SA 270. Mr. McCONNELL proposed an amendment to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the Bipartisan Budget Resolution on the budget for fiscal year 2017.

SA 271. Mr. ENZI (for Mr. PAUL) proposed an amendment to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra.

SA 272. Mr. JOHNSON submitted an amendment intended to be proposed by amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 273. Mr. JOHNSON submitted an amendment intended to be proposed by amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 274. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 275. Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. McCONNELL to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 276. Mr. Kaine (for himself, Mr. CARPER, Mr. COONS, Mrs. SHAHEEN, Mr. CARDIN, Ms. HAWKINS, Ms. STARK, Mr. WARNER, Ms. HITTAK and Mr. NELSON) submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

SA 277. Mr. Kaine submitted an amendment intended to be proposed by him to the bill H.R. 1628, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table.

SA 278. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, supra; which was ordered to lie on the table.

SA 279. Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the Bipartisan Budget Resolution on the budget for fiscal year 2017; which was ordered to lie on the table.

SA 280. Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 262. Mrs. SHAHEEN (for herself and Mr. Sasse) submitted an amendment intended to be proposed by her to the bill S. 1519, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

SEC. 1235. SYRIA STUDY GROUP.

(a) ESTABLISHMENT.—There is hereby established a working group to be known as the “Syria Study Group” (in this section referred to as the “Group”).

(b) PURPOSE.—The purpose of the Group is to examine and make recommendations with respect to the military and diplomatic strategy of the United States with respect to the conflict in Syria.

(c) COMPOSITION.—The Group shall be composed of 8 members appointed as follows:

(1) Membership.—The Group shall be composed of 8 members appointed as follows:

(A) One member appointed by the chair of the Committee on Armed Services of the House of Representatives.

(B) One member appointed by the ranking minority member of the Committee on Armed Services of the House of Representatives.

(C) One member appointed by the chair of the Committee on Foreign Relations of the Senate.

(D) One member appointed by the ranking minority member of the Committee on Foreign Relations of the Senate.

(E) One member appointed by the chair of the Committee on Armed Services of the House of Representatives.

(F) One member appointed by the ranking minority member of the Committee on Armed Services of the House of Representatives.

(G) One member appointed by the chair of the Committee on Foreign Affairs of the House of Representatives.

(H) One member appointed by the ranking minority member of the Committee on Foreign Affairs of the House of Representatives.

(2) CO-CHAIRS.—The Group shall be co-chaired by the Chair of the Committee on Armed Services of the House of Representatives and the Chair of the Committee on Foreign Relations of the Senate.

(3) MEMBERSHIP.—The Group shall be composed of:

(A) One member appointed by the chair of the Committee on Armed Services of the Senate.

(B) One member appointed by the ranking minority member of the Committee on Armed Services of the Senate.

(C) One member appointed by the chair of the Committee on Foreign Relations of the Senate.

(D) One member appointed by the ranking minority member of the Committee on Foreign Relations of the Senate.

(E) One member appointed by the chair of the Committee on Armed Services of the House of Representatives.

(F) One member appointed by the ranking minority member of the Committee on Armed Services of the House of Representatives.

(G) One member appointed by the chair of the Committee on Foreign Affairs of the House of Representatives.

(H) One member appointed by the ranking minority member of the Committee on Foreign Affairs of the House of Representatives.

(3) PERIOD OF APPOINTMENT; VACANCIES.—

(A) One member appointed by the chair of the Committee on Armed Services of the House of Representatives is designated as the chair of the Group.

(B) The ranking minority member of the Committee on Armed Services of the Senate is designated as the ranking minority member of the Group.

(C) Period of appointment; vacancies.—Members shall be appointed for one year from the date of their appointment, or until their successors are appointed, and such members shall continue to serve until the expiration of the last year of their terms, unless sooner terminated or removed as provided in this section.

(4) REPORT.—

(A) Final report.—Not later than September 30, 2018, the Group shall submit to the President, the Secretary of Defense, the Committee on Armed Services of the Senate, the Committee on Armed Services of the House of Representatives, the Committee on Foreign Relations of the Senate, and the Committee on Foreign Affairs of the House of Representatives a report on the findings, conclusions, and recommendations of the Group under this section. The report shall do each of the following:

(i) Assess the current security, political, humanitarian, and economic situation in Syria.

(ii) Assess the current participation and objectives of various external actors in Syria.

(iii) Assess the consequences of continued conflict in Syria.

(iv) Provide recommendations for a diplomatic resolution of the conflict in Syria, including options for a gradual political transition to a post-Assad Syria and actions necessary for reconciliation.

(v) Provide a strategy for a United States and coalition strategy to reestablish secular, government and governance in Syria, including recommendations for the provision of stabilization, development, counterterrorism, and reconstruction efforts.

(B) Address any other matters with respect to the conflict in Syria that the Group considers appropriate.

(5) Terminal briefing.—Not later than June 30, 2018, the Group shall provide to the Committee on Armed Services of the Senate and the House of Representatives a briefing on the status of its review and assessment under subsection (d), together with a discussion of any interim recommendations developed by the Group as of the date of the briefing.

(Sec. 1088. Foreign Agents Registration.)
(2) by inserting after section 7 (22 U.S.C. 617) the following:

"CIVIL INVESTIGATIVE DEMAND AUTHORITY"

"Sec. 8. (a) Whenever the Attorney General has reason to believe that any person or entity, or the possession, custody, or control of any documentary material relevant to an investigation under this Act, the Attorney General, before initiating a civil or criminal proceeding with respect to the production of such material, may serve a written demand upon such person to produce such material for examination."

"(b) Each such demand under subsection (a) shall—"

"(1) state the nature of the conduct constituting the alleged violation which is under investigation and the provision of law applicable to such violation;"

"(2) describe the class or classes of documentary material required to be produced under such demand with such definiteness and certainty as to permit such material to be fairly identified;"

"(3) state that the demand is immediately returnable or prescribe a return date which will provide a reasonable period within which the material may be assembled and made available for inspection and copying or reproduction;"

"(4) identify the custodian to whom such material shall be made available.

