say that, this morning, the Republicans are giving to the American people a poison meal that would affect my friend, the senior citizen, with $175 billion being taken out of Medicare; a poison meal that will affect a young child who is being seen by a doctor.

The Children’s Hospital Association, including the Texas Children’s Hospital, has said to vote “no” on this bill because 30 million children will have no health insurance.

This will impact working families making $31,000 a year. They will have to pay $4,000 more out of pocket. In 2026, under pay for more than, $352 million Americans will be uninsured.

This poison meal is getting worse and worse.

Then, in the dark of night, what did they do? They took away hospitalization. They took away pregnancy, maternity, and newborn care. They took away mental health and substance abuse care.

Those States that are experiencing the opioid abuse and epidemic, what are they going to do?

They have threatened community health centers. They are closing rural hospitals.

What is this disaster of TrumpCare?

It is injuring my good friend who is sitting there in the hospital room. It is injuring Anna Nunes. It is injuring small businesses who say that they can live better under the Affordable Care Act, and the youngster that is a junior in college who said she would not go to college had it not been for the Affordable Care Act.

More than half of the American people—and it is growing—are against this bill done in the dark of night. It is the poison meal that is being kept those who need health insurance away from health insurance.

I ask my colleagues to vote “no.” Don’t feed the American people a poison meal.

Mr. Speaker, as a member of the Budget Committee and the representative of a congressional district that has benefited enormously from the Affordable Care Act, I rise in strong and unyielding opposition to H.R. 1628, the so-called “American Health Care Act,” which more accurately should be called “Trumpcare, the Pay More For Less Act.”

Seven years ago yesterday, March 23, 2010, President Barack Obama signed into law the landmark Affordable Care Act passed by the Democratic controlled 111th Congress.

Seven years later, the verdict is in on the Affordable Care Act; the American people have judged it a success and are unanimously opposed to any effort to repeal a law that has brought to more than 20 million Americans the peace of mind and security that comes with...
knowing they have access to affordable, high quality health care.

Before the passage of the Affordable Care Act, 17.1 of Americans lacked health insurance; today nearly nine of ten (89.1%) are insured, which is the highest rate since Gallup began tracking health insurance coverage in 2008.

Because of the Affordable Healthcare Act:
1. insurance companies are banned from discriminating against anyone, including 17 million children, with a preexisting condition, or charging higher rates based on gender or health status;
2. 6.6 million young-adults up to age 26 can stay on their parents’ health insurance plans;
3. 100 million Americans no longer have annual or life-time limits on healthcare coverage;
4. 6.3 million seniors in the “donut hole” have saved $6.1 billion on their prescription drugs;
5. 3.2 million seniors now get free annual wellness visits under Medicare, and
6. 360,000 Small Businesses are using the Healthcare Tax Credit to help them provide health insurance to their workers;
7. Pregnancy is no longer a pre-existing condition and women can no longer be charged a higher rate just because they are women.

We are becoming a nation of equals when it comes to access to affordable healthcare insurance.

The President and congressional Republicans call this enviable record of success a “disaster.”

The American people do not agree and that is why they reject overwhelmingly (56%–17%) this Republican attempt to repeal the Affordable Care Act according to the latest Quinnipiac poll.

Americans know a disaster when they see one and they see one in the making: it is called “Trumpcare,” masquerading as the “American Health Care Act,” which will force Americans to “pay more for less.”

And they are right to be alarmed at what they see.

This “Pay-More-For-Less” bill is a massive $900 billion tax cut for the wealthy, paid for on the backs of America’s seniors, the vulnerable, the poor, and working class households.

This “reverse” bill is unprecedented and breath-taking in its audacity—no bill ever tried to give so much to the rich while taking so much from the poor and working class.

Trumpcare represents the largest transfer of wealth from the bottom 99% to the top 1% in American history.

This callous Republican scheme gives gigantic tax cuts to the rich, and pays for it by taking insurance away from 24 million people, leaving 52 million uninsured, and raising costs for the poor and middle class.

In addition, Republicans are giving the pharmaceutical industry a big tax repeal, worth nearly $25 billion over a decade without demanding in return any reduction in the cost of prescription and brand-name drugs.

To paraphrase Winston Churchill, of this bill, it can truly be said that “never has so much been taken from so many to benefit so few.”

The Pay-More-For-Less plan destroys the Medicaid program under the cover of repealing the Affordable Care Act Medicaid expansion.

CBO estimates 14 million Americans will lose Medicaid coverage by 2026 under the Republican plan.

In addition to terminating the ACA Medicaid expansion, the bill converts Medicaid to a per-capita cap that is not guaranteed to keep pace with health costs starting in 2020.

The combined effect of these policies is to slash $880 billion in federal Medicaid funding over the next decade.

The cuts get deeper with each passing year, reaching 25% of Medicaid spending in 2026.

These steep cuts will force states to drop people from Medicaid entirely or ration care for those who most need access to comprehensive coverage.

The Pay-More-For-Less plan undermines the health care safety net for vulnerable populations.

Currently, Medicaid provides coverage to more than 70 million Americans, including children, pregnant women, seniors in Medicare, people who are too disabled to work, and parents struggling to get by on poverty-level wages.

In addition to doctor and hospital visits, Medicaid covers long-term services like nursing homes and home and community-based services that allow people with chronic health conditions and disabilities to live independently.

By 2026, 31 states and D.C. have expanded Medicaid eligibility to low-income adults, which, when combined with the ACA’s other improvements, has helped to reduce the nation’s uninsured rate to the lowest in history.

Trumpcare throws 24 million Americans off their health insurance by 2026 according to the Congressional Budget Office.

Low-income people will be hit especially hard because 14 million people will lose access to Medicaid by 2026 according to CBO.

Trumpcare massively shifts who gets insured in the nongroup market.

According to CBO, “fewer lower-income people would obtain coverage through the nongroup market under the legislation than current law,” and, “a larger share of enrollees in the nongroup market would be younger people and a smaller share would be older people.”

The projected 10% reduction in premiums is not the result of better care or efficiency—it is in large part the result of higher-cost and older people being pushed out of a market that is also selling plans that provide less financial protection.

People with low incomes suffer the greatest losses in coverage.

CBO projects the uninsured rate for people in their 30s and 40s with incomes below 200% of poverty will reach 38% in 2026 under this bill, nearly twice the rate projected under current law.

Among people aged 50–64, CBO projects 30% of those with incomes below 200% of poverty will be uninsured in 2026.

Under current law, CBO projects the uninsured rate would only be 12 percent.

Being uninsured is not about “freedom.”

Speaker Ryan has argued that people will happily forgo insurance coverage because this bill gives them that “freedom.”

The argument makes as much sense as the foolish claim that slaves came to America as “immigrants” seeking a better life.

The freedom to be uninsured is no freedom at all to people in their 50s and 60s with modest incomes who simply cannot afford to pay thousands of dollars toward premiums.

They do not really have a choice.

The claim of our Republican friends that Trumpcare provides more freedom to all Americans calls to mind the words of Anatole France:

“The law, in its majestic equality, forbids the rich as well as the poor to sleep under bridges, to beg in the streets, and to steal bread from the market.”

Trumpcare raises costs for Americans nearing retirement, essentially imposing an “Age Tax.”

The bill allows insurance companies to charge older enrollees higher premiums than allowed under current law, while reducing the size of premium tax credits provided.

Again, these changes hit low-income older persons the hardest.

A 64-year-old with an income of $26,500 buying coverage in the individual market will pay $12,900 more toward their premiums in 2026, on average.

Trumpcare raises costs for individuals and families with modest incomes, particularly older Americans.

A recent analysis found that in 2020, individuals with incomes of about $31,000 would pay on average $4,000 more out of pocket for health care—which is like getting a 13% pay cut.

And the older you are, the worse it gets.

An analysis by the Urban Institute estimates that for Americans in their 50s and 60s, the tax credits alone would only be sufficient to buy plans with major holes in them, such as a $30,000 deductible for family coverage and no coverage at all of brand-name drugs or many therapy services.

Another reason I oppose the Trumpcare bill before us is because its draconian cuts in Medicaid funding and phase-out of Medicaid expansion put community health centers at risk.

Community health centers are consumer-driven and patient-centered organizations that serve as a comprehensive and cost effective primary health care option for America’s most underserved communities.

Community health centers serve as the health care home for more than 25 million patients in nearly 10,000 communities across the country.

Across the country, 550 new clinics have opened to receive 5 million new patients since 2009.

Community health centers serve everyone regardless of ability to pay or insurance status:
1. 71% of health center patients have incomes at or below 100% of poverty and 92% have incomes less than 200% of poverty;
2. 49% of health center patients are on Medicaid; and
3. 24% are uninsured.

4. Community health centers annually serve on average 1.2 million homeless and more than 300,000 veterans.

Community health centers reduce health care costs and produce savings—on average, health centers save 24% per Medicaid patient when compared to other providers.

Community health centers integrate critical medical and social services such as oral health, mental health, substance abuse, case management, and translation, under one roof.
Community health centers employ nearly 190,000 people and generate over $45 billion in total economic activity in some of the nation’s most distressed communities.

Community health centers serve on the front lines of major health crisis our country faces, from trauma centers to care (and employment) to veterans to respond to addressing the opioid epidemic to responding to public health threats like the Zika virus.

Mr. Speaker, community health centers are on the front lines of every major health crisis our country faces, from trauma centers to care (and employment) to veterans to respond to addressing the opioid epidemic to responding to public health threats like the Zika virus.

We should be providing more support and funding to community health centers, not making it more difficult for them to serve the communities that desperately need them by slashing Medicaid funding.

Trumpcare Republican plan leaves rural middle class worse off.

Mr. Speaker, health insurance has historically been more expensive in rural areas because services cost more and it is hard to have a stable individual market with a small population.

Under the Affordable Care Act, premium subsidies are tied to local costs, which helps keep premium costs down.

But they are not under the Republican plan.

So, under the Republican plan residents in rural areas, who tend to be older and poorer, will pay much more and get much less health insurance.

At the end of the day, Mr. Speaker, the powerful and compelling reasons to reject Trumpcare lies in the real world experiences of the American people.

Let me briefly share with you the positive, life-affirming difference made by the Affordable Care Act in the lives of just three of the millions of Americans it has helped.

Joan Fanwick: “If Obamacare is repealed, I don’t know if I will live to see the next President”

“After nearly a decade of mysterious health scares, I was diagnosed with an autoimmune disorder called Sjogren’s Syndrome last year, when I was a junior at Temple University.

“It’s a chronic illness with no known cause or cure, and without close medical surveillance and care, it can lead to life-threatening complications (like the blood infections I frequently experience).

“For me, having this disorder means waking up every morning and taking 10 different medications.

“It also means a nurse visiting my apartment every Saturday to insert a needle into the port in my chest, so I can give myself IV fluids throughout the week.

“Without insurance, my medical expenses would cost me about $1,000 per week—more than $50,000 per year. And that doesn’t even include hospitalizations.

“My medical bills aren’t cheap under Obamacare, but I can afford them.

“Under Obamacare, insurance companies aren’t allowed to cut you off when your costs climb so right now, the most I personally have to pay out of pocket is $1,000 per year.”

Brian Norgaard: “I am a small business owner and leadership trainer who Obamacare has helped tremendously.”

“Last year, I was a Dallas, Texas resident, called my office to express his opposition to Trumpcare and to offer share how the Affordable Care Act has helped small business owners like himself:

“I am a small business owner and leadership trainer who Obamacare has helped tremendously.

“My wife and I both small businesses in the Dallas, Texas area and as a result of the huge savings we received after paying lower [healthcare] premiums under Obamacare, we were able to reinvest those savings into both of our businesses and the community.

“And the healthcare we received was quality, at that.”

Ashley Walton: “For cancer survivors, we literally live and die by insurance”

Ashley Walton was 25 when a mole on her back turned out to be melanoma. She had it removed, but three years later she discovered a lump in her abdomen.

She was then unemployed and uninsured, and so she put off going to a doctor.

She tried to buy health insurance.

Every company rejected her.

Ashley eventually became eligible for California’s Medicaid program, which had been expanded under the Affordable Care Act.

The 32-year-old Oakland resident credits her survival to the ACA.

Without it, “I would likely be dead, and my family would likely be bankrupt from trying to save me.”

But before any of our Republican colleagues supporting this bill cast their vote, I urge them to reflect on the testimony of Ashley and Askley, and to vote on this question posed by a constituent to Sen. COTTON of Arkansas at a recent town hall:

“I got a husband dying and we can’t afford—let me tell you something.

“If you can get us better coverage than this [Obamacare], go for it.

“Let me tell you what we have, plus a lot of benefits that we need.

“Have we $29 per month for my husband. Can you beat that? Can you beat that?

“With all the congestive heart failures, and open heart surgeries, we’re trying. $29 per month. And he’s a hard worker.

$39 for me.”

I urge all Members to reject Trumpcare, one of the most monstrosely cruel and morally bankrupt legislative proposals ever to be considered in this chamber.

To paraphrase a famous former reality television personality, “I believe Trumpcare is a [expletive] disaster.”

We should reject it and keep instead “something terrific” and that is the Affordable Care Act, regarded lovingly by millions of Americans as “Obamacare.”

Re: Trumpcare Republican plan leaves rural middle class worse off.

Mr. Speaker, health insurance has historically been more expensive in rural areas because services cost more and it is hard to have a stable individual market with a small population.

Under the Affordable Care Act, premium subsidies are tied to local costs, which helps keep premium costs down.

But they are not under the Republican plan.

So, under the Republican plan residents in rural areas, who tend to be older and poorer, will pay much more and get much less health insurance.

At the end of the day, Mr. Speaker, the powerful and compelling reasons to reject Trumpcare lies in the real world experiences of the American people.

Let me briefly share with you the positive, life-affirming difference made by the Affordable Care Act in the lives of just three of the millions of Americans it has helped.

Joan Fanwick: “If Obamacare is repealed, I don’t know if I will live to see the next President”

“After nearly a decade of mysterious health scares, I was diagnosed with an autoimmune disorder called Sjogren’s Syndrome last year, when I was a junior at Temple University.

“It’s a chronic illness with no known cause or cure, and without close medical surveillance and care, it can lead to life-threatening complications (like the blood infections I frequently experience).

“For me, having this disorder means waking up every morning and taking 10 different medications.

“It also means a nurse visiting my apartment every Saturday to insert a needle into the port in my chest, so I can give myself IV fluids throughout the week.

“Without insurance, my medical expenses would cost me about $1,000 per week—more than $50,000 per year. And that doesn’t even include hospitalizations.

“My medical bills aren’t cheap under Obamacare, but I can afford them.

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“I got a husband dying and we can’t afford—let me tell you something.

“If you can get us better coverage than this [Obamacare], go for it.

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Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin (Mr. GROTHMAN), who is also a member of the Budget Committee.

Mr. GROTHMAN. Mr. Speaker, I would encourage my colleagues to vote for the bill. The reason I ask you to vote for the bill is kind of like the reverse: What is going to happen if this bill fails?

If this bill fails, you won’t be able to have the huge increase in funding in HSAs, a free-market, patient-centered tax provision which is going to help many people and particularly allow flexibility for older married couples.

If this bill doesn’t pass, we are going to continue to levy fines on young people who don’t want health insurance, as so many people have no had when they are young. We will continue to levy fines on small business that can’t afford health insurance.

If this bill fails to pass, we are not going to allow States to put work requirements on Medicaid. Quite frankly, Medicaid, in many ways, is a more generous policy than the one that people who do work are able to afford through their insurers.
If this bill doesn’t pass, we won’t be able to stop the bleeding on Medicaid funding. We are approaching a $20 trillion debt. Of course, the bulk of that spiraling debt is caused by mandatory spending, of which Medicaid is one of the worst offenders.

Finally, for the first time in years, we are passing a law that will make a significant dent in that mandatory spending.

If this bill isn’t passed, we prevent putting in a provision in here requiring documentation of citizenship for Medicaid. Right now, we are becoming the healthcare provider for the world. We cannot afford to become the healthcare provider of the world.

Under this bill, we are providing funds, seed money for high-risk pools for States, which will hold down insurance costs, which is the underlying problem we have here.

If this bill doesn’t pass, we continue to fund our Medicare providers. I think this is the best bill in decades for those of us who wish we would stop funding these organizations.

We are providing assistance for people who want to get insurance through their employer. It is high time the Tax Code provided equality for people who get insurance from their employer and those who don’t.

Finally, if we don’t pass this bill, we won’t end ObamaCare.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Kansas.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 44,600 people from his congressional district in Wisconsin losing health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Illinois (Ms. Schakowsky), a distinguished member of the Budget Committee and the Energy and Commerce Committee.

Ms. SCHAKOWSKY. Mr. Speaker, I sincerely thank my Republican colleagues: Did you really come here to take health care away from 24 million people?

Over 40,000 people in my district will lose their coverage.

Did you come to Congress to impose a crippling age tax on Americans 50 to 60 years old?

Your bill would increase their premiums an average of $8,000 a year. According to the Congressional Budget Office, within 10 years, nearly 30 percent of those 50-to 64-year-olds would be without any insurance.

Did you really come to Congress to take nurses out of the home and care away from the elderly and the disabled?

Did you get elected in order to take health care from mothers?

Your bill would kick them off of Medicare Advantage, find a job 60 days after they give birth.

We have heard over and over that patients need choice and should be empowered to choose the care that they want. But, apparently, that doesn’t apply to women. The bill would block millions of women from choosing Planned Parenthood, a trusted healthcare provider to 2.5 million patients every year.

The American people are not clamoring for you to repeal ObamaCare. Only 17 percent of Americans say that you should vote to repeal ObamaCare. The average American overwhelmingly wants you to vote “no.”

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Kansas (Mr. Marshall), who is a physician.

Mr. MARSHALL. Mr. Speaker, Kansas voters sent me to fix health care. Doing nothing is not an option. I cannot sit here idle while the ACA destroys and bankruptcy America’s healthcare system.

This bill eliminates nearly a trillion dollars of taxes. This bill eliminates funding for Planned Parenthood. This bill will save many hospitals in Kansas from closing by increasing funding for Medicare patients. This bill allows $100 billion for high-risk pools. This bill specifies another $15 billion specifically for maternity coverage, which is near and dear to my heart; newborn care; mental health care; and substance abuse disorders.

Mr. Speaker, this is the best bill that we can get through this process. I am excited to be part of it. This is the first chapter of a new book, with many more chapters to come. We will fix health care.

Mr. YARMUTH. Mr. Speaker, I remind my colleague that his vote for this bill will result in 50,000 people from his congressional district in Kansas losing health coverage and care.

Mr. Speaker, I yield myself 2 minutes.

Mr. Speaker, in concluding the presentation from the Budget Committee, I just have to say that the bill we are considering today is a mess. It is not a healthcare bill at all.

This bill is driven by a desire to cut taxes for the wealthiest Americans and many wealthy corporations by nearly $1 trillion in all. It is paid for by making health care unaffordable for millions of people.

This is irresponsible. It is not what the American people want, it is not what they deserve, and it is certainly not what they can afford.

We are not the only ones opposing this legislation. It is opposed by an amazing array of American organizations and individuals, including the American Medical Association, the American Hospital Association, the American Nurses Association, the National Rural Health Association, AARP, the National Disability Rights Network, the American Diabetes Association, American Cancer Society, and Easterseals, virtually every healthcare consumer advocacy group, Governors from both sides of the aisle, and a growing list of our Republican colleagues.

Mr. Speaker, I thank the Budget Committee staff for the incredible job they have done throughout this process.

Mr. Speaker, I reserve the balance of my time, and I ask unanimous consent that the gentleman from New Jersey (Mr. Pallone), chairman of the Energy and Commerce Committee, control the balance of my time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Kentucky?

There was no objection.

Mrs. BLACK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to remind my fellow colleagues that, currently, when we look at the access to care for people, one-third of our counties only have one provider; two-thirds of our counties only have two providers. In my State of Tennessee, there are 14 counties where they will have no insurance provider on the marketplace. So when we talk about people losing their insurance, they are losing their insurance by not having access to even purchase the insurance.

One of my former colleagues, the gentleman from Minnesota, asked: What are my colleagues on the other side of the aisle trying to preserve?

I want to point to this chart here to ask that question, because these are the broken promises of ObamaCare. Why are you trying to preserve something where they say premiums will decrease by $2,500, and we see the average family premiums have soared by $1,300, making insurance unaffordable for many families?

Another broken promise: the cost of health care will go down.

We see some deductibles that have gone up as much as 60 percent. In my own State, they have gone up by 65 percent, making coverage unaffordable.

You can keep your doctor—70 percent of the plans consist of narrow networks, which means they cannot keep their doctor. I cannot tell you the number of people who have called me because their doctor was not on their inept plan.

Finally, “middle class Americans won’t see a tax increase.” This was a promise by former President Obama. ObamaCare penalties were put in place, so people are receiving a tax penalty. These are the broken promises that the other side of the aisle wants to continue to protect. As opposed to that, we
want a system that is going to be open with patient care and give affordability so people can get the services that they want with a cost that they can afford.

I also thank the Budget Committee for the work that they have done, and all the staff that have worked endless hours. I am proud to be here for this to be here on the floor today.

Mr. Speaker, I yield 30 minutes to the gentleman from Oregon (Mr. WALDEN), and I ask unanimous consent that he may control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Tennessee?

There was no objection.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

After 7 years, we have heard the stories of our constituents, patients, friends, and family who have suffered under ObamaCare. We have heard from those who have benefited in some respects.

I think of the struggles of constituents like Indra from Bend, Oregon. She lost her private insurance and her preferred doctor. When she went to look for a new plan under ObamaCare, she found the plans were too expensive, and she was uninsured for almost 2 years. See, her story should not be lost in this debate either.

Then there is April. Last fall, she found out her insurer would not be offering her plan this year. The most comparable plan available would raise her monthly premium by $564 per month, bringing her total monthly premium to $1,535.

You see, there is a whole other group of Americans out there who are suffering these effects of ObamaCare. The American Health Care Act represents a better way for patients like Indra and April all across our country. Our plan will rescue and revitalize the market and lower costs and increase flexibility for patients to choose. They will have more choices for health care and keep a health insurance plan that works for them and for their family.

This legislation creates the Patient and State Stability Fund. Now, this is an innovative approach to give States the financing and flexibility to repair the damage done to the insurance markets by ObamaCare and meet the unique needs of their citizens. More importantly, we provide an additional $15 billion. Mr. Speaker, to States devoted for maternity coverage. We heard from people who said we need to do more in this area: newborn care, mental health, and substance disorders.

We are also taking action to strengthen Medicaid. We want to put Medicaid on a sustainable path so it can better care for those it was intended to serve, a path through this per capita program for States that, frankly, was embraced by Democrats, including President Clinton.

The most vulnerable in our communities need this help. It represents the most substantive reform to the Medicaid program since its creation and will restore power to our States and local communities and governments where they can make better decisions than a one-size-fits-all here in Washington. We want to give our States more choices to ensure these people that they are closest to.

In closing, I want to thank our colleagues and the President of the United States and the Vice President and Secretary Price. They have worked day in and day out, without hesitation, to help get to the best policy possible here and to work and listen to our colleagues, as we have all done, to craft the best bill we can, given the constraints under which we must operate.

The end result highlights the diverse ideas of our Conference that come from the American people and the determination that we share to save this market and make it work again.

Mr. Speaker, I yield.

REMEMBER THE 3 million Americans who are going to get costs down. There is a narrow slice of the insurance market, that driven by ObamaCare, that last year, there were 225 counties in America where, if you were looking for insurance on that exchange, you had only one option. One. That is one out of every three in America. And that was before Humana pulled out and other companies said this market is about gone.

We need to fix this market. That is what this legislation seeks to do.

Mr. Speaker, I want to thank our terrific staff that has worked day and night to get us to this point. We know there is a lot more work to do. This should not be taken in isolation as the only healthcare reform on our list. We are going to go after the cost drivers. We are going to go after prescription costs. We are going to go after hospital costs.

Wherever it is in the health system, if you have nothing to hide, you won't have to fear our investigations. But we are going to get costs down. We are going to get costs down.

The American Health Care Act is just the first step in our mission to rescue the American people from the failures of the underlying law. We know they are there. We are going to fix this. We are committed to it.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I remind my colleague, my chairman, GREG WALDEN, that his vote for this bill will result in 64,300 people from his congressional district in Oregon losing health coverage and care.

Mr. Speaker, President Trump and congressional Republicans are not leveling with the American people when they say no one will be worse off under this repeal bill. TrumpCare dismantles the health and economic security that millions of hardworking Americans have gained over the last 7 years, and it should be defeated.

There is a reason this bill was hatched up in the back rooms only to be finalized last night, and that is because congressional Republicans did not want the American people to see what was in it:

TrumpCare provides less coverage, fewer protections, and higher costs.

TrumpCare is Robin Hood in reverse, taking benefits and financial assistance from hardworking, middle class Americans and our most vulnerable in order to give tax breaks to the wealthy and the corporations.

TrumpCare cuts a combined $1 trillion from Medicare and Medicaid. These cuts are devastating, Mr. Speaker.

TrumpCare will ration care for the 76 million Americans who rely on Medicaid, including seniors with long-term care needs, Americans with disabilities, pregnant women, and vulnerable children.

I fear for seniors. Mr. Speaker, those in nursing homes. When States get less money, what will they do? They will give less money to nursing homes. We will go back to the days that I remember in New Jersey when nursing homes were terrible places, where there were not enough nurses, where there were fires because of lack of maintenance of the nursing home.

Working families are going to pay more for less. They will see their premiums and deductibles skyrocket. My family colleagues talk about the high deductibles and copays. Well, you ain't seen nothing yet.

You are going to see that this repeal repeals the limits on deductibles and copays that exist under the current law. Out-of-pocket costs are going to go through the roof. The deductibles will go even higher. The copays will go even higher. The out-of-pocket costs will go even higher.

And the bottom line is Americans between the ages of 50 and 64 will pay an age tax and be forced to pay premiums five times higher than what younger people pay for their coverage.

I have heard my colleagues on the other side say, well, that is only fair. Well, I don't think it is fair that seniors should have to pay a lot more, that those between 50 and 64 should have to pay a lot more.

Also, TrumpCare leaves the sickest and vulnerable Americans at the mercy of insurance companies, allowing them to charge a 30 percent penalty or sick tax to those who are unable to maintain continuous coverage. So if you fail to pay your insurance for a month and then you want to get it again, even if you have a preexisting condition, which is often the case, you are going to pay a 30 percent penalty, or sick tax. I don't think that is very fair.

Last night, in order to garner votes from the extreme right in their party, House Republicans added a provision that eliminates protections for essential health benefits. Now, maybe people don't understand that, but let me explain it.
The ACA ensured that, when a consumer purchased health insurance on the individual market or gained coverage through Medicaid expansion, their plan would cover 10 critical, essential benefits.

TrumpCare eliminates this guarantee, meaning that unscrupulous insurance companies can sell skeletal plans, junk insurance, without benefits for hospitalization, maternity care, mental health, drug treatment services, and Americans won’t even know what they are getting. They won’t realize that they have worthless insurance until they get sick and it is too late.

The bottom line is this bill should be defeated for so many reasons because so many more people will not have health insurance, because their costs are going to go up, and because they won’t even know what insurance they are buying. We are going go to back to the old days of the Wild West when insurance companies could sell whatever junk they want and the public won’t even know what they are getting. It is a disaster for the American people.

I urge my colleagues to vote “no,” and I reserve the balance of my time.

Mr. BARTON. Mr. Speaker, I yield myself 20 seconds.

The irony of that argument is it was just a year or so ago that every Member of this House who was here at the time and the Senate, by a unanimous vote, agreed to waive the essential benefits he just listed off for the employment market between 51 and 100—and, by the way, those essential benefits don’t apply to the large group market—so this has already been done. I yield 1½ minutes to the gentleman from Texas (Mr. BARTON), the vice chairman of the full committee.

Mr. BARTON. Mr. Speaker, I supported this bill when it came out of the Energy and Commerce Committee 2 or 3 weeks ago, and I want to thank Chairman WALDEN for his excellent leadership.

As he knows, I had some concerns about the bill at the time. I didn’t think it addressed all the problems that we needed to address.

At the start of this week, I was a “no” vote—a friendly “no” vote, but I was a “no” vote. Our Republican leadership in the House and the President and his senior advisers continued to involve me in constructive discussions with people like myself. Yesterday they agreed to put back in the bipartisan bill that passed the Senate, by a unanimous vote, agreed to waive the essential benefits to States like Michigan. This has more than the entire population of Australia. Who comes to Congress to hurt people?

The promise of the Affordable Care Act was no one—no one ever again will be able to take away your insurance the way the insurance companies did 7-plus years ago. Now it is only the Republican Party that can take away Americans’ insurance. There isn’t one developed country in the world that has your plan. It is a combination of all kinds of things to get votes.

What free markets? What are you talking about? There is hypocrisy here because you all have the Affordable Care Act insurance. Every single Member of Congress does. So I guess it is good enough for you but it is not good enough for your constituents. This is a matter of life and death. You are playing with people’s lives. It is a profound issue. This doesn’t deserve one vote in the House of Representatives.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. WALDEN. Mr. Speaker, I yield myself 10 seconds before I yield to the gentleman from Michigan.

I would just suggest that the American people are very smart. Unfortunately, under ObamaCare, 19.2 million Americans said: I am not going to buy ObamaCare. I am going to pay a penalty to the IRS instead.

You see, we are trying to fix it so they will want to buy it.

I yield 2 minutes to the gentleman from Michigan (Mr. UPTON).

Mr. UPTON. Mr. Speaker, you know, there is an old Upton family quote that my grandfather would always say: Was you always perfect? No, none of us are. And you know what? This is not a perfect bill. That is for sure. But ObamaCare is broken. One out of three counties has only one provider, and it looks like it is going to get worse as other major insurance companies are on the verge of pulling the plug.

Nearly two dozen of the nonprofit CO-OPS have already gone belly up. In my home State, folks saw their premiums increase by nearly 17 percent. Some States have had premium increases of more than 100 percent. Most had double-digit increases, many over 20 percent, and some forecast 40 to 50 percent increases come fall if nothing happens.

The calls on both sides of the aisle have often used the R word—on this side, “replace”; on your side, the Democratic side, “repair.” Let’s both agree. The status quo is not acceptable. This, this bill, is the only train leaving the station. Is it going to improve if it gets to the Senate? Of course it will. We should all work for that goal.

For me, I worked with Medicaid expansion States like Michigan providing a reasonable transition until 2020 and then grandfathering all those folks until they are off. Some of my colleagues called to end Medicaid expansion this year. They want total repeal.

What would total repeal mean? Total repeal would mean taking away the ability of HHS to provide flexibility to the States to administer this critical program. It would mean taking away insurance for young kids on their parents’ policies. It would reinstall a cap and CO-OPs have already gone belly up. In my home State, folks saw their premiums increase by nearly 17 percent. Some States have had premium increases of more than 100 percent. Most had double-digit increases, many over 20 percent, and some forecast 40 to 50 percent increases come fall if nothing happens.

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Mr. PALLONE. Mr. Speaker, I remind my colleague from Michigan that his vote for this bill will result in 43,500 people from his congressional district in Michigan losing health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. ENGEL).

Mr. ENGEL. Mr. Speaker, when people look at these bills, they want to know what they are going to pay. What this bill does is simple—you pay more and you get less. That is the bottom line—pay more and get less.

The President promised better health care for more people at a lesser cost. But my Republican colleagues can no longer claim with any credibility that their plan achieves these goals.

Twenty-four million people will lose coverage. People 50 to 64 will be hit with an age tax and pay premiums five times higher than everybody else. Deductibles will go up. And protections that make sure insurance companies offer minimum value will be thrown out.

Again, the Republican bill, TrumpCare—pay more, get less—but it gives billionaires a tax break. That is really important; isn’t it? With the Affordable Care Act, we set out to give Americans more affordable, higher quality health care.

Is the law perfect? No. We should be working together to tweak the law. We should be working together to improve the law. But what we cannot do is sign off on this bill, which will roll back the time on people’s coverage. Roll back the time, give people less coverage, and let them pay more. That is not what the American people want. I urge my colleagues to vote “no.”

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Mississippi (Mr. HARPER), the chairman of the House Administration Committee, and a valuable member of the Energy and Commerce Committee.

Mr. HARPER. Mr. Speaker, ObamaCare has failed. Contrary to what was promised, premiums have gone up and there are fewer health insurance options. This bill addresses a crisis that before now had no end in sight.

Not only does this bill work to solve the problems we see in the private insurance market, it addresses one of our Nation’s most vital programs—Medicaid. This program is a critical lifeline for hundreds of thousands of Mississippians.

Medicaid is a safety net program that was designed for children, the elderly, pregnant mothers, and the disabled. This bill will refocus attention back on Medicaid. This program is a critical lifeline for our seniors, our disabled, pregnant women, and one in seven seniors on Medicare.

We should move decisionmaking authority down to those who are best positioned to address these problems. A program run primarily by the States with assistance from the Federal Government will best be able to help those who need it most.

By giving States more tools to address costs, this bill will allow States to explore ways to make accepting Medicaid more attractive to providers, leading to better health outcomes. Without addressing the current problems facing the Medicaid program, it will not survive. This bill puts Medicaid on a path to sustainability. An insolvent safety net will harm those it intends to help.

This is our moment. We have a historic opportunity to enact the biggest entitlement reform in our lifetime. We have a chance to save Medicaid.

I urge my colleagues to vote for this bill.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Mississippi that his vote for this bill will result in 69,600 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GENE GREEN), ranking member of the Health Subcommittee.

Mr. GENE GREEN of Texas. Mr. Speaker, this is outrageous. TrumpCare will rip health insurance from 24 million Americans, almost as many people who live in the State of Texas.

TrumpCare is a direct assault on the President’s promise to the American people. It will saddle families across the country with massive health costs. It will provide less benefits, less protections, and more people uninsured.

Under this bill, premiums increase 15 to 20 percent in each of the next 2 years. It will particularly be terrible for the near-elderly Americans because TrumpCare allows insurance companies to charge them five times higher than what others would pay for coverage. It destroys protections for Americans with preexisting conditions.

It guts the essential benefits so consumers won’t know what coverage they have. Plans would not have to cover things like emergency care, hospitalization, or even prescription drugs.

What do you do when you leave people with that? Junk plans that are insurance in name only. What is the point of having insurance if it doesn’t cover anything?

For those who aren’t one of the 21 million who lose insurance, many will be left with plans that are more expensive but don’t have to cover things like prescription drugs or mental health and substance abuse.

This bill will make it harder for people to get treatment. It will destroy the Medicaid program, the bedrock of our social safety net that insures 74 million Americans, including children, pregnant women, and one in seven seniors on Medicare.

TrumpCare harms Medicare. It will make the program insolvent 3 years earlier. Directly causes part B premiums to go up $8.7 billion, and takes away funds that seniors depend on for long-term care. It is impossible to overstate how terrible TrumpCare will be for the American people.

This is a dangerous bill. It is opposed by physician groups and hospital associations.

I urge my colleagues to vote “no.”

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Kentucky (Mr. GUTHRIE), the former head of the Medicaid task force.

Mr. GUTHRIE. Mr. Speaker, about 7 years ago, I was on the floor talking about the Affordable Care Act. And I remember talking about. I had just left the State Senate, and bringing up that my colleagues are in Frankfort and they are doing work on the budget; and, in the future, it is going to make it more difficult for them to pass budgets because of the expansion in Medicaid, and that is coming to pass. It will be in the next budget session they have to deal with moving forward, if we don’t address this situation.

So people keep talking about a rush process. Over a year ago, we put together a Medicaid task force, met with groups of people, met with Governors, we took a lot of information, and put together a plan that addresses the needs of Medicaid. Medicaid is growing. We have to get over a plan to do a program within 10 years if we don’t deal with it. It is going to implode. So we actually worked to put it on a sustainable budget. It is growing. People talk about cuts to Medicaid. Only in Washington, D.C., are we going to address that to except that small-business plan for those programs. It passed by voice vote in the House, unanimous consent in the Senate, and signed by then-President Obama.

So the question is, if small businesses can design and keep their own plans, I think individuals can, too.

I agree with my friend from California that the American people are smart. I disagree with my other colleague who says: They will buy things, and they won’t even know what is in it. They are smart, and I urge support for this bill.

Mr. PALLONE. Mr. Speaker, I remind my friend from Kentucky that his vote for this bill will result in 44,000 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 2 minutes to the gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, President Trump promised a healthcare plan would be “much better health care at a much lower cost.” Secretary of Health and Human Services Tom Price even promised “nobody will be
worse off financially." In reality, of course, the TrumpCare bill will leave just about everybody worse off, with less care at a higher cost.

This bad bill would rip health insurance money away from millions of people—$24 million over 10 years, and 14 million next year alone.

Americans who are lucky enough to hold on to coverage if this bill becomes law will pay more for it in premiums, deductibles, other out-of-pocket costs, especially people age 50 and up.

Mr. Speaker, the deals that were cut last night to win more Republican votes for TrumpCare would be even more devastating. Trips to the emergency room, mental health treatment, substance abuse treatment, maternity care, and critical healthcare decisions in the hands of bureaucrats in Washington, D.C., and a vote against the largest entitlement reform in a generation.

And here we stand, 7 years after ObamaCare passed, with the opportunity to finally deliver on that promise, and to bring relief to patients across this country who haven't been able to find care, or more promised at a cost they can afford.

It is an opportunity for us to fulfill our promise to our constituents. Let's be clear: a vote against this bill today is a vote for preservation of the ObamaCare disaster, a vote to keep critical healthcare decisions in the hands of bureaucrats in Washington, D.C., and a vote against the largest entitlement reform in a generation.

I urge all of my colleagues to do the right thing. I urge all of my colleagues to do the right thing for this bill.

Mr. WALDEN. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. MICHAEL F. DOYLE).

Mr. MICHAEL F. DOYLE of Pennsylvania. Mr. Speaker, for the last 7½ years, Republicans have promised Americans something better than the ObamaCare disaster. Instead, they are giving us something much worse.

Twenty-four million people lose their insurance? Stripping away guaranteed benefits? Putting maternity, mental health, and pediatric care at risk? Shame on you.

Pitting the elderly against children, the disabled, and the mentally ill in the Medicaid program? Placing a tax penalty on veterans? Charging a crushing age tax on 50- to 64-year-olds, forcing them to pay five times more than others pay? Charging a crushing tax on 50- to 64-year-olds, forcing them to pay five times more than others pay? Shame on you.

This isn't a healthcare bill. This is a tax bill masquerading as a healthcare bill. This bill does nothing to lower premiums, copays, or deductibles.

You cut taxes by almost $1 trillion for corporations and the rich, while ransacking Medicaid and the Medicare trust fund. That is shameful.

Americans will not forget who did this to their coverage for this bill.

Mr. WALDEN. Mr. Speaker, I yield ½ minutes to the gentleman from Texas (Mr. FLORES), a real leader on Energy and Commerce Committee.

Mr. FLORES. Mr. Speaker, I have heard numerous comments from the left extolling the virtues of ObamaCare, and I think it is instructive to hear the words of a former Democratic President that is beloved by the left. Here is what he said less than 6 months ago: "So you've got this crazy system where all of a sudden 25 million more people have health care and then the people who are out there busting it, sometimes 60 hours a week, wind up with their premiums doubled and their coverage cut in half. It's the craziest thing in the world."

Mr. Speaker, hardworking American families in my district, they don't want crazy. They want the American Health Care Act, a sane plan that gives them their freedom back.

In a few minutes, Mr. Speaker, you are going to hear somebody from the left say that bunch of my constituents are going to lose coverage. That is absolutely false. Those constituents are getting their freedom back to choose whether or not they want healthcare coverage and what kind of healthcare coverage they want. I say vote "yes.''

Mr. PALLONE. Mr. Speaker, I remind my colleague from Texas that his vote for this bill will result in 61,900 people from his congressional district losing health coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BUTTERFIELD).

Mr. BUTTERFIELD. Mr. Speaker, over the last few days, 110 organizations have written to me in opposition to TrumpCare. You know who they are: AARP, American Hospital Association, American Heart Association, American Medical Association, American Academy of Physicians, American Academy of Pediatrics, American Psychiatric Association, National Association of School Nurses, Alliance for Retired Americans, American Federation of Teachers, National Association of School Psychologists, National School Boards Association, National Education Association, the Children's Defense Fund, March of Dimes, the National Committee to Preserve Social Security and Medicare, the American College of Physicians North Carolina Chapter, North Carolina Society of Addiction Medicine, Consumers Union, United Steelworkers, AFL-CIO, Families USA, Center for American Progress, National Association of Pediatric Nurse Practitioners, and the list goes on and on.

Mr. Speaker, I include in the RECORD a list of entities opposing TrumpCare.