(c) A demand under subsection (a) may not—"

"(1) contain any requirement that would be considered unreasonable if contained in a subpoena duces tecum issued by a court of the United States in aid of grand jury investigation of such alleged violation; or"

"(2) require the production of any documentary evidence that would be privileged from disclosure if demanded by a subpoena duces tecum issued by a court of the United States in aid of a grand jury investigation of such alleged violation;"

"(d) INFORMATIONAL MATERIALS.—"

"(i) DEFINITIONS.—Section 1 of the Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611 et seq.), as redesignated by this Act, is amended as follows:

(1) in subsection (c), by striking "Expect as provided in subsection (d) hereof," and inserting "Except as provided in subsection (d),"; and

(2) by inserting after subsection (1) the following:

"(1) The term "informational materials" means any oral, visual, graphic, written, or pictorial informative information or matter of any kind, including matter published by means of advertising, books, periodicals, newspapers, lectures, broadcasts, motion pictures, or any means or instrumentation of interstate or foreign commerce or otherwise."

"(2) INFORMATIONAL MATERIALS.—Section 4 of the Act (22 U.S.C. 614) is amended—"

(A) in subsection (a)—"

(i) by inserting "as provided in subsection (b)," and

(ii) by striking "not later than forty-eight hours after the beginning of the transmittal thereof, file with the Attorney General or the Department of Justice, and inserting "file such materials with the Attorney General in conjunction with, and at the same intervals as, disclosures required under section 2(b); and"

(B) in subsection (b)—"

(i) by striking "It shall" and inserting "(1) Except as provided in paragraph (2), it shall"

(ii) by striking the end following:"

"(2) Foreign agents described in paragraph (1) may omit disclosure required under that paragraph by filing an "as provided in subsection (b)," and inserting "file such transmissions on social media on behalf of a foreign principal if the social media account or profile from which the information is sent includes a conspicuous statement that—"

"(A) the account is operated by, and distributes information on behalf of, the foreign agent; and"

"(B) additional information about the account is on file with the Department of Justice in Washington, District of Columbia."

"(d) FEES.—The Foreign Agents Registration Act of 1938, as amended (22 U.S.C. 611 et seq.), as amended by this Act, is further amended by adding after section 14, as redesignated by subsection (b)(1), the following:

"FEES"

"Sec. 15. The Attorney General shall—"

"(1) establish and collect a registration fee, as part of the initial filing requirement, to help defray the expenses of the FARA Registration Unit; and"

"(2) credit such fees to the amount appropriated to the National Security Division, which shall remain available until expended."

"(e) REPORTS TO CONGRESS.—Section 12 of the Foreign Agents Registration Act of 1938, as amended, is further amended by adding after section 16, as redesignated by subsection (b)(1), the following:

"REPORTS TO CONGRESS"

"Sec. 12. The Assistant Attorney General for National Security, through the FARA Registration Unit; and"

"(f) the number of investigations initiated based upon a perceived violation of section 8; and"

"(g) the number of such investigations that were referred to the Attorney General for prosecution;"

"(h) 80 percent for calendar quarters in 2020;"

"(i) 82 percent for calendar quarters in 2021;"

"(j) 84 percent for calendar quarters in 2022;"

"(k) 86 percent for calendar quarters in 2023;"

"(l) 88 percent for calendar quarters in 2024;"

"(m) 90 percent for calendar quarters in 2025;"

"(n) 92 percent for calendar quarters in 2026;"

"(o) 94 percent for calendar quarters in 2027;" and"

"(p) 96 percent for calendar quarters in 2028;" and"

"(q) 98 percent for calendar quarters in 2029;" and"

"(r) 100 percent for calendar quarters in 2030."

"SA 265. Mr. McCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Beginning on page 61, strike lines 1 through 19 and insert the following:

"(3) APPLICABLE ANNUAL INFLATION FACTOR.—In paragraph (2), the term "applicable annual inflation factor" means, for a fiscal year—"

"(A) for each of the 1993 enrollee categories described in subparagraphs (C), (D), and (E) of section (b)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from June of the previous fiscal year to September of the fiscal year involved, plus 1 percentage point; and"

"(B) for each of the 1993 enrollee categories described in subparagraphs (A) and (B) of subsection (a)(2), the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) from June of the previous fiscal year to September of the fiscal year involved, plus 2 percentage points.

"SA 266. Mr. McCAIN submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

"(I) by inserting after subsection (V), the following:

"(II) in subclause (IV), by striking the semicolon and inserting "and;"; and"

"(III) by striking subclause (VI)."
SEC. 101. RECAPTURE EXCESS ADVANCE PAYMENTS OF PREMIUM TAX CREDITS.

Subparagraph (B) of section 36B(c)(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 ending after December 31, 2017, and before January 1, 2020.".

SEC. 102. PREMIUM TAX CREDIT.

(a) PREMIUM TAX CREDIT.—

(1) REPEAL.—

(A) in general.—Subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986 is amended by striking section 36B.

(b) EFFECTIVE DATE.—The amendment made by this paragraph shall take to taxable years beginning after December 31, 2019.

(c) REPEAL OF ELIGIBILITY DETERMINATIONS.—

(1) in general.—The following sections of the Patient Protection and Affordable Care Act are repealed:

(A) Section 1412 (other than subsection (i), the last sentence of subsection (e)(4)(A)(ii), and such provisions of such section solely to the extent related to the application of the last sentence of subsection (e)(4)(A)(ii)).

(B) Section 1412.

(2) EFFECTIVE DATE.—The repeal in paragraph (1) shall take effect on January 1, 2020.

(d) DISCLOSURE AUTHORITY TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

(1) in general.—Paragraph (21) of section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(D) Termination.—No disclosure may be made under this paragraph after December 31, 2019.".

(2) EFFECTIVE DATE.—The amendment made by this paragraph (1) shall take effect on January 1, 2020.

SEC. 103. SMALL BUSINESS TAX CREDIT.

(a) SUNSET.—

(1) in general.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(D) Termination.—No disclosure may be made under this paragraph after December 31, 2019.".

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take to taxable years beginning after December 31, 2019.

SEC. 104. INDIVIDUAL MANDATE.

(a) in general.—Section 5000A(c) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (2)(B)(ii), by striking "2.5 percent" and inserting "2.5 percent".