1. AARP
2. American Hospital Association
3. American Heart Association
4. American Medical Association
5. American Academy of Physicians
6. American Academy of Pediatrics
7. American Psychiatric Association
8. National Association of School Nurses
9. Alliance for Retired Americans
10. American Federation of Teachers
11. National Association of School Psychologists
12. National School Boards Association
13. National Education Association
14. Children's Defense Fund
15. March of Dimes
16. National Committee to Preserve Social Security and Medicare
17. American College of Physicians North Carolina Chapter
18. North Carolina Society of Addiction Medicine
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20. Consumers Union
21. SEIU
22. United Steelworkers
23. AFL-CIO
24. Families USA
25. Center for American Progress
27. National Association of Pediatric Nurse Practitioners
28. Children’s Hospital Association
29. National Rural Health Association
30. American Lung Association
31. ACLU
32. National Urban League
33. Black Women’s Health Imperative
34. Communications Workers of America
35. International Brotherhood of Teamsters
36. National Rural Education Association
37. National Association of Social Workers
38. National Association of Pediatric Nurse Practitioners
39. Lutheran Services in America
40. NETWORK Lobby for Catholic Social Justice
41. Children’s Dental Health Project
42. Rahn Institute
43. First Focus Campaign for Children
44. American Psychological Association
45. National Council for Behavioral Health
46. National Aids Foundation
47. American Congress of Obstetricians and Gynecologists
48. American Social Health Association
49. Big Cities Health Coalition
50. National Women’s Law Center
51. Human Rights Campaign
52. Partnership for America’s Children
53. Friends Committee on National Legislation
54. National Partnership for Women & Families
55. Planned Parenthood Action Fund
56. National Center for Learning Disabilities
57. Save Medicaid in Schools Coalition
58. HIV Medicine Association
59. Drug Policy Alliance
60. League of Conservation Voters
61. Natural Resources Defense Council
62. Green Latinos
63. Green For All
64. Rainforest Action Network
65. Climate Reality Project
66. Center for Reproductive Rights
67. Interfaith Disability Advocacy Collaborative
68. International Federation of Professional and Technical Engineers
69. Trust for America’s Health
70. AIDS United
71. AFSCME
72. Cystic Fibrosis Foundation
73. AASA, The School Superintendents Association
74. Accelity
75. American Foundation for the Blind
76. Association of Assistive Technology Act
77. Programs Association of Educational Service Agencies
78. Association of School Business Officials International
79. Association of University Centers on Disabilities
80. Autistic Self Advocacy Network
81. Center for American Progress Center for Public Representation
82. Campaigning on Women’s Issues
83. Colorado School Medicaid Consortium
84. Conference of Educational Administrators of Schools and Programs for the Deaf
85. Council of Exceptional Children
86. Council of Administrators of Special Education
87. Disability Rights Education & Defense Fund
88. Division for Early Childhood of the Council for Exceptional Children (DEC)
89. Health and Education Alliance of Louisiana
90. Healthy Schools Campaign
91. Higher Education Consortium for Special Education
92. Judge David L. Bazelon Center for Mental Health Law
93. LEANet, a national coalition of local education agencies
94. Learning Disabilities Association of America
95. Literacy Services in America Disability Network
96. Michigan Association of Intermediate School Administrators
97. Michigan Association of School Administrators
98. National Association of Pediatric Nurse Practitioners
99. National Association of State Directors of Special Education (NASDSE)
100. National Association of State Head Injury Administrators
101. National Black Justice Coalition
102. National Center for Learning Disabilities
103. National Disability Rights Network
104. National Down Syndrome Congress
105. National Health Law Program
106. National Respite Coalition
107. Paradigm Healthcare Services
108. School Social Work Association of America
109. School-Based Health Alliance
110. Society for Public Health Education
111. Teacher Education Division of the Council for Exceptional Children

Mr. BUTTERFIELD. What is it about this, Mr. Speaker, that you don’t understand?

Mrs. BROOKS of Indiana. Mr. Speaker, I appreciate the passion I have heard from colleagues on both sides of the aisle and from Hoosiers on all sides of this issue. The issue of health care is personal for people, and it should be. But today, health care isn’t personal. Under ObamaCare, healthcare coverage has been a broken promise.

I have heard from so many of my constituents in my more than 4 years in Congress about how ObamaCare has cost them and their families—lost doctors, higher premiums and deductibles, and a lack of options for coverage. As an example of just one of those Hoosiers, Lon told me his premiums and deductibles doubled last year when he lost his healthcare plan. He has had to change his insurance 3 times in 3 years. That is not how healthcare coverage should work.

The American Health Care Act makes healthcare coverage more personal for every American. This bill empowers you, and every American, to choose the best health care for you and your family. It empowers our Governors and our State legislatures to meet the individual healthcare needs of their citizens, including the people struggling to make ends meet and the most vulnerable: the elderly, pregnant women, children, and people with disabilities.

I applaud our Hoosier Governor Holcomb, who wrote a letter to Congress with other Governors from around the country who support this bill, he, too, believes it is in the best interest of Hoosiers. I agree and I urge my colleagues to join me in support of the American Health Care Act.

Mr. PALLONE. Mr. Speaker, I remind my colleagues from Indiana that her vote for this bill will result in 37,700 people from her congressional district losing health coverage and care.

Ms. CASTOR of Florida. Mr. Speaker, my neighbors back home in Florida work very hard for their health coverage. When they pay their hard-earned copayments and premiums, they expect something meaningful in return: real health care. That is what the Affordable Care Act promised: not just a piece of paper, but real health services, an end to discrimination against pre-existing conditions, and all sorts of other consumer protections.

But in the middle of the night last night, the Republicans turned back the clock. They have eliminated from the basic health insurance policy coverage for emergency room visits, hospitalization, prescription drugs, and more. They have raised the moniker of pay more for less. And on top of it, remember, this bill rips health insurance away from millions of our neighbors back home. It raises costs on hardworking Americans, especially our older neighbors. It is practically an age tax, if you are over 50 years old. It breaks that fundamental guarantee that has existed for 50 years, that if your family is struck with an Alzheimer’s diagnosis, a child with a competitive condition, that you are not going to live your remaining years in poverty, all the while, taking your tax dollars and shifting it to millionaires and billionaires and corporations.

TrumpCare is a recipe for disaster. It is a fundamental violation of the values we share as Americans, and it should meet its demise today.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from New York (Mr. COLLINS), a real leader on our committee.

Mr. COLLINS of New York. Mr. Speaker, today is a historic day, make no mistake about it. The American Health Care Act changes the trajectory of health policy in this country. Here are just a few of the highlights:

This bill eliminates the individual mandate penalty; eliminates the employer mandate penalty; eliminates the ObamaCare subsidies in 2020; eliminates ObamaCare tax increases; eliminates insurance mandates so we can lower premiums; provides refundable tax credits for individuals and families who do not get their health insurance through their employer or the government, and allows them to choose the health care that works for them; almost doubles the contribution limits.
for health savings accounts; provides $115 billion for the Patient and State Stability Fund to lower patient cost and stabilize the insurance market; and enacts the most significant reforms to Medicaid in history, ensuring that Medicaid is sustainable and available for generations to come.

The American Health Care Act is a monumental step toward freedom, choice, and individual responsibility in health care.

Mr. Speaker, I will proudly vote for this bill today, and I urge all of my colleagues to do the same.

Mr. PALLONE. Mr. Speaker, I remind my colleague from New York that his vote for this bill will result in 18,000 people from his congressional district losing healthcare coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from Maryland (Mr. SARBANES).

Mr. SARBANES. Mr. Speaker, this is a terrible bill. It is a terrible bill. It is wrong for the country.

Why would the President, why would the leadership on the Republican side in Congress, why would they choose as the first order of business taking healthcare coverage away from 24 million Americans?

It is wrongheaded. It is immoral. It is inhumane. It makes no sense. It is wrong for America.

In the people’s House, we need to vote it down.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Michigan (Mr. WALBERG).

Mr. WALBERG. Mr. Speaker, for 7 years, I have heard story after story from people in my district about how the Affordable Care Act is anything but affordable.

Families and small businesses are paying more for less, and insurers are dropping out of the marketplaces, leaving behind fewer options. Government-run health care isn’t working, and we are repealing and replacing ObamaCare like we promised our constituents we would do.

The American Health Care Act is the first step of a three-step process to repair our broken healthcare system.

This bill moves power away from Washington and puts doctors and patients at the center of their healthcare decisions, strengthens Medicaid and gives States the flexibility to innovate and best meet the needs of their citizens.

This patient-centered approach will bring costs down, increase choice and competition, and provide important protections for patients with pre-existing conditions.

Mr. Speaker, these are the types of things we promised, and doing nothing is not an option. May I remind my colleague from the other side of the aisle: I have 110 numbers. My constituents will not simply walk away and do nothing just because the other side says that they will be uncovered.

Now they will have a choice. Those thousands of people will not walk away. They will choose something better for them. There will be thousands of people that have insurance that covers their needs, and not what, Mr. Speaker, my colleague says they will do. They won’t do that stupid. They won’t walk away.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Michigan that his vote for this bill will result in 39,000 people from his congressional district losing health care coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. MCNERNEY).

Mr. MCNERNEY. Mr. Speaker, since the implementation of the ACA, over 3.9 million women age 18 to 64 have gained health care coverage through Medicaid. The ACA ended gender rating, meaning that the insurance companies couldn’t charge men for the same coverage. TrumpCare also eliminates Medicaid funding for Planned Parenthood, reducing access to health care for women.

Millions of women rely on Planned Parenthood for routine and lifesaving care, such as preventative services, family planning, and preventing unwanted pregnancies. When the GPO strips Planned Parenthood funding, health care of women will suffer.

TrumpCare and its Medicaid cuts also hurts seniors. Older Americans account for over 60 percent of Medicare spending. Insurance companies will now be able to charge more based on their age, which will increase premiums by thousands.

Mr. Speaker, watching Republicans sell this bill is like buying a used car from a guy with a crooked smile, even they don’t believe in it. I ask my Republican colleagues to withdraw this horrible bill and work with Democrats to improve the ACA instead of trying to sell this atrocity.

Mr. WALDEN. Mr. Speaker, I yield 1½ minutes to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER. Mr. Speaker, I am joyous to be here today on such a historical day. You see, for the past 7 years, I have practiced in ObamaCare. I have practiced under ObamaCare, and I have practiced in that setting; and I can tell you that what it promised, it has not delivered on.

There has not been increased accessibility, no. Instead of that, we have got five States in our country that only have one plan to offer. We have a third of the counties in our country that only have one plan to offer. We have 16 counties in Georgia that don’t even have a plan, and now we are going to have the opportunity to have access.

Now we are going to have choice.

We have also been told about affordability. Well, let’s talk about affordability, Mr. Speaker. What ObamaCare did. It increased premiums 25 percent this year alone; 50 percent in seven States. That is unsustainable.

What is our plan going to do?

It is going to give affordability. It is going to give choice. We are going to have choices.

And what else?

It is going to remove red tape. It is going to remove the barriers between healthcare professionals and patients. It is going to empower patients. That is what health care in America is about: people making healthcare decisions with their healthcare practitioners. That is what we are going to do.

That is what this does.

The two worst things that ObamaCare did to the healthcare system in America, first of all, is it took the free market out of America. It took the free market out of health care in America. It also expanded Medicaid, a safety net program that was intended for the aged, the blind, the disabled, children, and mothers, and extended it to able-bodied adults—something that it was never intended to do.

Mr. Speaker, I look forward to hearing how many people in my district are going to be empowered now from the gentleman from New Jersey.

Mr. PALLONE. Mr. Speaker, I remind my colleague from Georgia that his vote for this bill will result in 62,000 people from his congressional district losing health care coverage and care.

Mr. Speaker, I yield 1 minute to the gentleman from Vermont (Mr. WELCH).

Mr. WELCH. Mr. Speaker, those of us who support the Affordable Care Act know that the work of improving health care and making it more affordable and accessible is never done. It matters. It really matters to the mothers and fathers we represent and to the children that they love. But this bill, stripping 24 million Americans of health care, a $1 trillion tax cut to the wealthiest among us, making people 50 to 64 pay five times as much as other Americans, obviously, is a giant step backwards.

One of those Americans is Linda from Burlington. She left an abusive marriage, but had to leave her health care behind. The Affordable Care Act rescued her, and she has gone on to revive her life and her future.

Our community hospitals that do so much good in our communities have gone from red ink to black ink by the strength that the Medicare expansion provided.

It is a sad day for this institution. We did all of this without hearing from a single patient, a single doctor, a single person. We had no hearings.

Mr. Speaker, can we do better than that?

Mr. WALDEN. Mr. Speaker, I yield 2 minutes to the gentlewoman from North Carolina (Ms. FOXX), the chairwoman of the Education and the Workforce Committee.

Ms. FOXX. Mr. Speaker, skyrocketing cost, diminished choices for patients, small businesses destroyed, fewer jobs, and lower wages, that is
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Obamacare’s legacy. That is what Democrats imposed on our country.

We believe the American people deserve a better way, and that is what this legislation will deliver. The American Health Care Act puts the American people in control of their health care. It restores choices, protects the most vulnerable, encourages lower healthcare costs, empowers States, and frees families and small businesses from costly taxes and mandates.

Let’s keep our promise to provide a better way on health care by voting “yes” on the American Health Care Act.

Mr. Speaker, I ask the gentleman from Oregon (Mr. WALDEN) to engage in a brief colloquy.

Health sharing ministries play an increasingly important role in the lives of many Americans, particularly in the devastating wake of Obamacare or, during recent days, constituents have expressed concerns about the future of these ministries, particularly as it relates to whether they would be considered credible coverage under the bill’s continuous coverage provisions.

Will Chairman WALDEN work with me, as the bill moves forward, to ensure we address the concerns of those who benefit from health sharing ministries?

Mr. WALDEN. Will the gentlewoman yield?

Ms. FOXX. I yield to the gentleman from Oregon.

Mr. WALDEN. Mr. Speaker, I would be delighted to work with the gentlewoman from North Carolina.

Health sharing ministries are a vital part of our healthcare system. They are a shining example of how communities can come together without government mandates or dictates to provide innovative healthcare solutions.

I look forward to working with Chairwoman FOXX on these concerns that have been raised and will work with the Senate to get repeal and replacement of Obamacare to the President’s desk.

Mr. PALLONE. Mr. Speaker, I remind my colleagues from North Carolina that her vote for this bill will result in 80,600 people from her congressional district losing health coverage and care.

I yield 1 minute to the gentleman from New Mexico (Mr. BEN RAY LUJÁN). Mr. Speaker, my Republican colleagues and I have called TrumpCare everything from a act of mercy to a rescue mission. In the past, we have been battling with the Senate to get repeal and replacement of Obamacare to the President’s desk.

Mr. FALLONE. Mr. Speaker, I would be delighted to work with the gentlewoman from New York (Ms. CLARKE). I yield 1 minute to the gentlewoman from New York (Ms. CLARKE). Ms. CLARKE of New York. Mr. Speaker, I rise today in strong opposition to this sham American Health Care Act.

I am from Brooklyn, and in Brooklyn we know: Men lie; women lie; the numbers don’t. Here are the numbers: This reckless and destructive bill leaves 24 million Americans without coverage. It will cause the uninsured rate for my district to skyrocket over 12 percent and leave over 400,000 Brooklynites without coverage.

Because of age discrimination in this bill, the age tax, it will put our seniors in the terrible position of having to choose between eating, visiting their doctors, or purchasing medication.

Which one do you, Mr. Speaker, suggest they choose?

I also vehemently oppose the Empire State kickback language put in this bill as an attempt to get Republican votes. This language is a dressed up earmark that specifically targets New York City. It targets my home.

This would further reduce Medicaid funds for New York by an additional $2 billion. The trade-off, raising city taxes to cover the gap.

For most Americans, Medicaid benefits are not the end goal but rather [provides] temporary support, but for our seniors Medicaid can mean the difference between nursing home care, family home care and dying alone.

I urge my colleagues to consider the harmful real life impact of this legislation and to oppose it. Brooklyn Resists . . . America must resist.
Thank you and I yield the balance of my time.

Mr. WALDEN. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, may I inquire how much time remains on both sides?

The SPEAKER pro tempore (Mr. Cot- lins of Georgia). The gentleman from New Jersey has 68 minutes remaining, and the gentleman from Oregon has 65½ minutes remaining.

Mr. PALLONE. Mr. Speaker, what did the Chair say?

The SPEAKER pro tempore. One hour and eight minutes remaining.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Iowa (Mr. LOEBSACK).

Mr. LOEBSACK. Mr. Speaker, I am dismayed at what Congress is doing here today.

My number one goal has always been to ensure Iowans have access to quality, affordable care. This legislation does not accomplish that, it imposes an age tax, raising costs on older Americans. It cuts nearly $900 billion from the elderly, nursing homes, and disabled children.

This is unacceptable. Exactly those who need health coverage the most—middle class families, people with disabilities, and those who are less fortunate—are the ones who lose out in this Republican bill.

I remain committed to working to improve healthcare coverage so it works better for Iowans and all Americans. We cannot go back to a time when Iowa families had to choose between putting food on the table and getting medical care for their children. Unfortunately, that is just what this bill does.

I urge my colleagues to vote this bill down.

Mr. WALDEN. Mr. Speaker, if I could get an indication in terms of the amount we are down on each side here? I think we were allocated a half an hour.

The SPEAKER pro tempore. The gentleman referring to the time in which he is acting as the designee of the gentleman from Tennessee on behalf of the Committee on Energy and Commerce?

Mr. WALDEN. Yes.

The SPEAKER pro tempore. The gentleman from Oregon has 9½ minutes remaining in the Energy and Commerce portion of this debate.

Mr. WALDEN. Mr. Speaker, and the minority side? Or is that what is remaining split equal?

The SPEAKER pro tempore. The gentleman from Kentucky has not assigned designees on the basis of committee affiliation. The rule provides for four total hours of debate.

Mr. PALLONE. Mr. Speaker, could we just ask the total because then maybe we can figure it out on the minority side?

The SPEAKER pro tempore. The Chair has provided the total time remaining for the minority. So that is the total time we are working back off of. The Chair will consult with the gentleman on the committee time.

The gentleman from Oregon has 9½ minutes remaining in the Energy and Commerce.

Mr. PALLONE. What is the total time remaining currently?

The SPEAKER pro tempore. There are 67 minutes remaining for the gentleman from New Jersey as the designee of the gentleman from Kentucky. That is 1 hour and 7 minutes.

Mr. WALDEN. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. SCHRADER).

Mr. SCHRADER. Mr. Speaker, after all these late nights and backroom deals, here we are. This version of the bill was just dropped on our lap this morning, so we ought to take a careful look at what is in front of us.

First of all, the bill defunds access to preventative health care and wellness. All the programs that we made progress on will be gone.

It shortchanges the Medicare trust fund. Seniors might be paying thousands more than they are now to get the care they need.

It returns us to a system with skimpy benefits without serious coverage for maternity care and mental health.

Most dramatically, the bill dismantles the Medicaid system as we know it, which has been a success across much of the country. In Oregon, children and families finally have access to care that fits their needs. People living with disabilities are leading productive lives now. Hospitalizations and emergency room visits have been cut in half, and costs are down.

We are all going to do this—take health care away from 24 million Americans, 14 million just this next year—and not going to save any more money than under the original ACA?

Look, I keep parts of the ACA that need fixing. While millions of people got coverage for the first time, premiums are still too high in the individual market. That is only 5 percent. Vote ‘nay’ on this bill, and let’s make the system better.

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Mr. WALDEN. Mr. Speaker, I don’t believe I have any other speakers, so I will continue to reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from Massachusetts (Mr. KENNEDY).

Mr. KENNEDY. Mr. Speaker, 5 years ago, I got the phone call everyone dreads. My wife had collapsed at work and was being rushed to an emergency room. It is a moment that is painfully familiar to far too many. Time stops. You fight to push your breath down your throat. Your brain gets stuck in thathighlight reel of worst-case scenarios. You are terrified.

Fortunately, we were among the lucky ones. Lauren was okay. Most critically, our health coverage gave us the support that we needed to be able to focus on the one thing that mattered most, her recovery.

Here in America, that is the simple expectation of our country’s healthcare system, a commitment that our society makes to care for one another in our time of deepest need because our health is our great equalizer.

No matter your power or privilege, no one among us escapes our time here on Earth without watching someone we love fight for their life. So we fortify this social contract, not just out of sympathy for the suffering, but so that it is there for us, too, when we need its sturdy brace.

“Blessed are the merciful, for they shall be shown mercy.”

Mr. WALDEN. Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield to the gentleman from California (Ms. LOFGREN) for a unanimous consent request.

(Ms. LOFGREN asked and was given permission to revise and extend her remarks.)

Ms. LOFGREN. Mr. Speaker, I rise in opposition to this terrible bill that will hurt my constituents in California.

Mr. Speaker, each one of us was elected by our constituents to stand up for them here in Washington. Today, I will stand up for people who live in the 19th Congressional District by voting no on this terrible bill.

It’s small wonder that polling shows only 19 percent of Americans are in favor of this bill. With the bill, the 24 million fewer Americans will have health care insurance. Families will pay increased out of pocket costs with higher deductibles.

Incredibly, it allows insurance companies to penalize people older than 50 by allowing them to charge 5 times more for insurance than younger Americans.

It hurts Seniors in other ways too. By shortening the life of the medicare trust funds, by increasing costs for medicine for medicare recipients and by smashing the safety net for nursing home care which the Medicaid program provides.

Incredibly, it also has a special penalty for veterans, by barring veterans from receiving tax credits if they are nominally eligible for VA care, even if there is no room for them at the VA.

Let’s stand together for our hardworking Americans all over our country and in our own districts by voting no on this poorly crafted bill that cuts taxes for the richest Americans and leaves regular Americans on the short end of the stick when it comes to health care.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. CARDENAS).

Mr. CARDENAS. Mr. Speaker, I rise today to urge my colleagues to own up to their bad bill. It is clear this is not what the American people deserve or what the American people are asking for.

This legislation guts Medicaid. It steals from Medicare. It crushes our seniors and our working families. And
just when you thought it couldn’t get worse, they went after veterans and their children.

What’s more, this bill means insurance companies won’t cover new mothers, newborn babies, and prescription drugs. The Republicans are making health care for Americans worse and worse and worse.

The Republicans have secretly wheeled and-dealed in back rooms at the expense of millions of Americans in our next election, while giving tax breaks to millionaires and billionaires.

Mr. Speaker, I urge my colleagues to own up to this bill and oppose it for the sake of the American people.

God bless us.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

One of the great tragedies of this debate is some of the scare tactics we have heard. And to listen to the gentleman from California talk about how removing essential benefits from the Federal mandate is the law is going to cause all that to happen is tragic because he, on March 25 of 2015, cosponsored legislation that did precisely that, removed the same Federal mandates for workers in the 51-100 pool of employers. He said it was too much of a mandate then on those businesses, when they provide insurance.

So every Member of the House who was here then and every Senator, including the Democrat leader of the Senate at the time, voted for that, passed unanimously.

By the way, the Congressional Budget Office said that those regulations that we are pulling back here would have made nongroup premiums 27 percent to 30 percent higher in 2018, than they otherwise would have been. So we are basically taking what CBO said is a good policy and implementing it here once again.

Last time, in 2015, that was bipartisan. It was a voice vote. Today, you would think the world was falling around us, the sky was falling. Yet, everybody who was here in 2015 said, that is okay, it is the right thing to do because it will lower premiums, like CBO said, by 27 to 30 percent.

So we thought what was good for those in the work world, for everybody who is insured through a large group plan, which is about 155 million Americans, who don’t live under this mandate, the Affordable Care Act, many had to decide between bankruptcy and death.

Whether this bill dies today, or in the Senate, I hope we can get to work together, Republicans and Democrats, to do better for the American people.

Mr. WALDEN. Mr. Speaker, I yield myself 30 seconds.

Actually, we did reach out to Democrats. We have always reached out to Democrats. The vice chair of the Committee held lunches with Democrats to say, how can we work together on this? And we were told: No, we can’t work with you on this particular measure. I hope we can. I agree, there is a lot we need to do together. It is what the American people expect.

We have had these individual conversations out of the bright lights of the cameras. Let’s get together. Let’s get this done. A lot hangs in the balance.

Mr. Speaker, I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. Ruiz).

Mr. RUÍZ. Mr. Speaker, the majority of my patients in the emergency department are age 50 and older. This bill’s age tax will devastate Americans ages 50 to 64 who have worked their whole lives, planned for retirement, and now are wondering how they will make ends meet.

The age tax will force older Americans to pay premiums up to five times higher than others, no matter how healthy they are, no matter how responsibly they have lived, making coverage too expensive, and forcing them to be uninsured.

For example, Rex, from my district, wrote me that he was worried about choosing between affordable insurance or saving for his retirement. Insurance for older Americans like Rex will be too expensive, leaving them uninsured when they need coverage the most.

Under this bill, a 64-year-old like Rex, with an income of $26,500, in the individual market, will pay up to $14,000 for health insurance. That is more than half of their income on premiums alone, leaving little for food, for medicine, rent, and other basic necessities.

I stand with our older Americans, and I urge everyone, Democrats and Republicans, to stand with older Americans. Put ideology, partisanship, and politics aside and do the right thing.

Mr. WALDEN. Mr. Speaker, I reserve the balance of my time.

Mr. PETERS. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. Peters).

Mr. Peters. Mr. Speaker, I came to Congress ready to help improve our healthcare system. And as our colleagues on the other side have pointed out, there are some insurance markets that aren’t providing the choice and the low cost that consumers want, so let’s fix them.

But that is not what this bill does. This bill takes away health insurance from 24 million Americans, including 37,000 people in my district in San Diego. And the last-minute changes made will cost the Federal Government even more money, without increasing coverage or reducing premiums. Is that really fair?

The only reason we are in this mess is because the Speaker of the House only ever sought 218 Republican votes.

That is why we are left with a bill that is opposed by doctors, nurses, hospitals, and just about everyone because it makes the problems in our healthcare systems worse, not better. That is what happens when you never even reach out to the other side.

Mr. Speaker, I think it is very telling that the gentleman from Oregon has no more speakers on his side for what they claim to be a very significant bill, 40 people or so, for a bill that is opposed by doctors, nurses, hospitals, and just about everyone. It makes the problems worse, not better.
Don't tell the real people, don't tell the Americans in my district or the rest of the country who are coming to your doors and going to your legislative offices and calling you by the thousands to tell you not to pass this bill, don't tell them your answer that I hear over and over again: Well, trust us. Trust us.

The problem is we have to look at the bill that is before us today. This is a terrible bill. Millions of people, 24 million people, are going to lose their insurance. Many more are going to pay a lot more out of pocket with higher deductibles and higher copays.

And the worst part of all is you are allowing the insurance companies to sell junk insurance that doesn't even cover their care; it doesn't even necessarily provide any coverage.

So I ask my colleagues on the other side, think of the people. Think about your heart. Think about what this really means. And if you look at it, you will know that this is a bad bill and should be defeated.

Vote "no." I urge my colleagues to vote "no."

Mr. Speaker, I yield back the balance of my time.

Mr. WALDEN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, here is what I would say: What you have heard from the other side is everything is working perfectly; leave it alone.

Democrats created ObamaCare. Democrats created the exchange. They said: We are going to tell you the kind of insurance you have to buy; we are going to force you to buy it, or you will answer to the IRS and pay a penalty. They mandated that.

Then they came back and said: Well, that didn't work so well, so we had better get rid of the essential benefits for the workers and employers, 51–100 employees in a company; we are going to take that off because that will drive up premiums. And they voted unanimously to do that. Today, they come back and say: Oh, that would be horrible. But they did it before, so they were for it before they were against it.

But let me talk about what really matters here. First of all, there is lot of scare tactics out there by a lot of organizations. The first is, we preserve your right as a citizen to acquire health insurance regardless of your health condition.

So here is the deal: preexisting conditions, we protect that; lifetime caps, we protect that so that insurance companies can't be over the top of you; keep your kids on until they are 26, we protect that. Those were good things. We agree in a bipartisan way those should be protected. We do that.

But we also recognize that 19.2 million Americans looked at the Democratic exchanges and plans, went the other direction, and said no. They have walked with their wallets and their feet and said: I don't like what you are selling and I can't afford what you are selling. I will even pay the IRS $600 or $700 not to take ObamaCare.

Meanwhile, Mr. Speaker, the insurers have said that the way the Democrats created the insurance markets all over the country, we can stay in them. We are losing too much money, and we are out.

That is why, in one out of three counties today in America you only have one choice, and that is called a monopoly. We are trying to fix this market so people will have choices that are affordable. We are trying to make sure people have access to coverage they want and can afford. This is the first step, not the last step, toward fixing this market.

I look at it like we have poured the foundation. Construction projects are a little messy when you are just pouring the foundation. Now we are going to put up the walls, we are going to put the roof on, and we are going to build this out in multiple steps throughout this year and next.

We provided complete coverage. We do all the protections ObamaCare continues in its support for people while we fix the market and allow it to come back. We have timed this out. I know there are some on my side of the aisle who wanted to get rid of those protections, and we brought them around or they are going to vote "no." But we said: No; we have to do those protections in place—existing conditions, and lifetime, and keep your kids on until they are 26.

We have a product here that needs to go to the next step. We will all work on it and continue to make it better as we go forward. But if we do nothing and let it fall today, these markets are going to get worse and worse under the Democrats' ObamaCare plans, and people won't have a choice in States and counties all over America.

I wish we could join together today and put forward a bipartisan vote to save these markets and help our constituents going forward. Mr. Speaker, we owe it to them. They have asked for it for 7 years, and we owed it.

Mr. Speaker, I urge support for this legislation, and I reserve the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield the balance of my time to the gentleman from Massachusetts (Mr. Neal), and I ask unanimous consent that he be allowed to control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mrs. BLACK. Mr. Speaker, I yield 30 minutes to the gentleman from Texas (Mr. Brady).

Mr. BRADY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, last month, President Trump stood right here in this room and said to Congress: ObamaCare is collapsing. He called on us to take decisive action to protect all Americans.

Today we have a choice to make; will we stop ObamaCare's enactment and pass legislation to repeal and replace ObamaCare? Or will we allow ObamaCare to remain fully in place and deny our constituents the relief they urgently need?

I have written for years to allow my constituents in Texas to suffer ObamaCare's impacts any longer. For the past 7 years, we have watched ObamaCare fail Americans on every single promise, and throughout this time, as the Obama administration turned a deaf ear to the American people, House Republicans were listening. We were listening to all those facing severe premium increases, people like Lauren in my district, in my hometown of The Woodlands. Lauren recently emailed me that premiums this year have gone up by nearly 70 percent. Now they are $900 a month.

We were listening to all those who can no longer see the doctor of their choice. We were listening at an affordable price, people like Elizabeth from Conroe, Texas, another constituent of my mine. Her family pays about $800 a month in healthcare premiums, yet they can no longer see any of the doctors they know and trust.

This includes the primary care doctor that Elizabeth and her husband have been seeing for over a decade. It includes her children's longtime pediatrician. All of these doctors are now out of reach, thanks to ObamaCare.

That is the thing with this law. It has helped some, no doubt, but far more people have been hurt, people like Lauren and Elizabeth, who are paying significantly more for significantly less access to care and trust.

It doesn't have to be this way. After 7 years of listening carefully to the American people, we have now arrived at this moment of decisive action.

With the American Health Care Act, we have the best opportunity since ObamaCare's enactment to repeal this harmful law, clear the deck, and begin over with a step-by-step process to deliver a healthcare system based on what patients and families truly want and need, not what Washington thinks is best.

This bill gets us off to an excellent start. First, it delivers swift relief to the American people by immediately repealing ObamaCare's most harmful provisions. The individual mandate—the tax penalty—is gone. The employer mandate tax penalty is gone. Nearly $900 billion in ObamaCare tax hikes that have driven up costs and reduced access to care for families, patients, and jobs, those tax hikes are gone.

Here's where the American Health Care Act takes significant action to replace ObamaCare with patient-focused solutions that expand choice, lower
costs, and enhance competition. This is where we reclaim control of health care from Washington and put it back where it belongs—with patients, families, and States.

We expand health savings accounts, making them flexible and more user-friendly. We protect health coverage for the more than 150 million Americans who receive it through their job. We deliver the largest entitlement reform in decades, giving power to States to improve and streamline Medicaid so they can better serve the needs of local patients and families.

For low- and middle-income Americans who don’t receive coverage through work or a Federal program, we offer an advanceable, refundable tax credit that people can use immediately to help purchase coverage that is tailored to their needs. These tax credits provide a conservative, free-market alternative to inefficient ObamaCare subsidies that exist today. They deliver support to lower-income Americans. At the same time, they will encourage real competition and choice in the health insurance market.

Finally, as a committed pro-life conservative, I am pleased to say this bill embodies our 100% pro-life President’s party platform. We fund the community health centers for women’s truly needed health care, and takes vital action to protect the right to life. No Federal funding can be used for elective abortions. The language is crystal clear.

The American Health Care Act represents a critical first step in our multiphase effort to tear down ObamaCare and reinstate patient-focused solutions that help all Americans. But we know there is more work to do. ObamaCare was a massive government takeover of health care. To fully uproot the law, it is going to take a sustained, coordinated, and relentless effort from both Congress and the administration.

Fortunate to have incredible partners in President Trump and Secretary Price at the Department of Health and Human Services. They are already beginning work on the next phases of the process, stripping away ObamaCare’s regulations so we can enact additional free-market solutions. These include conservative proposals, such as allowing insurance to be sold across State lines.

But to see success in the next phases, we have to take the first step today. We have to pass the American Health Care Act, deliver immediate relief to the American people, and provide a conservative path forward.

In closing, I thank all the leaders in the House who worked hard to create the bill before us today. Chairman Greg WALDEN, Chairman DIANE BLACK, and so many others.

I also want to offer my gratitude to everyone from the Congressional Budget Office, the Joint Committee on Taxation, and the House Office of Legislative Counsel who provided analysis and support as we developed this legislation.

I would like to give a special thanks to Emily Murry, Stephanie Parks, and all of our hardworking staff on the Ways and Means Committee.

At the end of the day, on this day, we will have our first true vote to repeal ObamaCare. History will record where we stand. This is a clear choice. We can stand with President Trump and more freedom for Americans to buy health care they choose, or stand with ObamaCare and more government that gets in the way. I proudly stand with President Trump and more freedom for the American people.

Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield myself such time as I may consume.

Recently, President Trump said: Who knew that health care could be so complicated?

Well, 70 years ago, Harry Truman knew how complicated it could be when he first proposed national health insurance. John Johnson knew more than 50 years ago when he proposed, successfully, Medicare and Medicaid. Richard Nixon knew when he proposed the individual mandate. Bob Dole knew when he proposed the individual mandate. In Massachusetts, Mitt Romney knew when he proposed the individual mandate.

Mr. Speaker, recently, within the last week, the great on-the-street writer, Jimmy Breslin, died. Amongst the great columns and the great books he wrote, one of them that he wrote that will be with us in a timeless manner was “The Gang That Couldn’t Shoot Straight.”

That is what this institution has been like for the last 10 days. There were caucuses and there were conferences. People were running back and forth with new CBO scores and coming back to the floor with new proposals. Members are put in the position of being offered special arrangements so that they might be brought over the goal line—that, after 61 times they have voted in this House to try to repeal the Affordable Care Act.

Well, here is what we have in front of us this afternoon: a CBO score says that 24 million Americans will see either an increase in premiums or they will lose their insurance, there will be an imposition of an age tax on older Americans, and a tax cut of $1 trillion. This bill has gone from bad to worse.

If that wasn’t enough, to get the votes to pass the bill, they want to cut prescription drug benefits, mental health benefits, hospital benefits, and maternity care; and, yes, every one of us in this institution knows a family who is struggling with a loved one’s addiction, and they want to roll back that benefit.

Recently, the conservative columnist Bill Kristol tweeted:

The healthcare bill doesn’t, A, lower costs that they have; B, it doesn’t improve insurance; C, it doesn’t increase liberty; D, it doesn’t make health care better. So what is the point?

Here is the point: it is a $1 trillion tax cut so that they can change the baseline for their tax cuts that are coming down the road. That is what this is about.

Now, the President said he wanted an insurance protection that covered all members of the American family. What they are offering up today is a plan that cuts health insurance for 24 million American family members. It does not increase coverage, it does not lower costs, and it does not strengthen conscience protections.

So what does it do?

Sadly enough, back to the old argument that we have had in this institution for years: a $1 trillion tax cut for the people at the top and special interests.

The former speaker here a minute ago, the chairman of the Energy and Commerce Committee, spoke about perfection. I was here when this legislation was authored. He wanted to write it. I can tell you this right now: we knew it was not about perfection, but we subscribed to the idea, as was the case with Social Security, Medicare, and Medicaid, that we would improve as time would fix it so that all members of the American family might benefit from the basic notion of access and affordability as it relates to health care.

So what do we have here?

Sixty percent of Medicaid dollars go to nursing home care, and they want to cut $839 billion to provide a $1 trillion tax cut. Let me tell you, members of the American family can understand that.

In Massachusetts, where proudly I can say 100 percent of the children in our State are covered, 97 percent of the adults in Massachusetts are covered. And guess what? It polls regularly in the high seventies as to consumer satisfaction. A Republican Governor of Massachusetts has advised them to go slowly and to go carefully, that this is not the path that they want to travel down, as well as other Governors across the country who happen to be a Republican.
Mr. TIBERI. Mr. Speaker, I thank the gentleman for his leadership in this important matter, and I echo his words with respect to the staff, Emily Murry and her team, as well as Whitney Daffner and Abby Finn in my office.

Mr. Speaker, like the chairman, I had a front row seat in 2009 and 2010 to the passage of the Affordable Care Act and a front row seat to all the promises made about this wonderful bill called the Affordable Care Act.

For just 6 years, like the chairman, I heard from my constituents and fellow Ohioans. I heard about their sad ObamaCare stories of a road of broken ObamaCare promises.

There was a lady east of Columbus who had cancer. She was a survivor. Fast-forward to a few years ago. She gets cancer again and finds out that the oncologist that she had, she could no longer have. He was not in the network. She could not go to the hospital in her community. She had to go 60 miles away.

Or there is the small-business owner and his wife and family on the individual market and now on the exchange not getting employer-provided health care and, therefore, not getting the breaks. They saw their plan price quadruple in the last several years. Mr. Speaker, we are going to take care of that person and give them a tax credit so they have the ability, just like employer-provided employee's health care.

In Ohio, last year, our CO-OP collapsed. We had 20,000 people without health care. Many saw bills not being paid. Twenty counties in my State had one provider and fewer choices.

One promise wasn’t broken, and that is a government-mandated, one-size-fits-all Washington plan that many of my constituents didn’t want and others couldn’t afford. That was their ObamaCare.

We can do better, and in this bill we do. In one step, in the first step, more steps to come, we begin creating a path to affordable care.

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Mr. Speaker, some in my district, Pam, who is self-employed, lost her insurance four times under ObamaCare. Prior to ObamaCare’s implementation, she had a plan she liked and that actually covered her pre-existing condition. She was forced off that original plan when ObamaCare began and then lost her coverage three more times through no fault of her own.

For Pam and millions of others across the country, ObamaCare has severely limited options for affordable care. This is simply unsustainable.

Constituents in rural districts like mine have been hit the hardest by ObamaCare’s dwindling insurance markets. Because of ObamaCare, Nebraskans are down to only two insurers from which to choose, and other rural areas are down to one or even zero providers on their exchanges.

Adding insult to injury, according to the Obama administration’s own report on the “individual market, 2017 premiums in Nebraska increased by 51 percent.

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We can do better, and in this bill we do. In one step, in the first step, more steps to come, we begin creating a path to affordable care.
I ask you, Mr. Speaker: Who will stand for the American people? Who will speak up for those who have been left out and left behind?

Mr. Speaker, I have said it time and time again: Health care is a right. It is not a privilege reserved for a wealthy few, but a basic need lived by every American. That's why we have increased research and development, and we have new investments in facilities coming online.

We need to permanently repeal this onerous tax or it is going to start up again. Voting “yes” today means permanent repeal of the medical device tax.

Mr. Speaker, I am also encouraged to see several provisions I have authored to enhance and expand the use of health savings accounts and flexible spending accounts that are included in this legislation today. HSAs and FSAs are now more popular than ever and used by 20 million Americans. It is time to remove the restrictions on HSAs that were imposed in ObamaCare so that we can make them more accessible and easier to use and empower Americans to take more control of their healthcare decisions.

Expanding HSAs will help us also begin to address the rising costs of health care. One recent study showed that, when a large employer switched their employees from FSA plan, it lowered their healthcare spending by an average of $900 per employee over a 5-year period. That is real savings, Mr. Speaker.

Let’s support a better way forward to lower out-of-pocket costs for patients and put them back in control of their healthcare decisions.

Mr. NEAL. Mr. Speaker, I remind my colleague that his vote for this bill will result in 49,200 people in his congressional district in Minnesota losing their healthcare coverage and care. Mr. Speaker, I include in the Record a letter from Governor Charlie Baker of Massachusetts that relates to the debate we are having today.

OFFICE OF THE GOVERNOR, COMMON-WEALTH OF MASSACHUSETTS,
STATE HOUSE, Boston, MA, March 21, 2017.

DEAR DELEGATION MEMBER: Health care is once again at the forefront of national and state policy discussions; I know we will share the goal of ensuring access to quality, affordable health care coverage for the people of Massachusetts. With Congress set to take up the American Health Care Act (AHCA) imminently, I wanted to share with you my administration’s analysis of the potential effects this bill would have on our state.

The Congressional Budget Office (CBO) released its score of the AHCA on March 13. This analysis is broadly consistent with concerns we have raised, with you and others, regarding the AHCA in regards to the state and its residents’ access to affordable healthcare. Applying CBO’s assumptions to Massachusetts results in at least $1 billion of reduced federal revenue in potential eliminations of 1115 payments not captured under the per capita targets, including federal matching funds for a state-run CommonwealthCare Wrap around plan.

The actual experience for these and other factors is significantly dependent on how the U.S. Department of Health and Human Services implements the legislation and unpredictable factors in the future (e.g., pharmaceutical growth). Without reduced federal revenue for Medicaid, the CBO also projects a reduction in employer-sponsored health insurance of 7 million people nationwide as a result of the repeal of the federal Employer Mandate. This would exacerbate a trend that Massachusetts has seen over the last several years. Massachusetts repealed the Chapter 58 Fair Share Contribution in 2013 in order to comport with the ACA. My administration has proposed reinstating an employers’ shared responsibility for the costs of health care.

This would be increasingly important if the federal Employer Mandate were repealed, as the AHCA proposes. The Commonwealth does have certain protections in place that could mitigate the impact of some of these changes. Massachusetts retains its individual health insurance mandate, reducing the likelihood that many people would drop out of the market due to the repeal of the federal mandate. Massachusetts also has protective insurance coverage laws that would not be superseded by the federal legislation.