(2) in paragraph (3)—

(A) by striking "9555" in subparagraph (A) and inserting "9550";

(B) by striking subparagraph (D).

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

SEC. 105. EMPLOYER MANDATE.

(a) in general.—

(1) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting "($0 in the case of months beginning after December 31, 2015)" after "$2,000".

(2) Paragraph (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting "($0 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.

(b) in subparagraph (A), by inserting "through 2019" after "each year thereafter"; and

(c) in paragraph (2), by inserting "and each subsequent year" after "for payments to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract.".

(b) Definitions.—In this section:

(1) PROHIBITED ENTITY.—The term "prohibited entity" means an entity, its affiliates, subsidiaries, and clinics—

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

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

(ii) is an essential community provider described in section 45E of the 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, and 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;

(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

(IV) for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act in fiscal year 2014 made directly to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity and to any affiliates, subsidiaries, successors, or clinics of the entity as part of a network of a health care provider network, exceeded $1,000,000.

(2) DIRECT SPENDING.—The term "direct spending" has the meaning given that term under section 256(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

SEC. 107. MEDICAID.

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(1) in section 1902—

(A) in subsection (a)(10)(A), in each of clauses (i)(VIII) and (ii)(XII), by inserting "and ending December 31, 2019, after "January 1, 2014," and

(B) in subsection (a)(47)(B), 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 semicolon at the end;

(2) in section 1905—

(A) in the first sentence of subsection (b), by inserting "(50 percent on or after January 1, 2020)" after "55 percent"; and

(B) in subsection (y)(1), by striking the last sentence of such subparagraph (D) and all that follows through "thereafter"; and

(C) in subsection (z)(2)—

(i) in subparagraph (A), by inserting "through 2019" after "each year thereafter"; and

(ii) in subparagraph (B)(iv)(V), by striking "and each subsequent year" after "that election".

(3) in section 1915(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.".

(4) in section 1927(e)(3), by adding at the end the following:

"This subsection shall not apply after December 31, 2019.

(5) in section 1944(a), by adding at the end the following: "This paragraph shall not apply after December 31, 2019.

(6) in section 1947(a), by inserting "and before January 1, 2020," after "January 1, 2014,".

SEC. 108. REPEAL OF DSH ALLOTMENT REDUCTIONS.

Section 1907(c)(3) of the Social Security Act (42 U.S.C. 1396d–5(f)) is amended by striking paragraphs (7) and (8).

SEC. 109. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

(a) in general.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking section 4980I.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2019.

(c) Subsequent Effective Date.—The amendment made by subsection (a) shall not apply to taxable years beginning after December 31, 2025, and chapter 43 of the Internal Revenue Code of 1986 is amended to read as such chapter would read if such section had never been enacted.

SEC. 110. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

(a) HSAs.—Paragraph (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) Archer MSAs.—Paragraph (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.

(c) Health Flexible Spending Arrangements and Health Reimbursement Arrangements.—Section 223 of the Internal Revenue Code of 1986 is amended by striking subsection (f).

(d) EFFECTIVE DATE.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2019.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2019.

SEC. 111. REPEAL OF 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) Archer MSAs.—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 this section shall apply to distributions made after December 31, 2016.

SEC. 112. 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 plans beginning after December 31, 2017.
TITLE II
SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.
Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300a–11) is amended—
(1) in paragraph (3), by striking ‘‘each of fiscal years 2018 and 2019’’ and inserting ‘‘fiscal year 2018’’; and
(2) by striking paragraphs (4) through (8).
SEC. 202. SUPPORT FOR STATE RESPONSE TO SUBSTANCE ABUSE PUBLIC HEALTH CRISIS AND URGENT MENTAL HEALTH NEEDS.
(a) In General.—There are authorized to be appropriated under this subsection such sums as may be necessary—
(1) to make grants to States for the treatment or prevention of public health crises caused by substance use disorders or mental health needs; and
(2) for other purposes, of amounts appropriated under this section for the treatment or prevention of public health crises caused by substance use disorders or mental health needs within the State.
(1) In General.—Subtitle (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ‘‘10 percent’’ and inserting ‘‘7.5 percent’’.
(b) Effective Date.—The amendment made by this subsection shall be effective beginning with the taxable year beginning after December 31, 2016.
SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO INCOME FROM SELF-EMPLOYMENT.
(a) In General.—Section 129A of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:
‘‘(g) ELIMINATION OF DEDUCTION FOR EXPENSES.—’’
(1) in paragraph (3), by striking ‘‘42 U.S.C. 300a–11’’ and inserting ‘‘42 U.S.C. 300a–11 to 42 U.S.C. 300a–16’’;
(2) in paragraph (4), by striking ‘‘the Secretary’’ and inserting ‘‘the Secretary or the Secretary’s delegate’’; and
(3) by striking subparagraph (A) and inserting the following:
‘‘(A) The term ‘medical debt’ means any debt incurred voluntarily or involuntarily—’’.
(5) Other public health-related activities,
(4) Supporting access to health care services, and
(3) Training for health care practitioners, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance abuse, referral of patients to treatment programs, and overdose prevention.
(4) Supporting access to health care services provided by Federally certified opioid treatment programs and appropriate health care providers to treat substance use disorders or mental health needs.
(5) Other public health-related activities, as the State determines, related to addressing the substance abuse public health crisis or responding to urgent mental health needs within the State.
SEC. 203. COMMUNITY HEALTH CENTER PROGRAM.
Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 87), paragraph (1) of section 221(a) of such Act is amended by inserting ‘‘, and an additional $422,000,000 for fiscal year 2017’’ after ‘‘2017’’.
SEC. 204. FUNDING FOR COST-SHARING PAYMENTS.
There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary for payments for cost-sharing reductions authorized by the Patient Protection and Affordable Care Act (including adjustments to any prior obligations for such payments) for the period beginning on the date of enactment and ending on December 31, 2018. Notwithstanding any other provision of this Act, payments and other actions for adjustments to any obligations incurred for plan years 2018 and 2019 may be made through December 31, 2020.
the debtor's aggregate interest, not to exceed $250,000 in value, in property described in paragraph (3) of this subsection.