The AHCA includes a provision that would prevent Medicaid from reimbursing Planned Parenthood for providing important health services such as cancer screenings. My administration opposes this provision, and has already committed to funding these services with state dollars if it should pass.

During conversations with governors across the country, the Trump Administration has expressed a general openness to providing greater state flexibility with respect to health care, including through a letter issued by HHS Secretary Price on March 14 to states. Our administration will pursue additional flexibilities to stabilize our markets and ensure that Massachusetts residents and we urge you to support these efforts by leading discussions in Congress to ensure the people of Massachusetts continue to have access to quality health care.

Overall, our analysis indicates that the AHCA would increasingly strain the fiscal resources necessary to support the Commonwealth’s continued commitment to universal health care coverage. I hope this information is helpful to you as Congress takes up the American Health Care Act.

My administration and I will continue to stay in touch with you as we work together to ensure access to quality, affordable health coverage for all Massachusetts residents.

Sincerely,

CHARLES D. BAKER,
Governor.

Mr. NEAL. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. DOGGETT), who will make a major role in the substantive contributions he made to writing the ACA.

Mr. DOGGETT. Mr. Speaker, TrumpCare is big on Trump, but it is weak on care. After falsely promising that there would be coverage for everyone for less and better, TrumpCare only cares about huge tax breaks for the superrich and special interests, like...
the totally unjustified $28 billion windfall for the pharmaceutical industry that they grab right out of the Medicare trust fund so that premiums will go up. Those earning $1 million within a single year get 79 percent of a $230 billion windfall but there is no genuine relief for middle class taxpayers.

Removing the essential health benefits provisions will only enable insurers to exclude the very healthcare protections that folks thought they were getting when they paid their premiums. Insurance plans will not just be skinny, they will be a sham; a provision that at the very time you need the care, it won’t be there. Many certificates of insurance will become as worthless almost as a diploma from Trump University.

This Republican bill targets our veterans by denying them tax credits. For millions of people who are just a few years too young to qualify for Medicare, millions will go through the roof. It will cost thousands of dollars more in order to get insurance. Yes, the Republicans have been divided and factionalized. They are divided between those who want nothing care and those who want little care. But, most importantly, they don’t seem to care how many millions of people lose their health insurance.

Mr. President, this is not the art of the deal. It is the art of the steal, of taking away insurance coverage from families that really need it to provide for the roof. It will cost thousands of dollars more in order to get insurance. The American people are lost in this healthcare bill. The American people are desperate. They want mandates. They want to choose the insurance that works best for them. They want to access their doctors that they select. They want to have the promise that was made to them, that they could have their insurance and keep it going forward honored and respected by this institution. That is what our legislation starts today.

Not a single person on this side of the aisle says the issue of health care will go away because of the first step we take today, because we have to do better for the American people when it comes not only to health insurance, but for health care when we can, when we must, and I want to be a voice to say let us join together to get this done for the American people.

Mr. NEAL. Mr. Speaker, I remind my colleagues that his vote for this bill today will deny millions of people from across my congressional district losing their health care and care.

Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. THOMPSON), a very thoughtful member of the Committee on Ways and Means who also helped to write the ACA.

Mr. THOMPSON of California. Mr. Speaker, I rise in opposition to this bad bill. It is not a step toward fixing the ACA, this is a step toward destroying health care. It ripped billions out of health care away from 24 million Americans. It was bad when it created an age tax, forcing seniors to pay five times that of what other people pay. It was bad when it forced hardworking Americans to pay higher premiums and deductibles while billionaires get a trillion dollars’ worth of tax cuts. And it was bad when it shortened the life of Medicare.

But today it got worse. Today Republicans have added coverage for emergency services, prescription drugs, hospitalization, mental health coverage, and preventative coverage. This bill also prevents millions of veterans from getting health care. This is a truly bad bill. It will cost millions of Americans their health care in order force them to pay more for fewer benefits, and it gives the richest Americans a huge tax cut. This is a tax-cut bill, not a healthcare bill. The American people deserve much better. I urge everyone who voted yes today to do this today.

Mr. BRADY of Texas. Mr. Speaker, I remind my friend from California, 1.5 million Californians forced into ObamaCare and given generous subsidies found a way to exempt themselves because ObamaCare failed.

Mr. Speaker, I am proud to yield 3 minutes to the gentleman from Pennsylvania (Mr. KELLY), a small-business man and a key member of our committee.

Mr. KELLY of Pennsylvania. Mr. Speaker, I am proud to stand today in support of this bill. I have been told that this is a rookie mistake. I understand the criticism. We have spent 7 years undoing the error of ObamaCare. That is why we are here today. A rookie who didn’t know what he was doing, but lectured to us, told us: This is what you have to do; and if you do this, you can keep your doctor, you can keep your health plan, you can just stay on board, and we are going to insure millions of you.

Nothing could be further from the truth. The big thing was you are going to save $2,300 on your premiums. He failed to tell everyone who were actually in that business. Incredible. Incredible.

Now, this isn’t about me, and it is not about you. This is about people. We are in this people’s House. Let me just read to you a couple letters from the people who I represent back home. By the way, out of the seven counties I represent, five have one insurer, and the rest of them got out because they couldn’t stand to try and work under this unworkable law.

Let me tell you what Amanda says: I am very happy to hear that you are working to repeal the Affordable Care Act. I just got an up-close-and-personal look at how dysfunctional it is while trying to shop for my own plan. It is hard enough to start a business in this country due to so many rules, regulations, and confounding taxes. This law makes it even harder. And I don’t think the government should make me give up more money for less coverage. I simply don’t need it. I know my situation, and I should be able to buy whatever I want without incurring four-figure tax penalties.

Jason says to me: Dear MIKE, I am a self-employed father of four feeling the hurtful effects of ObamaCare. For years there has been so much talk from Republicans about repealing ObamaCare. I am paying yet more money for less coverage. We are really feeling the effects of this in my family’s budget. My kids are going to bed hungry after dinner. We desperately need relief and now, not next year. I enthusiastically pulled the lever for Donald Trump and for you, and we are counting on you to make some real change in D.C. Please keep up the fight, and do it quickly.

So this is not about MIKE, it is not about John, it is not about any of us. What it is about is taking care of the people that we were sent here to represent. They are Republicans and they are Democrats. Some people could care less about any of us, but they expected us to do something for them. We are sitting here today because this law
is so bad. If it was so good, we wouldn’t have to worry, but it is bad, with a capital B.

Now, I have got to tell you, growing up, as a young kid, as it got toward Christmas—and I say this to my friends, by the way, on the outside—to make a list right before Christmas. I put on that list everything I wanted. You know what, Mr. Speaker? Come Christmas morning, I never got everything I wanted, but I was so thankful for everything I got.

We have to deliver today. We have to keep a promise today to the American people. We have to backtrack on a rookie mistake 7 years ago and make it better for the American people, not just for Republicans, not just for Democrats, not just for those who vote blue or red, but for those who expect us to do what we are supposed to do in the people’s House. This is not the Republican House or the Democrat House, this is the people’s House.

Isn’t it time for all of us to come together to get this done?

We have a marvelous opportunity, but we could lose it. I ask you all and I urge you all to please vote for this acre.

Mr. NEAL, Mr. Speaker. I remind my colleague and my friend that with his vote for this bill, 41,400 people from his congressional district in Pennsylvania will lose their healthcare coverage.

Mr. Speaker. I yield 2 minutes to the gentleman from Connecticut (Mr. Larson), who is from an adjacent district and a close friend and a long-time member of the Committee on Ways and Means and an individual who also contributed mightily to the development and writing of the Affordable Care Act.

Mr. LARSON of Connecticut, Mr. Speaker, I associate myself with Mr. NEAL’s remarks, and especially framing this issue from the outside about the arc of history.

As you know, we were pressed in this Chamber time and again, dating back to Franklin Delano Roosevelt, when you look at the impact of 24 million people, you have to look at your colleagues on the other side of the aisle and say: Are you frozen in the ice of your indifference to what impacts the daily lives of people who have showed up at our forums and the forums that you have conducted?

The sheer humanity of what is taking place across this country cries out for a solution. Yet all we have heard, as Mr. NEAL said, is the helter-skelter back and forth of who is winning politically, what is happening with the Freedom Caucus, what is going to—if Trump leaves, is RINO out?

The American people don’t care about that. They care about their families. And this is the institution that we were sent to to work on their behalf. It is up to us to come together and work on behalf of the American people.

This is our healthcare bill. This is a tax bill. We are going to work on that later on, but we shouldn’t start by saying that we are going to have a transition of wealth in this Chamber from people who are begging and pleading and showing up at the townhalls and asking for our help, and our answer is a transfer of wealth in a tax bill. Everybody wants to know why we are taking this up first and not taxes. Because it is a tax bill, that is what I yield.

Mr. BRADY of Texas. Mr. Speaker, I would remind my friend from Connecticut that 190,000 residents in Connecticut, two out of three eligible for ObamaCare, believed it failed them so badly they paid a tax or exempted themselves.

Mr. Speaker. I yield 2 minutes to the gentlewoman from South Dakota (Mrs. NOEM), who has weighed in in such a key way on health care.

Mrs. NOEM. Mr. Speaker, it is no surprise that the Democrats today are upset that they don’t like this bill because their number one goal all along, and I have heard them say it to me in conversations over the years, their number one goal was to go to a single-payer system. They wanted government-run health care, and we are on the track to that today.

In fact, in my home State of South Dakota, at one time, we had 17 options and companies that people could shop for their healthcare policies from. Today we have two.

We are well down our road now to giving them exactly what they want. They hate this bill because it puts people back in control of their own health care. It doesn’t let some bureaucrat in Washington, D.C., decide what treatment they can get in the future. It lets people decide that with their doctors.

This is a vote, today, for freedom for people who have lived under the bureaucracy of the Federal Government and how it turns people back in control of their health care. It doesn’t let some bureaucrat in Washington, D.C., decide what treatment they can get in the future. It is freedom for people who have lived under the bureaucracy of the Federal Government and how it turns people back in control of their health care.

Mr. Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. BLUMENAUER), a visionary, certainly, a forward-looking individual who also helped to write the ACA.

Mr. BLUMENAUER. Mr. Speaker, it has come to this: considering hopelessly flawed legislation that the Republicans have had 7 years to prepare for and still couldn’t do it right. It may still pass, but it is never going to be enacted because most people are figuring it out. They don’t like it and they are being heard.

That is why this bill has been stalled and the Republicans have been forced to twist the legislation in this fashion.

But the bottom line remains: TrumpCare will cost more than people who need it the most. It will hurt older and lower-income people in order to create tax cuts for people who need them the least. TrumpCare will destabilize health insurance and will slowly and surely destroy Medicaid.

It didn’t have to be that way, but as long as people continue speaking out and fighting back with us, it won’t be in the future, and we can have a new era in health care and in politics. With their help, in the future.

Mr. BRADY of Texas. Mr. Speaker, I remind my dear friend from Oregon, 153,000 Oregonians eligible for ObamaCare with generous subsidies said thank you, but no thank you.

Mr. Speaker, I yield 2 minutes to the gentleman from South Carolina (Mr. RICE), my good friend and a key member of the Ways and Means Committee.

Mr. RICE of South Carolina. Mr. Speaker, I stand in strong support of the American Health Care Act and urge my colleagues to vote in favor of the bill.

ObamaCare was built on broken promises. President Obama said you could keep your policy, keep your doctor, and it would bring down the cost of the insurance for a family of four by $2,500 per year.

It is time for the lies to stop. Let me share with Members the shameful reality of ObamaCare in South Carolina. It turns out you couldn’t keep your doctor. In fact, the Medical University of South Carolina is not an accepted provider under ObamaCare in South Carolina. That is right. South Carolinians cannot go to the Medical University of South Carolina if they are...
covered by ObamaCare exchange policies.

It turns out you couldn’t keep your policy. It is hard to believe, but more South Carolinians had their plans canceled by ObamaCare than have enrolled in the exchange. 207,000 have a Carolina’s policies were canceled in ObamaCare.

It turns out South Carolinians did not see a $2,500 reduction in their healthcare premiums. In fact, premiums have increased by double digits every year since the exchange opened; and this year, premiums increased 28 percent and deductibles 26 percent.

I submit to you that if you have a health insurance policy with $6,000 in deductibles and copays so high you can’t afford to use your policy, regardless of the fact that statistics say you are covered, you are not covered.

206,000 South Carolinians have signed up for ObamaCare—4 percent of the population. Ninety-six percent of South Carolinians are not on ObamaCare. Three times as many people in South Carolina have chosen to pay the mandate penalty rather than to purchase policies.

Mr. Speaker, President Obama promised South Carolinians we would have many competitive plans to choose from, but after only 3 years of Obama’s damage to our healthcare system, only one provider remains, and they are threatening to pull out.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. BRADY of Texas. Mr. Speaker, I yield my time to the gentleman from South Carolina.

Mr. RICE of South Carolina. The CEO of a major hospital in South Carolina stated, the way it is going right now, it is probably going to implode in the next year or two. Our State’s director of insurance, last year, said companies have given their best shot and can’t sustain this business model, can’t make a profit. The Affordable Care Act has left too many people, including me, and cannot work under this structure in South Carolina.

Mr. NEAL. Mr. Speaker, I would remind my colleague that his vote for this bill will result in 70,000 people in his congressional district in South Carolina losing their healthcare coverage.

Mr. Speaker, I now yield ½ minutes to the gentleman from Wisconsin (Mr. KIND), who is a thoughtful member of the Ways and Means Committee and lucky enough to have been educated in the Commonwealth of Massachusetts.

Mr. KIND. Mr. Speaker, we face a truly historic day today in the United States Congress. For the first time in our history, we have a Congress working with an administration offering the American people a healthcare reform bill that, instead of reducing the number of uninsured in this country, increases the uninsured by 20%. Including 331,000 in my home State of Wisconsin.

And we understand why. It is a simple explanation. This is a tax cut bill for the most wealthy in the guise of healthcare reform. That is unfortunate because it is a missed opportunity of fixing what isn’t currently working in the healthcare system.

If we wanted to be honest with the American people today, we would admit that there are important, good features of the Affordable Care Act that should remain and we should not end. But there are things that need to be fixed, and we have to stay focused on making the reforms costs for all Americans. Let’s continue to work on delivery system reform and payment reform so we get better results at a better price.

But a bill before us that increases the uninsured by 24 million, that delivers huge tax breaks to the most wealthy, that applies a new older American tax, especially in rural areas like mine in Wisconsin, and that robs money from the Medicare trust fund is not only a missed opportunity, it is bad legislation.

I encourage my colleagues to vote “no.” We can do better. We must do better.

Mr. BRADY of Texas. Mr. Speaker, I remind my good and thoughtful friend that 290,000 Wisconsinites that chose not to get ObamaCare were willing to pay a tax to stay out of a failed healthcare system.

I am proud to yield 2 minutes to the gentlewoman from Indiana (Mrs. WALORSKI), a new member of our committee who is doing tremendous things in health care.

Mrs. WALORSKI. Mr. Speaker, I rise today in strong support of the American Health Care Act.

Yesterday marked 7 years since the ObamaCare law was signed into law. For 7 years, we have seen the same pattern: rising premiums, dwindling options, broken promises, and a collapsing system.

In the State of Indiana, four insurers left the ObamaCare exchange just this year in the past 3 months, forcing 68,000 Hoosiers to shop for a new plan, making it impossible for them to choose and keep their doctor.

But today we have the opportunity to repeal ObamaCare and replace it with a patient-centered system, lowering costs, increasing choices, and providing real protection.

This legislation dismantles ObamaCare’s burdensome taxes, mandates, and the job-killer of the medical device tax.

It gives individuals and families access to quality, affordable health care through refundable tax credits and expanded health savings accounts.

It provides resources for States to tailor solutions to the needs of their citizens, broken promises to women’s health, addressing the opioid crisis.

It gives States flexibility to implement innovative reforms.

It allows my home State to continue building on our patient-centered Healthy Indiana Plan.

It protects patients with preexisting conditions and ensures a stable transition so no one has the rug pulled out from underneath them.

With the American Health Care Act, we are delivering on our promise and acting on the policies of President Trump. This bill is just the first step in the Trump administration effort to repair our Nation’s healthcare system. Coupled with administrative actions and additional legislation, the AHCA will lower costs and build a marketplace with real choices instead of a one-size-fits-all plan.

Mr. Speaker, 7 years of ObamaCare is long enough. Seven years of families seeing their premiums rise, plans canceled, and doctors dropped is enough.

Today we can deliver on our promise and put our bold solutions into decisive action. The AHCA is a bill 7 years in the making. I urge my colleagues to join me in supporting it.

Mr. NEAL. Mr. Speaker, I remind my colleague that her vote for this bill will result in 42,000 people in her congressional district in Indiana losing their healthcare coverage and care.

I include in the RECORD a letter from Republican Governor Snyder of the State of Michigan raising his concerns about this legislation.

STATE OF MICHIGAN,
EXECUTIVE OFFICE,

Hon. SANDY LRVIN,
House of Representatives,
Washington, DC.

DEAR REPRESENTATIVE LRVIN: As Congress considers legislation to repeal and replace the Affordable Care Act and reform Medicaid, I want to remind you that I am the 22nd Governor of Michigan and an estimated 15,000 of the beneficiaries in Michigan who rely on these programs for access to care and overall health.

I also want to provide my perspective on priorities for federal health reform and highlight how they have been utilized at the state level to drive meaningful reform that has increased access to cost-effective care.

In its current form, the American Health Care Act (AHCA) shifts significant financial risk and cost from the federal government to states without proving sufficient flexibility to manage this additional responsibility. The proposed legislation reduces federal resources that our state relies on to assist 2.4 million Michiganians enrolled in traditional Medicaid and the Healthy Michigan Plan, our state’s innovative Medicaid expansion program.

The current federal debate has largely focused on the Medicaid expansion population, including over 650,000 childless adults and parents that are enrolled in the Healthy Michigan Plan. However, half of all children in Michigan are served by traditional Medicaid each year and roughly 67,000 of them reside in your district. Moreover, more than 338,000 individuals with disabilities receive their health care and support services through Medicaid and an estimated 22,000 of these individuals reside in your district. Altogether, there are 1.75 million children, seniors, pregnant women and disabled individuals served by traditional Medicaid in Michigan, and roughly 15,000 of them reside in your district. As you know, these are our state’s most vulnerable citizens, friends and neighbors. The proposed AHCA will adversely impact them.

While reforming the nation’s health care system is vital, it is imperative that gains in healthcare coverage are maintained. These ideas are not mutually exclusive.
In Michigan, innovative approaches to improving quality and value are being utilized to support each individual's personal responsibility for their health. This has resulted in significant savings of nearly $50 million in uncompensated care, a dramatic decrease in the number of individuals using the emergency room as a regular source of care, and nearly halving of patients seeking care in a primary or preventive care visits. As drafted, the AHCA would eliminate coverage from the 48,000 individuals enrolled in the Healthy Michigan program in my district, as Michigan taxpayers assume responsibility over time for up to $800 million in additional costs. This cost shift will trigger a provision in Michigan law ending the Healthy Michigan program.

I believe Medicaid reform is necessary, however, that reform must be approached liberally to ensure that state flexibility and innovation are valued. Michigan providers remain strong, and our most vulnerable citizens do not fall through the cracks. Ideally, this would be done by removing prescriptive program requirements that require states to seek waivers when implementing innovative ideas. Instead, states would be given the flexibility to manage their own affairs. The Trump Administration may provide additional flexibility to states, however, I am concerned that federal agencies may encounter limitations in federal statute. Ultimately, Michigan cannot rely solely on the promise of future action without seeing all of the tools that will be at our disposal to manage the program.

In addition, under the proposed AHCA, I remain concerned about the affordability of insurance coverage in the individual market. I am particularly concerned about the impact this legislation may have on older Michiganders who could see significant cost increases. I welcome the opportunity to partner with you to provide greater federal budget predictability and improve health outcomes of Michiganders, which in turn relieves pressure on the individual market. I have worked with other Governors to develop a proposal to accomplish these objectives while also preserving coverage for Michiganders, and I hope we can arrive at a blueprint for what we work together to accomplish these goals.

I look forward to continuing our partnership to help Michiganders lead healthy and productive lives.

Sincerely,  

Rick Snyder,  
Governor.

Mr. NEAL. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL), who is a well-regarded member of the Ways and Means Committee. I think it is fair to say that everybody in this institution looks forward to his time when he gets up to speak.

Mr. PASCRELL. Mr. Speaker, the question I get asked is: What the heck were they thinking about?

Let me tell you what they are thinking about. Medicaid is the source of 25 percent of all projected public and private drug abuse treatment. It is about $8 billion.

Let’s consider James Suber from my hometown of Paterson, New Jersey.

Mr. Suber began seeking treatment when New Jersey expanded its Medicare program and provided more comprehensive access to treatment. At least New Jersey got it half right.

Each morning Mr. Suber receives treatment at Paterson Counseling Center, a local center. If he hadn’t got a job as a cleaner at Well of Hope, another treatment center in Paterson serving the homeless.

Without the treatment he receives through Medicaid, he wouldn’t be working. He wouldn’t be using the emergency department at St. Joseph’s hospital, the most expensive part of the hospital. Or maybe he wouldn’t have survived.

So, Mr. Speaker, for the life of me, I don’t understand why we would jeopardize treatment for James and the millions of other Americans facing similar challenges. What were they thinking?

Will this bill improve Medicaid? No.

Will this bill increase the number of Americans with health coverage? No.

Will it lower costs on the exchanges? No.

Will this bill bolster employer coverage? No.

Will coverage now provide more access to care, a promise time and time again by Mr. Trump, himself? No.

Will it strengthen Medicare? No.

Mr. Speaker, it is obvious. We know we are trying to change things and make them better.

We changed Medicaid. We did it together.

We changed Medicare. We did it together.

We changed Medicaid. We did it together.

We changed a lot of things together, but you chose the only lonely path.

Mr. BRADY of Texas. Mr. Speaker, I remind my good friend from New Jersey that 314,000 residents of New Jersey said “no thank you” to ObamaCare because it failed them.

I yield 2 minutes to the gentleman from Michigan (Mr. BISHOP), a new member of the committee, who dove into this issue with great thoughtful and conscientious work.

Mr. BISHOP of Michigan. Mr. Speaker, I rise today in support of the American Health Care Act, and I want to thank the chairman for his leadership on this measure.

Mr. Speaker, I came to Washington, D.C., to make a difference. When it comes to health care, it is readily apparent that ObamaCare does not work for most Americans. We know for a fact, as we are standing here today, that the current system is collapsing upon itself.

Our Nation has endured 7 long years of this mess, and today we have the obligation and the responsibility to act. I have heard many criticisms of this proposal, but I was raised to do what is right, to be a part of the solution, and not sit idly by on my hands as a spectator and watch Rome burn.

I came to Congress to make a difference, to find solutions to the many issues that vex our country. I came here to reduce the size and scope of an unwieldy government, to get government out of the way of everyday citizens. I came here to address spending, and $4 trillion debt in this country, to bring back free-market principles. I came here to defend the Constitution and our founding principles, and turn power back to the States and to the people.

And here is that, every single one of these principles can be found in this bill. The American Health Care Act reduces spending and cuts the taxes that have strangled businesses and individuals for the last 7 years. It represents the first real entitlement reform in the 52-year history of Medicaid. It deletes Federal mandates that rob citizens of their individual liberty.

Mr. Speaker, this bill may not be perfect, but it is a dramatic step in the right direction. An administration that was lectured as to unsubstantiated facts and fear tactics as to how this is going to impact my State, I would suggest to you that 420,000 Michiganders eligible for Medicare said “thanks”, but no thanks to the broken promise of affordable health care.

And that is why, Mr. Speaker, I am going to vote for this bill, and I would ask my colleagues to support it.

Mr. NEAL. Mr. Speaker, I would remind my colleague that his vote for this bill will result in 38,200 people from his congressional district in Michigan losing their healthcare coverage, and 313,123 people in the State of Michigan, indeed, did sign up for the Affordable Care Act.

Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. CROWLEY), a long-time friend, a very sound member of the committee, and also the well-regarded chairman of the Democratic Caucus.

Mr. CROWLEY. Mr. Speaker, this bill is a bad policy built on horrible process. Twenty-four million Americans will lose their coverage if this bill becomes law. Premiums and out-of-pocket expenses will skyrocket, especially for older Americans because of the age tax, as hardworking Americans are forced to subsidize tax cuts for the wealthy.

It is no wonder this bill was crafted in the dead of night behind closed doors. It is so bad, even Members of the Republican Party are rejecting this bill, but President Trump and Republican leadership insisted they need to repeal ObamaCare at any cost, even if the price will be making health care out of reach for veterans, seniors, and many of the hardest-working Americans.

So the majority made it worse, and then they made it worse again. Now they have taken away the bare minimum health coverage like covering emergency room visits or prescription drugs. It will crush any protections for preexisting conditions.
There is no guarantee the treatment you need for your condition will even be covered under this bill. Image that: healthcare coverage that doesn’t cover your health. Insurance that insures absolutely no peace of mind for what life may bring you.

That really blow to critical health protections was done just to win votes, like so many of the other provisions and political favors, like the Empire State kickback, the Buffalo bribe, and the Syracuse sellout. I call it simply a political ploy.

That provision, which will cut $2 billion from only New York State, has been blasted by newspapers from The Buffalo News to Newsday on Long Island. They have called it a train wreck. They have called it bloody money. Like everything else in this bill, it represents the worst kind of backroom, shady maneuvering.

This bill is bad for New York, bad for the democratic system, and bad for America going forward. The side of the aisle should be ashamed of themselves. I know many of you are. But this bill is appalling, and I urge everyone in this Chamber to vote it down. And, Mr. Chairman, I know that 27 million New Yorkers will lose their health care if this bill becomes law.

Mr. BRADY of Texas. I remind my friend from New York, nearly four out of five New Yorkers said no to ObamaCare because it failed them. Mr. Speaker, I yield 1 minute to the gentleman from Iowa (Mr. KING), my dear friend.

Mr. KING of Iowa. Mr. Speaker, I want to thank the chairman for yielding to me.

Seven years ago today, I brought the first repeal of ObamaCare here to this Congress. Forty words, to rip it out by the roots as if such act had never been enacted. I would like to be here today passing the full repeal of ObamaCare. We already know this is the first bite at the apple. I want to hope fully get all of this thing done in one day.

If I thought we could do it all in one bite, I would stand for that, but instead, here is what we have got. We have got a $1 trillion tax cut. We have got a $1.15 trillion spending cut. We have got a $150 billion deficit reduction. We have got a bill that eliminates the employer mandate, and it eliminates Federal mandates in the essential health benefits package of those 10 mandates—that I despise, by the way.

It expands health savings accounts—but doubles them—it allows for us to pass selling insurance across State lines, and it enables catastrophic health insurance. That is a pretty good list, and that is the list of things that I am going to support here when this goes up for a vote.

Mr. Speaker, I urge its adoption.

Mr. NEAL. Mr. Speaker, I remind my colleague that his vote for this bill will result in 40,900 people from his congressional district in Iowa losing healthcare coverage. I also want to thank the gentleman for being the first speaker on the Republican side to acknowledge that this is a tax cut.

Mr. Speaker, I yield 1 minute to the gentleman from Chicago, Illinois (Mr. DANNY K. DAVIS), a distinguished member of the Ways and Means Committee and my friend.

Mr. DANNY K. DAVIS of Illinois. Mr. Speaker, I rise in strong opposition to this draconian, Dracula-inspired health bill. It is not really a health bill at all. It is a plan for catastrophic cut for the wealthiest individuals in our country. This bill will decimate all of the public health gains that professional health personnel and activists have fought for the last 50 years.

This bill will take out the opportunity for those low- and moderate-income individuals who fall between the gap created by Medicaid and nothing. They are the least of those in our society. And when you take away health care for that group of individuals, history will not regard you well.

I believe that the best way to measure the effectiveness of a society is by how well it treats its young, how well it treats its old, and how well it treats those who have difficulty caring for themselves.

I will vote “no.” I urge us all to do so.

Mr. BRADY of Texas. Mr. Speaker, I remind my good friend from Illinois, Mr. Neal, I remind him that a little over half a million Illinoisans have said no to ObamaCare because it failed them.

Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. SANCHEZ), the vice chair of the Democratic Caucus, and a very strong performer on the Ways and Means Committee.

Ms. SANCHEZ. Mr. Speaker, I rise today in opposition to the Republican’s so-called health care bill because that provision, which will cut $2 billion for insurance CEOs that provides nearly zero healthcare benefits for the American people.

In fact, TrumpCare ensures that 24 million Americans will lose their health insurance coverage. Seniors will be charged more, and insurance companies will once again dictate the health of the American people. On the very day the Majority has said no to Medicaid, half a million Illinoisans have said no to ObamaCare because it failed them.

Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 2 minutes to the gentleman from Bucks County, Pennsylvania (Mr. TREШTIANI), a member of the Ways and Means Committee.

Mr. TREШTIANI. Mr. Speaker, I rise in strong opposition to this draconian, Dracula-inspired health bill.

In fact, TrumpCare promises the American people.

Mr. Speaker, what is clear, Mr. Speaker, is that the American people were promised the American people.

Mr. Speaker, what is clear, TrumpCare is not a healthcare bill. It is a tax-cut-for-the-wealthy bill—$600 billion in tax cuts. So I say to you, my Republican colleagues know what they are against, the Affordable Care Act. But what are they for? What are they for? I ask all of you.

Mr. BRADY of Texas. Mr. Speaker, I reserve the balance of my time.
Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Ms. CHU), a new member on the Ways and Means Committee, and a very thoughtful Member of Congress.

Ms. JUDY CHU of California. Mr. Speaker, my constituent Patty never had a worry about health care. Her husband had insurance through his job. But last year, Patty’s husband passed away suddenly. Overnight, Patty found herself without health coverage for herself and her 20-year-old son, who had a preexisting condition.

Even though she was grieving over the sudden loss of her husband, Patty couldn’t afford COBRA and had less than a month to find health care for her family. Thank goodness she was able to get coverage through the ACA. Under the Affordable Care Act, Patty could have her life upended all over again. Patty is 62 years old, and TrumpCare would cause premiums for people over 60 to increase by more than $6,000 a year, making insurance unaffordable. And under the age tax created in this bill, insurance companies could charge Patty five times as much as a young person. She could see skyrocketing costs for her hypertension and doctor’s visits.

TrumpCare is a bad deal for Americans like Patty.

Mr. Speaker, I urge my colleagues to vote a resounding “no” to this downright cruel bill.

Mr. BRADY of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, this so-called health bill is actually just mostly targeted for tax cuts for the wealthiest amongst us.

Let’s look at it this way: a millionaire will get a $30,000-a-year tax cut. A 64-year-old senior who earns $30,000 a year—that is all he earns, just the tax cut the millionaire gets—they will see their premium go from $1,700 a year, to $15,000 a year. That is half their income.

They are going to have a choice: give up their house so they can buy health insurance or don’t buy health insurance and don’t have a health emergency, and go bankrupt or die. Those are great choices.

This says a lot about the values of the Republican leadership and their obsession, instead of fixing the problems with the Affordable Care Act, they want to kill it. It says a lot about their values. They are pathetic.

Mr. BRADY of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 1 minute to the gentleman from Arizona (Mr. O’HALLERAN).

Mr. O’HALLERAN. Mr. Speaker, I rise in strong opposition to the so-called American Health Care Act. I am alarmed at the real consequences this bill will have on rural Arizona and rural America.

These communities will be disproportionately harmed by this bill. In Coconino County, a 40-year-old making $30,000 a year will go from a $2,400 payment to a $6,000 payment.

Getting away from my script for a second, I spent many years on the west side of Chicago looking at what the core side of poverty looks like night after night, family after family, in our cities and our towns across this wonderful America. I know a little bit about math, and I know that 20 million people insured is better than 24 million people uninsured.

Please vote “no.”

Mr. BRADY of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield 30 seconds to the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. Mr. Speaker, this is not a healthcare bill. This is a wealth care bill.

Unfortunately, President Trump, when he spoke in Louisville, said we had to pass this bill to get the big tax cuts. It is about wealth care. It is the Eocene epoch of this Congress.

The insurance you will get with the amendments made will be as worthless as the degree from Trump University. We do not need wealth care, but we need health care.

Mr. BRADY of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. NEAL. Mr. Speaker, I yield myself the balance of my time.

In closing, I want to make sure the people of America understand what we are doing here in about 1 hour. We heard during the course of a Presidential campaign the promise that everything was going to be covered and we would be tired of winning.

If winning means that 24 million Americans are going to lose their healthcare coverage, if winning means imposing an age tax on seniors, if winning means higher out-of-pocket costs for working Americans, and if winning means robbing $75 billion from the Medicare trust fund, we don’t want to be part of that victory lap.

This isn’t about one person making up alternative facts. Our statements today have been based upon the CBO, the National Rural Health Association, the American Medical Association, the American Association of Retired Persons, and the March of Dimes.

This bill has fewer covered, weaker protections, and higher costs. Let’s call this what it is today: it is a $1 trillion tax cut for the richest amongst us.

The Republicans are now facing the worst of the ordeal. They have a bad plan, and they know it. They have scrambled for the last week to try to figure out how to stitch it together, and it hasn’t worked.

For those across this country, think of the following: no maternity care, fewer hospital visits, no mental health services for those families who are struggling with a family member who has an opioid addiction, which is the crisis of our time.

This is more of the same: tax cuts for the wealthiest amongst us and healthcare cuts for everyone else.

Mr. Speaker, I yield back the balance of my time.

Mr. BRADY of Texas. Mr. Speaker, I yield myself the balance of my time to close.

Mr. Speaker, do you want to know how bad ObamaCare is?

Twice as many Americans have exempted themselves, have paid a fine, or found another way out of ObamaCare for everyone who took it.

I am a conservative, and I am proud of the conservative win in this bill. I am proud of the $1 trillion in tax relief on our small businesses, our patients, and our families. I am proud of the more than $1 trillion of spending cuts that Washington cannot afford nor sustain.

I am proud of the first reforms in Medicaid since the program was created in giving States back control of that plan, including the option of a work requirement.

I am proud to repeal ObamaCare mandates that have forced Americans into health care they can’t afford and don’t want. I am proud to defund Planned Parenthood once and for all.

And I am proud of the $150 billion of deficit reduction.

This is a clear choice, and we will stand where we stand today: the choice between President Trump and more freedom or ObamaCare and less freedom. I stand with President Trump.

Mr. Speaker, I yield back the balance of my time.

Mrs. BLACK. Mr. Speaker, I yield myself such time as I may consume.

I include in the RECORD a letter dated March 7, 2017, from Dr. Thomas Price, the Secretary of Health and Human Services, who sent a letter of support for the American Health Care Act to Chairmen Walden and Brady.


Hon. Greg Walden, Chairman, Committee on Energy & Commerce, Washington, DC.

Hon. Kevin Brady, Chairman, Committee on Ways & Means, Washington, DC.

DEAR CHAIRMAN WALDEN AND CHAIRMAN BRADY: On behalf of the Trump Administration, I am writing in support of the reconciliation amendments recently released for consideration by your Committees. Together, they align with the President’s goal of rescuing Americans from the failures of the Affordable Care Act. These proposals offer patient-centered solutions that will provide all Americans with access to affordable, quality healthcare, promote innovation, and offer peace of mind for those with pre-existing conditions.

Your legislative proposals are consistent with the President’s commitment to repeal the Affordable Care Act, provide advanceable, refundable tax credits for Americans who do not already receive such tax benefits through health insurance offered by their employers, and Medicaid on a sustainable path and remove burdensome requirements in the program to better target...
resources to those most in need; empower patients and put healthcare dollars and decisions back into their hands by expanding the use of health savings accounts; ensure a stable transition away from state lines, lowering drug costs for patients, providing additional flexibility in Medicaid for states to manage their programs in a way that best serves their citizens, or medical legal reforms. Your proposals represent a necessary and important first step toward fulfilling our promises to the American people. We look forward to working with you throughout the legislative process, making necessary technical and appropriate changes, and ensuring eventual arrival of this important bill on the President’s desk.

Yours truly,

Thomas E. Price, M.D.,
Secretary.

Mrs. BLACK. Mr. Speaker, I include in the RECORD a letter that comes from 24 of our Governors in support of the repeal of ObamaCare, and I would like to read just two quick paragraphs out of the letter:

"We support efforts to Reform the system.

"To provide access to affordable and quality health care, we must reform the system. We support a plan that gives state governments maximum flexibility to reform Medicaid and the system surrounding it. The states are more effective, more efficient and more accountable to the people. What works in one state may not work in another location, and true reform will allow states to recognize and meet the unique needs of the people all across America."

"We recognize that a vote in the House of Representatives is the first step in the Repeal, Replace and Reform process that the United States Senate will undoubtedly make additional improvements before final approval by the President. We also recognize that the Secretary of Health and Human Services is committed to working with state leaders to provide maximum flexibility for true reform."

March 24, 2017.

Hon. Mitch McConnell,
Majority Leader, U.S. Senate,
Washington, D.C.

Hon. Paul D. Ryan,
Speaker, House of Representatives,
Washington, D.C.

Dear Senator McConnell and Speaker Ryan: Thank you for your service to our country. Please allow us to offer our thoughts about the pending vote on the American Health Care Act. Americans want personalized, patient-centered healthcare that treats them as individuals not a statistic, and that demands we repeal ObamaCare, replace it, and reform the system.

WE SUPPORT THE REPEAL OF OBAMACARE

ObamaCare is collapsing. If we do nothing, people will lose access to health care coverage. The government now collects more than what is possible in a budget reconciliation bill, as procedural rules on this type of legislation prevent inclusion of key policies such as selling insurance across state lines, lowering drug costs for patients, providing additional flexibility in Medicaid for states to manage their programs in a way that best serves their citizens, or medical legal reforms. Your proposals represent a necessary and important first step toward fulfilling our promises to the American people. We look forward to working with you throughout the legislative process, making necessary technical and appropriate changes, and ensuring eventual arrival of this important bill on the President’s desk.

Yours truly,

Thomas E. Price, M.D.,
Secretary.

Mrs. BLACK. Mr. Speaker, I include in the RECORD a list of groups supportive of the American Health Care Act. We have many groups, from conservative groups to pro-life groups, to industry groups; and among those would be several insurance providers, such as Blue Cross Blue Shield, Anthem, and others.

GROUPS SUPPORTIVE OF THE AMERICAN HEALTH CARE ACT

American Legislative Exchange Council
American Federalists of Texas
Association of Mature American Citizens
Center of the American Experiment
Citizens Against Government Waste
Institute for Liberty
Independent Women’s Voice
Markets Institute
National Taxpayers Union—Key Vote

Protecting America’s Health Care Act

The American Health Care Community
"We support efforts to Reform the system.

"To provide access to affordable and quality health care, we must reform the system. We support a plan that gives state governments maximum flexibility to reform Medicaid and the system surrounding it. The states are more effective, more efficient and more accountable to the people. What works in one state may not work in another location, and true reform will allow states to recognize and meet the unique needs of the people all across America."

"We recognize that a vote in the House of Representatives is the first step in the Repeal, Replace and Reform process that the United States Senate will undoubtedly make additional improvements before final approval by the President. We also recognize that the Secretary of Health and Human Services is committed to working with state leaders to provide maximum flexibility for true reform."

Governors are pleased to have an administration and a Congress willing to collaborate with the states to address the legitimate needs of our people. We have compassion for those concerned about the uncertainty surrounding this plan. The important point is that the Congress act quickly on Repeal, Replace and Reform. This is a multi-stage process. There is much more work to be done, and process can only begin with a vote in the House of Representatives. With this in mind, we humbly request that you vote to repeal and replace ObamaCare and to reform the system going forward. Thank you.

Sincerely,

Governor Scott Walker, Wisconsin; Governor Robert Bentley, Alabama; Governor Rick Scott, Florida; Governor C.L. “Butch” Otter, Idaho; Governor Eric Holcomb, Indiana; Governor Terry Branstad, Iowa; Governor Sam Brownback, Kansas; Governor Matt Bevin, Kentucky; Governor Paul R. LePage, Maine; Governor Phil Bryant, Mississippi; Governor Eric R. Greitens, Missouri; Governor Pete Ricketts, Nebraska; Governor Christopher T. Sununu, New Hampshire; Governor Doug Burgum, North Dakota; Governor Ralph Northam, Virginia; Governor John Bel Edwards, Louisiana; Governor Nikki Haley, South Carolina; Governor Jared Polis, Colorado; Governor Jared Polis, Colorado; Governor Jack Markell, Delaware; Governor Gary R. Herbert, Utah; Governor Matthew H. Mead, Wyoming.

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. HENSARLING), the chair of the Financial Services Committee.

Mr. HENSARLING. Mr. Speaker, I yield back the time.

Mr. HENSARLING. Mr. Speaker, tragically, I receive correspondence every week like this, I heard from Rita in east Texas, who writes me:

Since ObamaCare took effect, my insurance no longer covers my colonoscopies as
proventative care. I now pay $1,000 and more out of pocket versus $100 outpatient fee.

I heard from Frances in the Dallas area near where I live. A few years ago she was tragically diagnosed with tonsil cancer. The good news is she had a good policy; $600-a-month premium and a maximum out of pocket of $3,500. But thanks to ObamaCare, her insurance company dropped her twice, and she wrote:

They dropped me again because they are leaving the Dallas market.

Her premiums and deductibles doubled. She lost her oncologist, and she writes that this is all because of ObamaCare, the Affordable Care Act.

I heard from Tonya in Van Zandt County, in my district:

We had five family members covered by insurance at around $800 a month until ObamaCare. Our insurance premiums skyrocketed to $1,500 a month, equivalent to a house payment, with a $15,000 deductible, and we cannot see the doctors that know our medical history. Repeal it. I should not be forced to pay for something I cannot use. This is a new nightmare.