(2) If a medically distressed debtor exempt property listed in subsection (b)(3) and the exemption provided under applicable law specifically for the kind of property described in paragraph (3) is for less than $250,000, the debtor may exempt the debtor's aggregate interest, not to exceed $250,000 in value, in any such property.

(3) The property described in this paragraph is—

(A) real property or personal property that the debtor or a dependent of the debtor uses as a residence;

(B) a cooperative that owns property that the debtor or a dependent of the debtor uses as a residence;

(C) a burial plot for the debtor or a dependent of the debtor.

SEC. 11. REAUTHORIZATION OF DEPARTMENT OF DEFENSE FUNDING TO STIMULATE COMPETITIVE RESEARCH.

(a) MODIFICATIONS OF PROGRAM OBJECTIVES.—Subsection (b) of section 257 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103–337; 10 U.S.C. 2358 note) is amended—

(1) by redesignating paragraphs (1) and (2) as paragraphs (2) and (3), respectively;

(2) by inserting before paragraph (2), as redesignated by paragraph (1), the following new paragraph (1):

"(1) To increase the number of university researchers in eligible States capable of performing scientific research responsive to the needs of the Department of Defense;"

and

(3) in paragraph (3), as redesignated by paragraph (1), by inserting "responsive to the mission of the Department of Defense and after "that is".

SEC. 12. MODIFICATIONS OF PROGRAM ACTIVITIES.—Subsection (c) of such section is amended—

(1) by redesigning paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2) the following new paragraph (3):

"(3) To provide assistance to science and engineering researchers at institutions of higher education in eligible States through research programs responsive to the needs of the Department of Defense laboratories and such researchers."

(b) MODIFICATION OF ELIGIBILITY CRITERIA FOR STATE PARTICIPATION.—Subsection (d) of such section is amended—

(1) in paragraph (3)(B), by inserting "in areas relevant to the mission of the Department of Defense" after "programs"; and

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

"(3) The Under Secretary shall not remove a designated benchmark under paragraph (2) because the State exceeds the funding levels specified under subparagraph (A) of such paragraph unless the State has exceeded such funding levels for at least two consecutive years.".

(c) MODIFICATION OF NAME.—

(1) IN GENERAL.—Such section is amended—

(A) in subsections (a) and (e) by striking "Experimental" each place it appears and inserting "Established"; and

(B) in the section heading, by striking "Experimental" and inserting "Established".

(d) CEREMONIAL AMENDMENT.—Such Act is amended in the table of contents in section 2(b), by striking the item relating to section 2(a) and inserting the following new item:

"Sec. 257. Defense established program to stimulate competitive research."

(e) CONFORMING AMENDMENT.—Section 307 of the 1997 Emergency Supplemental Appropriations Act for Recovery from Natural Disasters, and for Overseas Peacekeeping Efforts, Including An Act to Provide Assistance to the People of Bosnia (Public Law 105–18) is amended by striking "Experimental" and inserting "Established".

SA 267. Mr. McCONNELl proposed an amendment to amendment SA 267 proposed by Mr. McConnell to the bill H.R. 1628, to provide for reclassification pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; as follows:

Strike all after line one and insert the following:

"This paragraph may be cited as the "Better Care Reconciliation Act of 2017"."
in the individual market in the rating area in which the taxpayer resides which—

“(i) provides a level of coverage that is designed to provide benefits that are actuarially equivalent to the full actuarial value of the benefits (as determined under rules similar to the rules of paragraphs (2) and (3) of section 1302(d) of the Patient Protection and Affordable Care Act) provided under the plan, and

“(ii) has a premium which is the median premium of all qualified health plans described in clause (i) which are offered in the individual market in such rating area (or, in any case in which no such plan has such median premium, has a premium nearest (but not in excess of) such median premium),”.

(II) by striking “clause (ii)(I)” in the flush text after “premum” and inserting “clause (iv)(I)”.

(B) WAIVER OF ACTUARIAL VALUE STANDARD FOR HOMESTAY PLANS.—Section 36B(b)(3)(B) of the Internal Revenue Code of 1986, as amended by subparagraph (A), is amended by adding at the end the following new sentence: “If, for any plan year before 2027, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, determines that there will be no plan offered in a rating area in the individual market that meets the level of coverage described in clause (i), the Secretary of the Treasury may increase the 58 percent amount in such clause.”.

(3) MODIFICATION OF APPLICABLE PERCENTAGE.—Section 36B(b)(3)(A) of the Internal Revenue Code of 1986 is amended—

(A) in clause (i), by striking “from the initial premium percentage” and all that follows after “36B(b)(3)(A)” and inserting “to the final percentage specified in such table for such income tier with respect to a taxpayer of the age involved:

(B) by striking “0.5%” in clause (1)(II)(iii) and inserting “0.4%”.

(C) by adding at the end the following new clause:

“(iii) AVERAGE AGED DETERMINATIONS.—For purposes of clause (i), the age of the taxpayer taken into account under clause (i) with respect to any taxable year is the age attained before the close of the taxable year by the oldest individual taken into account on such taxpayer’s return who is covered by a qualified health plan taken into account under paragraph (2)(A).”.

(D) ELIMINATION OF ELIGIBILITY EXCEPTIONS FOR EMPLOYER-SUPPORTED COVERAGE.—

(1) IN GENERAL.—Section 36B(b)(3)(A) of the Internal Revenue Code of 1986 is amended by striking subparagraph (C).

(2) AMENDMENTS RELATED TO QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 36B(c)(4) of such Code is amended—

(A) by striking “which constitutes affordable coverage” in subparagraph (A), and

(B) by striking subparagraphs (B), (C), (E), and (F) and redesignating subparagraph (D) as subparagraph (B).

(E) MODIFICATIONS TO DEFINITION OF QUALIFIED HEALTH PLAN.—

(1) IN GENERAL.—Section 36B(c)(9)(A) of the Internal Revenue Code of 1986 is amended by inserting at the end the following new sentence: “Such term shall not include any 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).”

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2019.

SEC. 103. MODIFICATIONS TO SMALL BUSINESS TAX CREDIT.

(a) SUNSET.—

(1) IN GENERAL.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

“(d) Long-Term Actuarial Standard Percentage.—For taxable years beginning after December 31, 2019, no qualified health plan shall be taken into account under paragraph (2) of subsection (a) if the long-term actuarial standard percentage of the plan is less than 100 percent.

SEC. 104. INDIVIDUAL MANDATE.

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

(1) in paragraph (1) by striking “$2,000” and inserting “$2,000”.

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

SEC. 105. EMPLOYER MANDATE.

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

(1) in paragraph (1) by striking “$2,000” and inserting “$2,000”.

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

SEC. 106. STATE STABILITY AND INNOVATION GRANTS.

(a) IN GENERAL.—Section 107 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsection:

“(d) STATE STABILITY AND INNOVATION GRANTS.—

(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall provide grants to States for each of calendar years 2020 and 2021, to the Secretary of Health and Human Services, determines that there will be no plan offered in a rating area in the individual market that meets the level of coverage described in clause (i), the Secretary of the Treasury may increase the 58 percent amount in such clause.”.

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

SEC. 107. STATE STABILITY AND INNOVATION GRANTS.

(a) IN GENERAL.—Section 107 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsection:

“(d) STATE STABILITY AND INNOVATION GRANTS.—

(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall provide grants to States for each of calendar years 2020 and 2021, to the Secretary of Health and Human Services, determines that there will be no plan offered in a rating area in the individual market that meets the level of coverage described in clause (i), the Secretary of the Treasury may increase the 58 percent amount in such clause.”.

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

SEC. 108. STATE STABILITY AND INNOVATION GRANTS.

(a) IN GENERAL.—Section 107 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsection:

“(d) STATE STABILITY AND INNOVATION GRANTS.—

(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall provide grants to States for each of calendar years 2020 and 2021, to the Secretary of Health and Human Services, determines that there will be no plan offered in a rating area in the individual market that meets the level of coverage described in clause (i), the Secretary of the Treasury may increase the 58 percent amount in such clause.”.

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

SEC. 109. STATE STABILITY AND INNOVATION GRANTS.

(a) IN GENERAL.—Section 107 of the Social Security Act (42 U.S.C. 1397ee) is amended by adding at the end the following new subsection:

“(d) STATE STABILITY AND INNOVATION GRANTS.—

(1) IN GENERAL.—The Administrator of the Centers for Medicare & Medicaid Services shall provide grants to States for each of calendar years 2020 and 2021, to the Secretary of Health and Human Services, determines that there will be no plan offered in a rating area in the individual market that meets the level of coverage described in clause (i), the Secretary of the Treasury may increase the 58 percent amount in such clause.”.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to months beginning after December 31, 2015.
(i) a certification that the health insurer will use the funds in accordance with the requirements of paragraph (5); and
(ii) such information as the Administrator may require to carry out this subsection.

(3) PROCEDURE FOR DISTRIBUTION OF FUNDS.—The Administrator shall determine an appropriate procedure for providing to States receiving payments under this subsection that includes reserving an amount equal to 1 percent of the amounts appropriated under paragraph (1) for each calendar year for providing and distributing funds to health insurance issuers in States where the cost of insurance premiums are at least 75 percent higher than the national average.

(4) No Match.—Neither the State percentage applicable to payments to States under subsection (B) nor any other matching requirement shall apply to funds provided to health insurance issuers under this subsection.

(5) USE OF FUNDS.—Funds provided to a health insurance issuer under paragraph (1) or (6) shall be subject to the requirements of paragraphs (1)(D) and (7) of subsection (i) in the case of allotments to States receiving payments under sub-section (i) and shall be used only for the activities specified in paragraph (1)(A)(ii) of subsection (i).

(6) ADDITIONAL SUPPORT FOR STABILIZING PREMIUMS AND PROMOTING CHOICE IN PLANS OFFERED IN THE INDIVIDUAL MARKET.—(A) An allotment under this subsection shall be used to—

(i) make payments to health insurance issuers in States where the cost of insurance premiums are at least 75 percent higher than the national average; and

(ii) make payments to States in an amount equal to the Federal percentage is equal to 100 percent; and

(B) A certification that none of the funds provided under this subsection shall be used for the purpose of stabilizing premiums and promoting choice in plans offered in the individual market (within the meaning of section 500A(f)(1)(C) of the Internal Revenue Code of 1986). (C) The funds provided under this subsection shall only be used for the purpose of stabilizing premiums and promoting choice in plans offered in the individual market (within the meaning of section 500A(f)(1)(C) of the Internal Revenue Code of 1986).

(7) To establish or maintain a program to offer premium stabilization and to promote the purchase of health benefits coverage, in an amount as specified by the Administrator, to States in an amount equal to the Federal percentage is equal to 100 percent; and

(a) a certification that none of the funds provided under this subsection shall be used for the purpose of stabilizing premiums and promoting choice in plans offered in the individual market (within the meaning of section 500A(f)(1)(C) of the Internal Revenue Code of 1986). (b) A certification that the State shall make, from non-Federal funds, expenditures for 1 or more of the activities specified in paragraph (7)(B), in an amount that is not less than the State percentage required for the year under paragraph (5)(B)(ii).

(c) A certification that none of the funds provided under this subsection shall be used for the purpose of stabilizing premiums and promoting choice in plans offered in the individual market (within the meaning of section 500A(f)(1)(C) of the Internal Revenue Code of 1986).

(8) A certification that the State shall make, from non-Federal funds, expenditures for 1 or more of the activities specified in paragraph (7)(B), in an amount that is not less than the State percentage required for the year under paragraph (5)(B)(ii).

(9) One-Time Application.—If an application of a State submitted under this subsection is approved by the Administrator for a year, the application shall be deemed to be approved by the Administrator for that year and each subsequent year through December 31, 2026.