Mr. Speaker, ObamaCare has been a nightmare. It is collapsing as we speak. People are losing their coverages. Insurance plans are pulling out of States and counties. Tens of millions of our fellow countrymen have been forced to buy health insurance plans they cannot afford, they do not want, and that do not work for them.

Right here, right now, we have a choice: failed ObamaCare or the American Health Care Act that begins the process of providing Americans with guaranteed access to quality, affordable, patient-centered health care.

It clearly advances the cause of freedom, and all Members should support it and end the nightmare of ObamaCare.

Mr. SCOTT of Virginia. Mr. Speaker, I ask unanimous consent that I be allowed to manage the balance of the time remaining.

The SPEAKER pro tempore. Is there objection to the gentleman from Virginia?

There was no objection.

Mr. SCOTT of Virginia. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, as we talk about the Affordable Care Act, I think it is important to remind ourselves of the situation before it passed: costs were going through the roof, those with preexisting conditions could not get insurance, paying more than men, and every year millions of people were losing their insurance.

We passed the Affordable Care Act. Since then, the costs have continued to go up, but at the lowest rate in 50 years. Women are no longer paying more than men. Instead of millions of people losing their insurance every year, more than 20 million more people now have insurance.

The full name of the Affordable Care Act is the Patient Protection and Affordable Care Act.

Now your coverage can’t be canceled if your insurance company decides that it has paid too much. Preventive services, such as cancer screenings, are free with no copays and deductibles. We are closing the doughnut hole. Those under 65 can stay on their parents’ policies.

We also supported health centers, made investments in education to produce more doctors, nurses, and other professionals. Through all of that, the Medicare trust fund is more solvent than it was before. Still, the system is imperfect. But if we are going to make any changes, we ought to improve the law, not make it worse.

Incredibly this bill makes it worse. Now, the CBO has separated promises and press releases from reality. Twenty-four million fewer people will have insurance, and the Republicans call this choice in freedom to be uninsured. Most everybody else will pay more and get fewer benefits. All of those consequences will occur if the proposal actually works.

A number of States have done what this bill tries to do, and that is cover people with preexisting conditions without universal coverage. All of those attempts failed.

So the question we must ask is: Who will be better off if this bill passes? Some people who will face the bill’s age tax. Certainly not veterans who will lose benefits. Certainly not senior citizens in nursing homes and people with disabilities because Medicaid is cut. Even the solvency of the Medicare trust fund will be worse.

But millionaires will get tax cuts.

Mr. Speaker, we have been hearing a lot of complaints and shortcomings about the Affordable Care Act, but if we are going to make any changes, we should improve it. Unfortunately, this bill makes things worse: 24 million will lose their insurance, most everybody else will pay more and get less. This bill should be defeated.

Mr. Speaker, I reserve the balance of my time.

Mrs. BLACK. Mr. Speaker, it is now my honor to yield 2 minutes to the gentleman from Virginia (Mr. GOODLATTE), the distinguished chairman of the Judiciary Committee.

Mr. GOODLATTE. Mr. Speaker, I want to tell you why I am supporting this legislation, the American Health Care Act.

Kaye, from Roanoke, contacted me about President Obama’s promise that she could keep her health care. She shared that she received a letter from her insurer stating that her policy was going to increase by $600 per month—increase by $600 per month. Since she wasn’t of age to be on Medicare but wasn’t working because she was at home caring for her sick husband, she was frustrated with her situation.

Kaye couldn’t afford the extra money she owed on top of the bills for her husband’s medical treatment. She told me: “So I will now have to pay the fine, drop my insurance, and hope I do not get sick.”

I told Kay I would vote to repeal and replace ObamaCare.

Mr. SABLAN. Mr. Speaker, I oppose the American Health Care Act because it fails to increase coverage for 3.8 million Americans in the insular areas: American Samoa, Guam, the U.S. Virgin Islands, Puerto Rico, and my own district, the Mariana Islands.

President Trump promised, “Everybody’s going to be taken care of much better than they’re taken care of now,” but that is not happening. Instead of taking the opportunity to take care of all Americans, the American Health Care Act ignores the insular areas:

We are not included in the new Medicaid per capita funding proposal. As a matter of fact, in a year, what would see our Medicare funding reduced by 68 percent.

We are not included in the new Patient and State Stability Fund. And the new tax credit for insurance premium is legislatively a new cost, an unfunded Federal mandate, imposed by Congress on territorial governments.

Everyone in this Chamber wants affordable, quality health care for all Americans. This bill fails to do that. So let us begin again. Let us work together from Virginia to Washington to produce an affordable, patient-centered health care that begins the process of providing Americans with guaranteed access to quality, affordable, patient-centered health care.
Mrs. BLACK. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Florida (Mr. DUNN).

Mr. DUNN. Mr. Speaker, I rise to repeal Obamacare by supporting the American Health Care Act. We are here to take healthcare back from the bureaucrats and give it to the people.

The previous administration enacted Obamacare, and we saw its effects: higher premiums, less choice, lost coverage, and broken promises. The deductibles are huge, and it is like not having insurance at all.

The people who sent me to Congress sent me with strict orders: End this law. And on the American Health Care Act, I can report, it does.

With this bill, the Federal Government no longer forces you to buy a product you can’t use and don’t want. The individual mandate is gone, so is the job-killing employer mandate. Gone are a host of taxes on prescription meds, over-the-counter drugs, insurance premiums, and lifesaving medical devices.

It ends Obamacare’s Medicaid expansion, and it puts Medicaid on a budget and focuses State efforts on those people truly in need. This is the biggest entitlement reform in a generation.

Of course the bill is not perfect. There is more to do. But I spent 30 years as a surgeon. In medicine, as in life, you do not get to choose the perfect option. You learn not to make perfect the enemy of the good.

With this vote we decide whether Obamacare is our healthcare future or not. We can live with its failures and broken promises or create a market-based system that actually lowers the cost of healthcare and serves patients, not bureaucrats.

So I support the American Health Care Act, Mr. Speaker, and I urge that all Members do the same.

Mr. SCOTT of Virginia. Mr. Speaker, I remind my colleague that his vote for all Members do the same. Care Act, Mr. Speaker, and I urge that not bureaucrats. cost of health care and serves patients, based system that actually lowers the expense of health care.

Mr. ABRAHAM. Mr. Speaker, as a practicing physician in the Louisiana and Mississippi delta, I have some of the best patients, but some of the poorest. They can’t afford to see me because they can’t afford Obamacare. Increased costs, skyrocketing premiums, high deductibles. I can’t cure a disease if I can’t see the patient. The cost is just too high for Obamacare.

We have heard about Medicaid expansion here today. That is a second-class-insurance for first-class people. I can’t get my patients to see a specialist. They have to go to the hospital. They have to go to the emergency room. Prices go through the roof.

I have heard my colleagues on the other side of the aisle reference the Hippocratic Oath. With all due respect, I don’t think they would know what the Hippocratic Oath says if their life depended on it. Guess what? It does. Google it.

I let me educate you. Let me educate our colleagues. It says I will always do no harm to patients. ‘First, do no harm’ to patients.

We need to pass this American Health Care Act. Obamacare has failed. It is a sham of an insurance. Americans deserve better. We deserve better as Americans. Deserve better.

Mr. SCOTT of Virginia. Mr. Speaker, I remind my colleague that his vote for this bill will result in 63,900 people from his congressional district in Florida losing healthcare coverage and care.

I yield 1 minute to the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY. Mr. Speaker, in a few minutes, the American people will see clearly what each and every Member of this House is made of. Will we vote to willfully strip healthcare coverage from 24 million Americans, older Americans, working Americans, Americans with chronic illness and developmental disabilities and now, incredibly, we even know, Americans who wore the uniform of this Nation?

In a few minutes, we will see who will vote to raid the Medicare trust fund in order to cut Medicare taxes for the rich, and we will see who will vote to cut Medicaid’s coverage for patients struggling with the curse of opioid addiction.

Mr. Speaker, this is not just a vote. This is a gut check of who we are as people and whether our purpose, as elected officials, is to serve the public interest or, rather, feckless special interests.

Show the Nation that we care more about people than politics, that we care more about the long arc of American history toward justice rather than the short trend of who is up and who is down in Washington.

Make no mistake: History is watching this vote. Vote ‘no.’

Mrs. BLACK. Mr. Speaker, I yield 1½ minutes to the gentleman from Louisiana (Mr. ABRAHAM), who is a family practitioner and knows a little about medicine.

Mr. ABRAHAM. Mr. Speaker, as a practicing physician in the Louisiana and Mississippi delta, I have some of the best patients, but some of the poorest. They can’t afford to see me because they can’t afford Obamacare. Increased costs, skyrocketing premiums, high deductibles. I can’t cure a disease if I can’t see the patient. The cost is just too high for Obamacare.

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ABOUT THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (The College), a 501(c)(3) organization, is the nation’s leading group of physicians dedicated to the care of women. As a private, voluntary, nonprofit membership organization of more than 57,000 members, The College strongly advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among health care providers and the public of the changing issues facing women’s health care.

The American Congress of Obstetricians and Gynecologists (ACOG), a 501(c)(6) organization, is its companion.

ABOUT THE AMERICAN OSTEOPATHIC ASSOCIATION

The American Osteopathic Association (AOA) represents more than 129,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; and is the accrediting agency for osteopathic medical schools. Visit DoctorsThatDo.org to learn more about osteopathic medicine.

Mr. SCOTT of Virginia. Mr. Speaker, I yield 1 minute to the gentlewoman from Ohio (Ms. FUDGE).

Ms. FUDGE. Mr. Speaker, what is a life worth? What does it cost to save the life of a sick child or a senior citizen?

For all of the rhetoric about freedom and choices, this bill sends a clear message to the American people as to where Republican priorities lie. Tax breaks to the wealthy have been deemed more valuable than lifesaving care.

They are telling hardworking families that insurance that only benefits the wealthy, the healthy, and the young is more important than access to nursing homes, to pediatric care, mental health services, substance abuse treatment, and the overall peace of mind that, if you get sick, you can afford care.

Speaker RYAN calls this “an act of mercy.” This is by no means merciful, Mr. Speaker. Mercy is caring for the sick, the poor, for our elders. Mercy is extending a hand to those in need. This is heartless.

Human decency demands a “no” vote on TrumpCare. Vote “no.”

Mrs. BLACK. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. CONAWAY), the chairman of the Agriculture Committee.

Mr. CONAWAY. Mr. Speaker, we are faced with an unenviable choice of the fact that there is infinite demand for health care. There is no top on the amount of healthcare cost necessary to provide all the health care that we want for everybody in this country, and we have limited resources within which to do that.

The real question is: Does ObamaCare take up that task by asking government to make those hard choices, or do we as individuals and families prioritize the things that are important to us the same way we want others to do?

I believe that the bill that we will get to vote on today moves us toward that direction. This isn’t about health care, per se; this is about how do you pay for it.

Insurance is not a magic bullet anywhere across the spectrum. Insurance is simply a scheme in which we risk-manage together. We put a certain amount into a bucket, assuming not all of us will suffer the risks that we want to cover. If we do, we have got to put more money in; if we don’t, then the system works.

This bill is asking us to commit that choice that there is too much cost for the amount of resources that are available in any of these circumstances, and it is hard.

Many of my constituents ask: Why did Republicans spend 6 years railing against ObamaCare and not have the fix available on Inauguration Day? Well, this is Exhibit A. This is hard stuff. Even among Republicans, we have got more than 218 votes among us, and we can’t agree among ourselves necessarily on what to go forward.

But I do know this, that we are down to the final choice: Do we keep ObamaCare and the failure that is confronting us and will continue to be there, or do we take a chance on moving toward what I will call a different, moving toward freedom, moving toward choice, giving States back the opportunity to decide for their indigent population how they should take care of them?

I don’t think anybody in Washington, D.C., can come up with a plan that fixes that for all 50 States. I trust my colleagues in Austin to make that happen far better than anybody I would trust in D.C., and this bill moves that direction, and that is the right direction for us to go.

This is a hard choice, but for me it is relatively straightforward. You keep ObamaCare with a “no” vote. You move toward a brighter future for the health care reform that we have paid for, that we pay for, and the way we pay for it, who pays for it, and how we get that done by a “yes” vote. I encourage my colleagues to vote “yes” on this bill.

Mr. SCOTT of Virginia. Mr. Speaker, I remind my colleague that his vote for this bill will result in making things worse by 58,600 people in his district losing their healthcare coverage and care.

Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. WILSON).

Ms. WILSON of Florida. Mr. Speaker, I would like to begin by asking my Republican colleagues one simple question: Don’t you have constituents who get sick and need insurance?

Everyone gets sick, rich and poor. Black and White, men, women, and children.

Having insurance gives us peace of mind. It helps ensure that a medical crisis is not exacerbated by a financial crisis. It often makes a difference between life and death. If the Affordable Care Act is repealed, your constituents and millions of people will be kicked off the insurance roll, and that is a shame. They will suffer, and their families will suffer.

I have health insurance, and so does every Member of Congress. We even have a clinic and doctors at our disposal right here in this Capitol.

Doesn’t every American deserve the same treatment as Members of Congress?

Instead of moving backwards, Republicans should partner with Democrats to amend and strengthen the existing law. By working together, we can create a plan that works for all Americans, not just the Members of Congress. Vote “no.” Vote “no.”

Ms. KAPTUR. Mr. Speaker, the Affordable Care Act needs to be repaired, not repealed. In 2010, Democrats passed health care reform in an effort to move toward health insurance for all Americans. Though we have made progress and more work to do, we cannot move America backward. Tens of thousands of people in northern Ohio and millions across America will lose insurance if TrumpCare becomes law.

This bill is cruel. It will take away care from some of our most vulnerable citizens like those who suffer from opioid addiction, mental illness or have disabilities. This bill will undermine the Medicare and cut $28 billion from Ohio’s Medicaid program, the majority of which is spent on nursing home care. If Republicans succeed in repealing the Medicaid expansion, one in four Ohio hospitals would close according to the Ohio Hospital Association.

Our goal should be to make our health care system better, not worse. This merciless bill is not a health care bill. This bill is an $800 billion tax cut for corporations and the very rich. How that giveaway provides better health care to working and middle-class families is beyond me.

For Lent I gave up chocolate, I recommend the Republicans try giving up tax cuts to the rich!

Let me share a story about a young man in Ohio who was diagnosed with an extremely rare form of cancer one month before his 26th birthday.

Once he turned 26 he lost coverage under his parent’s health care policy.

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citizens like the mentally ill or disabled will lose care. Premiums for those over 50 could increase by 5 fold. As the old saying goes; “this dog won’t hunt.”

Ohio embraced the ACA and 866,000 people were finally able to receive health care coverage. For what this poorly conceived Republican tax giveaway bill do to Ohio:

1. About 47,000 people will lose health insurance because they are insured through the ACA in Ohio’s 9th district.

2. The 9th district’s uninsured rate has gone from 13.3% to 7.0% since the ACA was implemented. This 6.3 percentage point drop in the uninsured rate could be reversed if the ACA is entirely or partially repealed.

3. 318,900 individuals in the district who now have health insurance that covers preventive services like cancer screenings and flu shots without any co-pays, coinsurance, or deductibles stand to lose this access if the Republican Congress eliminates ACA provisions requiring health insurers to cover important preventive services without cost-sharing.

4. 370,700 individuals in the district with employer-sponsored health insurance are at risk of losing important consumer protections like the prohibition on annual and lifetime limits, pre-existing condition exclusions, and coverage of preexisting health conditions, if the ACA is entirely or partially repealed.

This Republican bill, hastily prepared, should be defeated. It is cruel, will leave millions of our fellow citizens bankrupt and destitute. What we are being asked to vote on it despite receiving the newest version of the manager’s amendment late last night. This is not the regular order and transparency that the Republicans promised.

Mr. Speaker, this bill pushes the cost of health care onto those who can least afford it while providing massive tax cuts for the wealthy. I urge my fellow members to defeat this misguided bill and let us begin the serious work of making real improvements in the Affordable Care Act for all Americans.

Mrs. BEATTY. Mr. Speaker, I rise today to express my opposition to TrumpCare and my strong support for the Affordable Care Act.

Since the ACA was enacted seven years ago, more than 20 million Americans have gained access to affordable and high quality health insurance, including nearly one million Ohioans.

We thought 129 million Americans with pre-existing conditions would be able to keep their health care coverage. We thought 105 million Americans would no longer have to worry about annual or lifetime limits. Yet, we are here today winding back the clock on all the progress we have made based on a bill that wasn’t released to the public until last night.

What’s the rush to pass a bill that affects so many people without letting the public view it? What’s the rush to pass a bill that affects so many people without a new CBO score?

Mr. Speaker, we know that TrumpCare will cause Americans to pay more for less coverage. We know that TrumpCare will provide a massive tax cut to the super rich 400 families and leave the other 99.9 percent of people behind. We know that TrumpCare will cause 24 million Americans to lose their health insurance, including tens of thousands of my constituents in the Third Congressional District of Ohio. We know that TrumpCare will slash Medicaid funding by $880 billion. We also know that TrumpCare will put 13 million children, people with disabilities and adults just one emergency visit away from financial catastrophe.

Mr. Speaker, these cuts hurt people all across the country. As TrumpCare will not make healthcare more affordable.

Democrats believe healthcare is a right, not a privilege. I join my colleagues in fighting for affordable healthcare for all Americans. I will vote no, and urge all my colleagues to vote no as well.

Mr. SMITH of New Jersey. Mr. Speaker, while the Affordable Care Act has been in effect since 2010, it has only provided actual access to health insurance benefits through the exchange and Medicaid expansion for a little over 3 years beginning in 2014.

In that short period of time, however, serious problems and flaws have been exposed, yet in recent months the law’s systemic problems have been trivialized or ignored by many.

Today, buying an insurance policy on the exchanges with high premiums, high copays, and most importantly, exceedingly high deductibles make the actual utilization of health benefits far costlier than originally advertised.

Americans were told repeatedly that the ACA would save up to $2,500 in premium payments per family per year. President Obama said: “I will sign a universal health care bill into law by the end of my first term as president that will cover every American and cut the cost of a typical family’s premium by up to $2,500 a year.”

That didn’t happen—not even close.

Nationwide, since 2016, gross premiums before subsidies in the Bronze-priced tier rose a whopping 27 percent, silver 24 percent and gold 32 percent.

That should come as no surprise. As early as August 2012, Politifact found President Obama’s promise to be untrue and labeled the statement a “promise broken” in a Politifact report entitled: NO cut in premiums for typical family.

Health insurance consumers were promised they could keep their insurance plan if they liked it and keep their trusted doctors as well. That didn’t happen either.

As a matter of fact, several million were kicked off insurance plans they were very satisfied with—like my wife and I—only to be forced into an Obamacare plan that we didn’t want and was more expensive.

Also, in New Jersey—like much of the nation—insurance companies are pulling out of the exchanges. Insurers continue to exit the individual market and the exchange has experienced a net loss of 88 insurers. Today, five states only have one insurer option at home, last year five insurance carriers offered plans on the New Jersey exchange, today only two remain.

The exodus of insurance companies from the individual market is an unsustainable and ominous trend.

Mr. Speaker, almost twice as many Americans have paid the financial penalty—pursuant to what is euphemistically called the “individual mandate”—for not buying a health insurance plan—or have received an exemption from the individual mandate as those who have actually purchased a plan through the exchange. By the numbers that means 19.2 million taxpayers either paid the individual mandate penalty or claimed an exemption, compared to 10.3 million individuals who paid for plans on the Obamacare exchanges.

Obamacare also increased taxes by about one trillion dollars.

For example, beginning in 2020, a new 40% excise tax on employer provided comprehensive health insurance plans is scheduled to take effect. Any plan provided by an employer exceeding $10,200 for individuals and $27,500 for families will be taxed at 40 percent for each dollar above those numbers. According to the Kaiser Family Foundation this so-called Cadillac tax will hit 26 percent of employers by 2020.

According to the IRS, approximately 10 million families took advantage of the chronic care tax deduction which is now been redefined out of reach for many. New taxes combined with skyrocketing premiums, copays and deductibles underscores the need for serious reevaluation and reform.

That said Mr. Speaker, I remain deeply concerned—and will vote no today—largely because the pending bill cuts Medicaid funding
by an estimated $839 billion over ten years according to the Congressional Budget Office (CBO), rolls back Medicaid expansion, cancels essential health benefits such as maternity and newborn care, hospitalization, pediatric services, and mental health and substance use treatment. The AHCA includes “per capita caps,” of which will likely hurt disabled persons, the elderly and the working poor.

For years, I have supported Medicaid expansion as a meaningful way of providing access to health care for struggling individuals and families living above the poverty line but still poor enough to qualify—80 percent of all Medicaid enrollees in New Jersey are families with at least one working adult in 2017. Although more than 800,000 children are served by Medicaid in my state, the bulk of Medicaid funds are spent assisting the disabled and the elderly. In New Jersey approximately 74 percent of all Medicaid spending goes directly to assist persons with disabilities and senior citizens. Two out of every five people in nursing homes are on Medicaid. According to the New Jersey Department of Human Services, in New Jersey total enrollment in Medicaid in February 2017 was 1.77 million people. Of that a significant number are newly enrolled under Medicaid expansion—663,523 “newly eligible.”