(10) Long-term State Stabilization Fund.—(A) Approval; Total Allocation.—For the purpose of providing allotments to States under this subsection, there is appropriated, out of any money in the Treasury, $10,000,000,000 for each of calendar years 2020 through 2026, to be used to—

(i) in the case of calendar year 2020, 2 percent; and

(ii) in the case of calendar year 2021, 2 percent; and

(iii) in the case of calendar year 2022, 2 percent; and

(iv) in the case of calendar year 2023, 2 percent; and

(v) in the case of calendar year 2024, 2 percent; and

(vi) in the case of calendar year 2025, 2 percent; and

(vii) in the case of calendar year 2026, 2 percent; and

(B) Allotment; Retrospective Adjustment.—(i) In General.—In the case of a State with an application approved under this subsection with respect to a year, the Administrator shall allot to the State, in accordance with an allotment methodology specified by the Administrator that ensures that the allotment to each State where the cost of insurance premiums are at least 75 percent higher than the national average, from amounts appropriated for each year under subparagraph (A), such amount as specified by the Administrator with respect to the State and application year.

(ii) Annual Redistribution of Previous Year’s Unused Funds.—(I) In General.—In carrying out clause (I) of section 212(b)(4)(A) for a year beginning after 2021, the Administrator shall, not later than March 31 of such year—

(a) determine the amount of funds, if any, remaining unused under subparagraph (A) from the previous year; and

(b) if the Administrator determines that any funds so remain from the previous year, redistribute such remaining funds in accordance with an allotment methodology specified by the Administrator to States that have submitted an application approved under this subsection for the year.

(ii) Applicable State Percentage.—The State percentage specified for a year in paragraph (5)(B)(ii) shall apply to funds redistribut- ed under subparagraph (I) in that year.

(C) Availability of Allotted State Funds.—(I) In General.—Amounts allotted to a State pursuant to subparagraph (B)(i) for a year shall remain available for expenditure by the State through the end of the second succeeding calendar year.

(5) Payments.—Subject to subparagraph (B), the Administrator shall pay to each State that has an application approved under this subsection, from the amounts remaining under paragraph (4)(B) for the State for that year, an amount equal to the Federal percentage of the State’s expenditures for the year.

(B) State Expenditures Required Beginning 2022.—For purposes of subparagraph (A), the Federal percentage shall be reduced by the State percentage for that year, and the State percentage is equal to—

(i) in the case of calendar year 2019, 0 percent;

(ii) in the case of calendar year 2020, 0 percent;

(iii) in the case of calendar year 2021, 0 percent;

(iv) in the case of calendar year 2022, 7 percent;

(v) in the case of calendar year 2023, 14 percent;

(vi) in the case of calendar year 2024, 21 percent;

(vii) in the case of calendar year 2025, 28 percent; and

(viii) in the case of calendar year 2026, 35 percent.

(6) ADVANCE PAYMENT RETROSPECTIVE ADJUSTMENT.—(i) In General.—If the Administrator deems it appropriate, the Administrator may make payments under this subsection for each year on the basis of advance estimates of expenditures submitted by the

SEC. 110. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.

(a) HSAs.—Subsection (j) of section 9010 of the Patient Protection and Affordable Care Act is amended—

(1) IN GENERAL.—Section 223(d)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “such 20 percent” and inserting “10 percent”.

(b) ARCHER MSAs.—Subparagraph (A) of section 220(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “such term” and all that follows through the period.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by striking subsection (f).

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2016.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2016.

SEC. 111. REPEAL OF LIMITATIONS ON CONTRIBUTIONS TO FLEXIBLE SPENDING 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) ARCHER MSAs.—Section 220(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 this section shall apply to distributions made after December 31, 2016.

SEC. 112. REPEAL OF TAX ON PRESCRIPTION MEDICATIONS.

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

“(1) IN GENERAL.—Section 4980I.

SEC. 113. 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 subsections:

“(a) APPLICABILITY.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2017.”.

SEC. 114. REPEAL OF HEALTH INSURANCE TAX.

Subsection (k) of section 9010 of the Patient Protection and Affordable Care Act is amended by striking “, and” at the end of paragraph (1) and all that follows through “2017”.

SEC. 115. REPEAL OF ELIMINATION OF DEDUCTION FOR EXCESSIVE PREMIUMS AND ADDITIONAL PREMIUMS AND HEALTH PLAN BENEFITS.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

“(1) IN GENERAL.—Section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “7.5 percent.”.

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

SEC. 116. REPEAL OF CHRONIC CARE TAX.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “15 percent”.

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

SEC. 117. 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 taxes imposed after September 30, 2017.

SEC. 118. PURCHASE OF INSURANCE FROM HEALTH SAVINGS ACCOUNT.

(a) PURCHASE OF HIGH DEDUCTIBLE HEALTH PLANS.

(1) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986, as amended by section 108(a), is amended—

(A) striking “or” at the end of clause (v) and inserting “, and”;

(B) striking paragraph (2) and inserting the following:

“(v) a high deductible health plan but only to the extent of the portion of such expense in excess of—

(I) any amount allowable as a credit under section 36B for the taxable year with respect to such coverage,

(II) any amount allowable as a deduction under section 162(l) with respect to such coverage, or

(III) any amount excludable from gross income with respect to such coverage under section 106 (including by reason of section 125 or 402(c)).

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to amounts paid for expenses incurred for, and distributions made for, coverage under a high deductible health plan beginning after December 31, 2017.

(b) CONSUMER FREDOM PLANS.—

(1) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 is amended by adding, by way of insertion after subsection (a) and section 122, is amended—

(A) by striking “or” at the end of clause (a) and by adding at the end the following:

“(1) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “7.5 percent.”.

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

SEC. 119. CHALLENGE TAX.

(a) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 is amended by adding, by way of insertion after subsection (a) and section 122, is amended—

(A) by striking “or” at the end of clause (a) and by adding at the end the following:

“(1) IN GENERAL.—Section 223(d)(2)(C) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “7.5 percent.”.

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

SEC. 120. REPEAL OF ELIMINATION OF DEDUCTION FOR EXCESSIVE PREMIUMS AND ADDITIONAL PREMIUMS AND HEALTH PLAN BENEFITS.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

“(a) APPLICABILITY.—The tax imposed under subsection (a) shall not apply to sales after December 31, 2017.”.

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

SEC. 121. REPEAL OF TANNING TAX.