The sick and sicker need and deserve our support. Current law provides states that opted to embrace Medicaid Expansion—like New Jersey—95 percent of the costs for the “newly enrolled.” The federal share drops to 90 percent by 2020.

The American Health Care Act continues Medicaid expansion however only until 2020. Those enrolled before December 31, 2019 would be grandfathered in at the 90 percent match rate but the federal-state match formula would then be reduced to a range between 75 percent-25 percent to 50 percent—50 percent or any new enrollee.

What does that mean?

The United States Conference of Catholic Bishops wrote each of us on March 17th: “...it is our assessment that some provisions of the AHCA... would fund mandated coverage and pro-life safeguards and other noteworthy provisions in the bill... while others present grave challenges that must be addressed before passage... millions of people who would be eligible for Medicaid under current law will be negatively impacted due to reduced funding from the per capita cap system proposed in the legislation, according to the CBO. Those struggling families who currently receive Medicaid coverage from the recent expansion will see dramatic changes through the AHCA as well, with clear indication of affordable, adequate coverage to replace their current options. Many states begin their legislative sessions every cycle by attempting to overcome major deficits. State and local resources are unlikely to be sufficient to cover the gaps that will be created in the health care system as financial responsibility is further shifted to the states. Congress must rework the Medicaid-related provisions of the AHCA to fix these problems and ensure access for all, and especially for those most in need.”

A letter led by the Consortium For Citizens with Disabilities, and signed by over 60 organizations states: “Dramatic reductions in federal support for Medicaid will force states to cut services and/or eligibility that puts the health and wellbeing of people with disabilities at significant risk. In fact, people with disabilities are particularly at risk because so many waivers and home- and community-based services are optional Medicaid services and will likely be the first services cut when states are addressing budgetary shortfalls. People with disabilities, independence, and wellbeing of 10 million enrollees living with disabilities and, often, their families, depends on funding the services that Medicaid provides. Likewise, Medicaid Expansion provides coverage for millions of people with disabilities in states that previously fell into healthcare coverage gaps. For many people with disabilities, being able to access timely, needed care is a life or death matter. The drastic cuts to Medicaid that will result from per capita caps and the ultimate elimination of Medicaid Expansion will endanger millions.”

Autism Speaks, a leading autism awareness, science, and advocacy group, further articulated another concern, that “the choice of 2016 as a baseline year for per capita caps may preclude states from addressing the needs of children with autism. In July 2014 the Center for Medicaid and CHIP Services issued an informational bulletin clarifying Medicaid coverage of services to children with autism, including benefit requirements for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Although EPSDT is a mandatory Medicaid program, few states in 2016 funded autism services at the required standard of care. Locking in 2016 as a baseline year can only perpetuate this historic under-funding of EPSDT benefits.”

Ms. ROYAL ALBERT, Mr. Speaker, for my constituents and all Americans, Trumpcare would result in higher costs, less coverage, a crushing age tax for persons 50 to 64, a shorter Medicare life span, and the ransacking of the Medicaid funds that enable seniors to get the long term care they need. And last night, Republicans added a provision that would prohibit our veterans who are eligible to receive VA care from receiving any tax credits to help pay for their care outside the VA, even if they are not enrolled in the VA.

In my congressional district, the uninsured rate dropped from 31.7 to 17.5 percent due to Obamacare.

Among my constituents who benefited are a young mother from Bell Gardens, California, and her 15-month-old daughter, Olivia, who was born with Down Syndrome. Because of Obamacare’s Medicaid expansion in California, Olivia was able to have her congenital heart defect repaired shortly after birth. She is now being followed by a cardiologist to ensure her ongoing care for a healthy heart.

Obamacare’s Medicaid expansion also makes it possible for baby Olivia to receive early intervention and physical therapy services to enhance and accelerate her development.

Olivia’s mom is terrified that if Trumpcare passes, her daughter may not be able to receive these services, which help her remain healthy and make it possible for her to reach critical developmental milestones.

Republicans like to call Obamacare a failed disaster. That is simply one more example of their “alternative facts.” The Republican Trumpcare bill before us is the disaster waiting to unfold for countless families like Olivia’s, and millions of Americans across our country.

I urge my colleagues to vote no on behalf of the American people. Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in strong opposition to H.R. The American Health Care Act, which not only seeks to repeal the Patient Protection and Affordable Care Act, but rework entitlements, redistribute wealth, and strip coverage from millions of people.

The American Health Care Act would reallocate coverage for Americans while increasing out-of-pocket costs for the sickest and the elderly. Health plans would fail to meet the needs of Americans with chronic or complex conditions. The bill also eliminates protections against annual and lifetime caps. With a last-minute manager’s amendment to repeal the Essential Health Benefits, the ten coverage rules set up by the Affordable Care Act, this ruthless bill has gotten even worse.

The Affordable Care Act required insurers to cover ten “Essential Health Benefits” from maternity care, mental health, and prescription drugs to hospitalization and hospice care. If this is repealed, comprehensive health insurance will become virtually unavailable in the individual market. This means that individuals with pre-existing conditions would not be protected. Younger and healthier people benefit, older and sicker people suffer.

While the new additions to this measure are startling, the original bill is just as shocking. Slashing and capping the Medicaid program will ration care and give tax breaks to the wealthy. This bill cuts $880 million from Medicaid and then caps each state’s funding at the end of 2019, the Medicaid expansion program will freeze and this bill will shift costs to states for the elderly, children, individuals with disabilities, and low-income adults.

This bill will kick 24 million people off their health insurance by 2026, and 7 million people will lose their employer-based coverage. While the Affordable Care Act subsidies were based on income and when premiums rose, the federal subsidy also rose to pay for premium increases. Under the American Health Care Act, those subsidies with a fixed credit amount. The age-based tax credits are a refundable tax credits that is larger for older individuals, however, it allows insurers to charge older enrollees five times more than a younger enrollee.

Mr. Speaker, the public has spoken about this so-called “replacement” bill. People will live or die as a result of this legislation. This bill will force Americans to pay for more to premiums, more for their care, more on out-of-pocket expenses and deductibles; all the while driving to breaks directly to the wealthy. The Republican leadership has rushed this bill to the floor without any consideration and I urge you all to consider its harmful effects. Your constituents are asking you to work with us to repair the Affordable Care Act. Work with us. Mr. AL GREEN of Texas. Mr. Speaker, although Trumpcare is a terrible Healthcare plan, it is a terrific Healthcare plan. Trumpcare is terrific Healthcare because in the final analysis, it allows the 400 richest families to get $7 million a year ad infinitum, $7 million a year for forever.

In the final analysis, 79% of the cuts become Healthcare dollars for the very rich, not healthcare dollars for the very poor.
In the final analysis, it sacrifices $1 trillion from Medicare and Medicaid to enrich the lives of millionaires and billionaires.

In the final analysis, it provides more money for Healthcare and less money for Healthcare.

Mr. Speaker, Trumpcare is more Wealthcare and less Medicaid.

Mr. CONYERS. Mr. Speaker, I’ve been here a while and it’s hard for me to recall a time when we’ve voted on something so obviously and willfully harmful to children, seniors and working Americans.

This bill strips healthcare from 24 million people.

It requires some states to pay 100 percent or more of their income in premiums.

This legislation dramatically cuts Medicaid, directly contradicting President Trump’s claim not to.

In Michigan, HALF of all children rely on Medicaid.

In my district alone, 56,000 people will lose coverage, including 16,000 children.

Let’s be clear: if we pass this bill, children, seniors, and working people will suffer and some will die, so that the wealthy can get a tax cut.

Healthcare is a right, not a privilege. That’s why I support a single-payer, Medicare-for-All plan, and why I will be voting “no” on this mean spirited legislation.

Mr. Speaker, as Ranking Member on the House Judiciary Committee, I include in the RECORD a legal analysis prepared by committee staff that concludes that the provision of H.R. 1628 that requires New York State to change how its counties fund the State’s portion of Medicaid expenses is not related to a legitimate Federal interest, that no rational Federal purpose has been proffered for the provision, and that it would severely intrude on traditional state prerogatives. As such, this provision would violate Constitutional limits on the Federal Spending Power, the Due Process and Equal Protection Clauses and the Tenth Amendment (reserving all undelegated powers to the States) and would likely be held unconstitutional if challenged in court.

MEMORANDUM
To: Interested Members.
From: House Judiciary Committee Democratic Staff.
Re: Constitutionality of Faso-Collins Amendment.
Date: March 24, 2017.

The Faso-Collins amendment, incorporated into the Manager’s amendment, would violate Constitutional limits on the Federal Spending Power, theDue Process and Equal Protection Clauses and the Tenth Amendment (reserving all undelegated powers to the States). Requiring New York State to change how its counties fund its portion of Medicaid expenses is not related to a legitimate Federal interest, no rational Federal purpose has been proffered for the provision, and it would severely intrude on traditional state prerogatives.

If the Faso-Collins amendment were ever enacted, it quickly would be invalidated by the Federal courts. The irony of this “buyout” is that the “payment” supposedly being delivered in exchange for votes—the unconstitutional provision—is the legislative equivalent of a check on a closed bank account, which will never deliver the promised benefits.

For the last 51 years, New York State has chosen to fund its portion of the Medicaid Program by using funds from county property taxes. Fifteen other States structure Medicaid funding through a similar legally authorized system.

The Faso-Collins amendment specifies that any State that had an allotment of Disproportionate Share (DSH) funds—federal funds that was more than 6 times the national average, and that requires subdivisions with the authority to contribute toward Medicaid costs, shall have its reimbursement reduced by the amount of contributions by such subdivisions. (This effectively apportioning those funds to New York State, and carves out New York City.) Under the amendment, New York State is at risk of losing $2.3 billion of its $32 billion in Federal Medicaid funding.

This provision is unconstitutional, and could be struck down for several reasons: Violation of Limits on Spending Power—Article I of the Constitution grants Congress spending power to “provide for the . . . general Welfare.” In South Dakota v. Dole, 483 U.S. 203 (1987), the Supreme Court held that any spending condition imposed on the States must be related to the Federal interest in that particular project or program and that Congress cannot coerce the States into compliance with the Federal government’s objectives. In NFIB v. Sebelius, 132 S. Ct. 2566 (2012), the Supreme Court found provisions of the Act that required all States to comply with the law’s Medicaid expansion violated this spending authority, noting the “Constitution has conferred upon Congress the ability to require the States to govern according to Congress’ instructions.” The Faso-Collins language does not appear to withstand the scrutiny of the Federal interest test in the use or allocation of Federal Medicaid funds: it does not further Medicaid’s purposes and has nothing to do with ensuring the proper functioning of a State’s system. Nor has it been applied in a single State—and leaves the very same system undisturbed in 15 other States—it could not possibly be justified by any legitimate Federal interest.

An additional line of Supreme Court cases, including New York v. United States, 505 U.S. 144, 146, 178 (1992), has held that conditions on Federal grants must be “reasonably related to the purpose of the [Federal] expenditure” because otherwise “the spending power could render academic any Constitution’s other grants and limits of Federal authority.” Likewise, in Massachusetts v. United States, 432 U.S. 444, 461 (1978), the Supreme Court noted that it “has repeatedly held that the Federal Government may appropriate conditions on the use of Federal property or privileges and may require that State instrumentalities comply with conditions that are reasonably related to the Federal interest in particular national projects or programs.” Under these precedents, the Faso-Collins language would be held to be an arbitrary exercise of Federal power which intrudes on only the Federal government’s sovereign rights, and conflicts with any Federal interest or purpose in the Medicaid Program.

As Yale Law School Professor Abbe Gluck wrote in an op-ed in today's New York Times, the Faso-Collins “amendment is like unconstitutional. The protection from foreign interference with the core sovereign function of how a State chooses to use its taxing power . . . is hard to see a reasonable federal purpose here other than garnering more GOP votes for the struggling repeal bill.”

Violations of Due Process and Equal Protection—Under the Tenth Amendment, the Federal government is not permitted to deprive its citizens of equal protection or due process of law. Those clauses have been interpreted on numerous occasions to prevent the government from discriminating against the treatment of the sovereign States absent a rational basis. For example, in Helvering v. Davis, 301 U.S. 619, 640 (1937), the Supreme Court held that Congress possesses the right to demonstrate a “display of arbitrary power” in its treatment of the various States. In this regard, in 2009, when an earlier version of the Patient Protection and Affordable Care Act sought to provide special treatment for Nebraska with respect to Medicaid reimbursements, 13 Republican State attorneys general wrote to Congress (available at http://www.law. columbia.edu/sites/ default/files/microsites/career-services/files/Letter%20to%20Honorable%20Nancy%20 Pelosi%20and%20Honorable%20Harry%20Reid.pdf) asserting the provision was unconstitutional (the protection from foreign interference with the core sovereign function of how a State chooses to use its taxing power).

For reasons of particular constitutional concern that the Faso-Collins provision directly interferes with New York's internal decisions about how to structure its own tax and spending policies, and how to allocate those responsibilities between the State and its subdivisions—which is a core function of a sovereign entity protected by the Tenth Amendment and potentially Article IV of the Constitution, which provides that the “United States shall guarantee to every State in this Union a Republican Form of Government.” This is by no means insignificant because in Reynolds v. Sims, 377 U.S. 533, 575 (1964), the Supreme Court held that political subdivisions such as counties and municipalities cannot be treated as a state’s use of federal funding to have been tied to a reasonable federal purpose . . . It is
out of State governmental functions." In Hunter v. City of Pittsburgh, 207 U.S. 161, 178 (1907), the Court noted that these subdivisions are "created as convenient agencies for exercising a portion of the governmental power of the state, as may be entrusted to them and that the "number, nature, and duration of powers conferred upon these [entities] and the term upon which they shall be exercised rests in the absolute discretion of the state." The Pass-Ocilla amendment purports to invoke Federal power to displace New York's exercise of "particulate discretion" and, for that reason, violates the Constitution. As Chief Justice John Marshall noted in Ogden v. Saunders, 22 U.S. 1, 198–200 (1824), the State's "power of taxation is indispensable to their existence." . . . In imposing taxes for State purposes, the States are not doing what Congress is empowered to tax for those purposes which Congress is empowered to do. Congress is not empowered to tax for those purposes which are within the exclusive province of the States.'

OFFICE OF THE ATTORNEY GENERAL
STATE OF SOUTH CAROLINA
December 30, 2009.

Hon. Nancy Pelosi,
Speaker, House of Representatives,
Washington, DC.

Hon. Harry Reid,
Majority Leader, U.S. Senate,
Washington, DC.

The undersigned state attorneys general, in response to numerous inquiries, write to express our grave concern with the Senate version of the Patient Protection and Affordable Care Act ("H.R. 3590"). The current iteration of the bill contains a provision that affords special treatment to the State of Nebraska under the federal Medicaid program. We believe this provision is constitutionally and legally flawed. As chief legal officers of our states we are contemplating a legal challenge to this provision and we ask you to take action to render this challenge unnecessary by striking that provision.

It has been reported that Nebraska Senator Ben Nelson's vote for H.R. 3590 was secured only after striking a deal that the federal government would bear the cost of newly eligible Nebraska Medicaid enrollees. In marked contrast all other states would not be similarly treated, and instead would be required to allocate substantial sums, potentially totaling billions of dollars, to accommodate Nebraska's non-Medicaid mandates. In addition to violating the most basic and universally held notions of what is fair and just, we also believe this provision of H.R. 3590 is inconsistent with protections afforded by the United States Constitution against arbitrary legislation.

In Helvering v. Davis, 301 U.S 619, 690 (1937), the United States Supreme Court warned that Congress does not possess the right under the Spending Power to demonstrate a "display of arbitrary power." Congressional spending must be arbitrary and capricious. The spending power of Congress includes authority to accomplish policy objectives by conditioning receipt of federal funds on compliance with statutory directives, as in the Medicaid program. However, the power is not unlimited and "must be in pursuit of the "general welfare." South Dakota v. Dole, 483 U.S. 203, 207 (1987). In Dole, the Supreme Court stated, "that conditions on federal grants might be illegitimate if they are unrelated to the federal interest in particular national programs."

It seems axiomatic that the federal interest in H.R. 3590 is not simply requiring universal health care, but also ensuring that the states share in the burden of providing such care to their citizens. This federal interest is evident from the fact this legislation would require every state, except Nebraska, to shoulder its fair share of the increased Medicaid costs the bill will generate. The provision of the bill that relieves a single state from a program appears to be not only unrelated, but also anti- constitutional to the legitimate federal interests in the bill.

The fundamental unfairness of H.R. 3590 may also give rise to claims under the due process, equal protection, privileges and immunities clauses and other provisions of the Constitution. As a practical matter, the deal struck by the United States Senate on the "Nebraska Compromise" is a disadvantage to the remaining states. Every state's tax dollars, except Nebraska's, will be devoted to cost-sharing required by the bill, and will be therefore unavailable for other essential state programs. Only the citizens of Nebraska will be freed from this diminution in state resources for critical state services. Since the only basis for the Nebraska preference is arbitrary and unrelated to the substantive legislation, it is unlikely that the difference would survive even minimal scrutiny.

We ask that Congress delete the Nebraska provision from the pending legislation, as we prefer to avoid litigation. Because this provision has divided the country and the future of our nation's legislative process, we urge you to take appropriate steps to protect the Constitution and the rights of the nations. We believe this issue is readily resolved by removing the provision in question from the bill, and we ask that you do so.

By singling out the particular provision relating to special treatment of Nebraska, we do not suggest there are no other legal or constitutional issues in the proposed health care legislation. Please let us know if we can be of assistance as you consider this matter.

Sincerely,

Henry McMaster, Attorney General, South Carolina; Rob McKenna, Attorney General, Washington; Mike Cox, Attorney General, Michigan; Greg Zoeller, Attorney General, Indiana; John Suthers, Attorney General, Colorado; Troy King, Attorney General, Alabama; Wayne Stenehjem, Attorney General, North Dakota; Bill Mims, Attorney General, Virginia; Tom Corbett, Attorney General, Pennsylvania; Mark Shurtleff, Attorney General, Utah; Bill McCollum, Attorney General, Florida; William J. rounded, Attorney General, Idaho; Marty Jackley, Attorney General, South Dakota.

Mr. NADLER. Mr. Speaker, for seven years, the Republicans have tried and failed to repeal the Affordable Care Act. So now, with a Republican-controlled House, a Republican-controlled Senate, and a Republican in the White House, what have they presented us to vote on today? Republicans complained that premiums were skyrocketing, so they offer a bill that raises premiums. They complained that insurance companies were abusing the system, so they pass a bill that will make it harder to sue insurance companies. They complained that too many people were losing their insurance, so they have embraced a plan that will take away health care from 24 million Americans.

This bill imposes a devastating age tax on older Americans and does next to nothing to protect Americans with pre-existing conditions. It gives nearly $900 billion in tax cuts to the insurance companies and the wealthy, while refusing coverage for services as basic as hospitalization. It's simple: Americans will pay more and get less under this bill.

In New York, 2.7 million people will lose insurance and the state will lose $4.6 billion in Medicaid funding. Compounding those cuts is a cynical so-called deal several upstate Members made to secure their votes on this bill. Under the bill, New York State, and ONLY New York State, will no longer be allowed to ask counties to provide a portion of state Medicaid funding.

Don't be fooled—this is no deal at all for New York and will actually gut the State's Medicaid program, forcing hundreds of hospitals to close and rationing health care for millions of New Yorkers.

But my colleagues who have traded their vote for this provision have made an empty bargain. This provision is flatly unconstitutional and will never be enacted. They are giving away health insurance for millions of New Yorkers for an empty promise.

My Republican colleagues claim we need to pass this bill to give people "freedom" to buy health insurance. Let me tell you, freedom to buy health insurance and actually being able to afford health insurance are two very different things.

They keep talking about "access" to health care. Access is not coverage. When they talk about access and not protection, they are conceding that this bill does nothing to ensure that Americans have affordable, comprehensive health insurance to cover them no matter what their health care needs are.

The Republicans seem to believe that Americans just need freedom to buy insurance, that when asked what a pregnant woman should do if her state no longer requires insurance companies to cover maternity care, OMB Director Mick Mulvaney said she can "figure out a way to change the state [so] that's in line." How callous are my Republican colleagues to believe that is a real option for Americans?

This bill is a cowardly, cynical effort to lower taxes on the rich and dismantle Medicare and Medicaid as we know it. I urge my colleagues to oppose this bill.

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule XIX, further consideration of H.R. 1628 is postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule XIX, further consideration of H.R. 1628 is postponed.

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. HOLDING) at 4 o'clock and 30 minutes.

TERRORIST AND FOREIGN FIGHTER TRAVEL EXERCISE ACT OF 2017

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the unfinished business is the question on suspending the rules and passing the bill (H.R. 1302) to require an exercise related to terrorist and foreign fighter travel, and for other purposes.