(a) IN GENERAL.—Paragraph (2) of section 223(d) of the Internal Revenue Code of 1986, as amended by section 108(a), is amended—

(A) striking “or” at the end of clause (v) and inserting “, and”;

(B) striking paragraph (2) and inserting the following:

“(v) a high deductible health plan but only to the extent of the portion of such expense in excess of—

(I) any amount allowable as a credit under section 36B for the taxable year with respect to such coverage,

(II) any amount allowable as a deduction under section 162(l) with respect to such coverage, or

(III) any amount excludable from gross income with respect to such coverage under section 106 (including by reason of section 125 or 402(c)).

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to amounts paid for expenses incurred for, and distributions made for, coverage under a high deductible health plan beginning after December 31, 2017.

(b) CONSUMER FREDOM PLANS.—
SEC. 119. MAXIMUM CONTRIBUTION LIMIT TO HEALTH SAVINGS ACCOUNT INCREASED TO AMOUNT OF DEDUCTIBLE AND OUT-OF-POCKET LIMITATION.

(a) SELF-ONLY COVERAGE. —Section 223(b)(2)(A) of the Internal Revenue Code of 1986 is amended by striking "$2,500" and inserting "the amount in effect under subsection (a)(1)(III)."

(b) FAMILY COVERAGE. —Section 223(b)(2)(B) of such Code is amended by striking "$4,500" and inserting "the amount in effect under subsection (c)(2)(A)(ii)(III)."

(c) COST-OF-LIVING ADJUSTMENT. —Section 223(g) of such Code is amended—

(1) by striking "sections (b)(2) and" and "both places it appears and inserting "subsection", and

(2) in subparagraph (B), by striking "determined by" and all that follows through "calendar year 2003," and inserting "determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

SEC. 120. ALLOW BOTH SPOUSES TO MAKE CONTRIBUTIONS TO THE SAME HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(b)(5) of the Internal Revenue Code of 1986 is amended to read as follows:

"(5) SPECIAL RULE FOR MARRIED INDIVIDUALS WITH FAMILY COVERAGE.—

"(A) IN GENERAL.—In the case of individuals who are married to each other, if both spouses are eligible individuals and each spouse has family coverage under a high deductible health plan as of the first day of any month—

"(i) the limitation under paragraph (1) shall be applied by not taking into account any other high deductible health plan coverage and (if such spouses both have family coverage under separate high deductible health plans, only one such coverage shall be taken into account),

"(ii) such limitation (after application of clause (i)) shall be reduced by the aggregate amount paid to Archer MSAs of such spouses for the taxable year, and

"(iii) in the case of application of clauses (i) and (ii) shall be divided equally between such spouses unless they agree on a different division.

(B) TREATMENT OF ADDITIONAL CONTRIBUTION AMOUNTS.—If both spouses referred to in subparagraph (A) have attained age 55 before the close of the taxable year, the limitation referred to in subparagraph (A)(iii) which is subject to division between the spouses shall include the additional contribution amounts determined under paragraph (3) for both spouses. In any other case, any additional contribution amount determined under paragraph (3) shall not be taken into account under subparagraph (A)(iii) and shall not be subject to the division between the spouses.

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

SEC. 121. SPECIAL RULE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF HEALTH SAVINGS ACCOUNT.

(a) IN GENERAL.—Section 223(d)(2) 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 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 a high deductible health plan 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 subsection shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 122. EXCLUSION FROM HSAS OF HIGH DEDUCTIBLE HEALTH PLANS WHICH DO NOT INCLUDE PROTECTIONS FOR LIFE.

(a) IN GENERAL.—Subparagraph (C) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking at the end the following flush sentence:

"A high deductible health plan shall not be treated as a high deductible health plan if the plan does not include coverage for (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)."

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 123. FEDERAL PAYMENTS TO STATES.

(a) IN GENERAL.—Notwithstanding section 501(a), 1902(a)(25), 1903(a), 2002, 2005(a)(4), 2102(a)(7), and 2105(a)(1) of the Social Security Act (42 U.S.C. 1396 et seq.), the Social Security Act is amended—

(1) by striking ''subsections (b)(2) and'' and inserting ''sub-paragraph (a)(10)(A),'' and

(2) in section 1115(c)(7) of the Social Security Act, by striking ''$2,250'' and inserting "the amount as determined by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.".

(b) EFFECTIVE DATE.—The amendment made by this subsection shall take effect on January 1, 2020.

SEC. 124. MEDICAID PROVISIONS.

The Social Security Act is amended—

(1) in section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), by inserting "and that has elected to cover 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 subsection shall apply with respect to coverage under a high deductible health plan beginning after December 31, 2017.

SEC. 125. 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) —

(i) in clause (i)(VIII), by inserting "and ending December 31, 2019," after "2014,"; and

(ii) in clause (ii), in subclause (XXIII), by inserting "and ending December 31, 2017," after "2014," and by adding at the end the following new subclause:

"(XXIII) beginning January 1, 2020, who are expansion enrollees (as defined in subsection (a)(11));".

(B) by adding at the end the following new subsection:

"(nn) EXPANSION ENROLLEES.—

"(1) IN GENERAL.—In this title, the term 'expansion enrollee' means an individual—

"(A) who is under 65 years of age;".

"(B) 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;".

"(D) who is not described in any of subsections (a)(10)(A) and (a)(11) (or subsection (a)(10)(A)); and

"(E) whose income (as determined under subsection (a)(14)) does not exceed 133 percent of the poverty line (as defined in section 1115(b)(2)) applicable to a family of the size involved.

"(2) APPLICATION OF RELATED PROVISIONS.—Any reference in subsection (a)(10)(G), (k), or (l) of this section or in section 1903, 1905(a), 1920(e), or 1937(a)(1)(B) to individuals described in subsection (VIII) of subsection (a)(10)(A) shall be deemed to include a reference to expansion enrollees; and

(2) in section 1905 (42 U.S.C. 1396d) —

(A) in subsection (y)(1)—

(i) in the matter preceding subparagraph (A), by striking "individuals who are under 65 years of age," and all that follows through "shall be equal to" and inserting "and that has elected to cover newly eligible individuals before March 1, 2014, pursuant to section 1905, and to newly eligible individuals by such State before January 1, 2020, for medical assistance for newly eligible individuals

(2) DIRECT SPENDING.—The term "direct spending" has the meaning given that term under section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 990(c)).
described in subclause (VIII) of section 1902(a)(10)(A)(i), and, with respect to amounts expended by such State after December 31, 2019, and before January 1, 2024, for medical assistance for expansion enrollees (as defined in section 1902(nn)(1)), shall be equal to the higher of the percentage otherwise determined for the State and year under subsection (b) (without regard to this subsection) and;

(ii) in subparagraph (D), by striking “and” after the semicolon;

(iii) by striking subparagraph (E) and inserting the following new subparagraphs:

"(E) 90 percent for calendar quarters in 2020;

“(F) 85 percent for calendar quarters in 2021;

"(G) 80 percent for calendar quarters in 2022;

“(H) 75 percent for calendar quarters in 2023; and

(iv) by adding after and below subparagraph (H) (as added by clause (iii)), the following flush sentence:

“The Federal medical assistance percentage determined for a State and year under subsection (b) for expenditures for medical assistance to newly eligible individuals (as so described) and expansion enrollees (as so defined), in the case of a State that has made a determination before March 1, 2017, for calendar quarters after 2023, and, in the case of any other State, for calendar quarters (or portions of calendar quarters) after February 28, 2017;” and

(B) in subsection (e)(2)—

(I) in subparagraph (A)—

(i) by inserting “through 2023” after “each year thereafter”; and

(ii) by striking “and” and, for periods after December 31, 2019 and before January 1, 2024, who are expansion enrollees (as defined in section 1902(nn)(1)) shall be equal to the higher of the percentage otherwise determined for the State and year under subsection (b) (without regard to this subsection) and;

and

(ii) subparagraph (B)(ii)—

(I) in clause (I), by adding “and” at the end;

and

(ii) by striking subclauses (V), (VI) and (VII) and inserting the following new subclauses:

“(IV) 2017 and each subsequent year through 2023 is 80 percent.”;

(b) SUNSET OF MEDICAID ESSENTIAL HEALTH BENEFITS REQUIREMENT.—Section 1907(bb)(5) of the Social Security Act (42 U.S.C. 1396u-7(bb)(5)) is amended by adding at the end the following:

“Following this paragraph shall not apply after December 31, 2019.”;

SEC. 126. RESTORING FAIRNESS IN DSH ALLOWMENTS.

SEC. 126. RESTORING FAIRNESS IN DSH ALLOWMENTS.

Section 1923A(a)(6) of the Social Security Act (42 U.S.C. 1396u–7(b)(6)) is amended by adding at the end the following new section:

“SEC. 1923A. (a) IN GENERAL.—Subject to the limitations of this section, for each year during the period beginning with fiscal year 2018 and ending with fiscal year 2023, 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)(XXII) or (ii)(XXIII) of section 1902(a)(10)(A) for medical assistance under this title (or a waiver of the Secretary under section 1115) (each such State or District referred to in this section for the fiscal year as a ‘non-expansion State’) may adjust the payment and otherwise provide the State plan under this title (or a waiver of such plan) to health care providers that provide health care services to individuals enrolled in this title (or permitted to so serve as ‘eligible providers’) so long as the payment adjustment to such an eligible provider does not exceed the provider’s costs in furnishing health care services (as determined by the Secretary and net of payments under this title, 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.

(b) INCREASE IN APPLICABLE FMAP.—Notwithstanding section 1905(b), the Federal medical assistance percentage is increased with respect to expenditures attributable to a payment adjustment under subsection (a) for which payment is permitted under subsection (a) and shall be

“(I) 100 percent for calendar quarters in fiscal years 2018, 2019, 2020, and 2021; and

“(II) 95 percent for calendar quarters in fiscal year 2022;

(c) ANNUAL ALLOWMENT LIMITATION.—Payment under section 1903(a) shall not be made 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 product of $2,000,000,000 multiplied by the rate of

“the population of the State with income below 138 percent of the poverty line in 2015 (as determined based the table entitled ‘Poverty thresholds’ in the 2015 Annual Supplement to the Current Population Reports, Series P-60, No. 245, as amended by the most recent supplemental issue of the Current Population Reports, Series P-60, No. 252).

(d) DISQUALIFICATION IN CASE OF STATE EXPANSION.—In the case of a non-expansion State for fiscal year and provides eligibility for medical assistance described in

SEC. 127. REDUCING STATE MEDICAID COSTS.

SEC. 127. REDUCING STATE MEDICAID COSTS.

(a) IN GENERAL.—Section 1902(a)(34) of the Social Security Act (42 U.S.C. 1396a(a)(34)) is amended by striking “in or after the third month” and inserting “in or after the third month in which the recipient makes application for assistance” and inserting “in or after the month in which the recipient makes application for assistance, or, in the case of a recipient who is 65 years of age or older or who is eligible for medical assistance on the basis of being blind or disabled at the time application is made, or in or after the third month before the month in which the recipient makes application for assistance (or deemed to be made) on or after October 1, 2023.”

SEC. 128. PROVIDING SAFETY NET FUNDING FOR NON-EXPANSION STATES.

SEC. 128. PROVIDING 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. 1396–4) the following new section:

“ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY NET PROVIDERS IN NON-EXPANSION STATES.

SEC. 129. ADMISSION TO MEDICAID OF PERSONS ELIGIBLE TO RECEIVE MEDICAID.

SEC. 129. ADMISSION TO MEDICAID OF PERSONS ELIGIBLE TO RECEIVE MEDICAID.

SEC. 130. ELIGIBILITY FOR MEDICAID.

SEC. 130. ELIGIBILITY FOR MEDICAID.

SEC. 131. TRANSITION TO MEDICAID.

SEC. 131. TRANSITION TO MEDICAID.

SEC. 132. ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY NET PROVIDERS IN NON-EXPANSION STATES.

SEC. 133. ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY NET PROVIDERS IN NON-EXPANSION STATES.

SEC. 134. ELIGIBILITY FOR MEDICAID.

SEC. 134. ELIGIBILITY FOR MEDICAID.

SEC. 135. TRANSITION TO MEDICAID.

SEC. 135. TRANSITION TO MEDICAID.

SEC. 136. ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY NET PROVIDERS IN NON-EXPANSION STATES.

SEC. 137. ADJUSTMENT IN PAYMENT FOR SERVICES OF SAFETY NET PROVIDERS IN NON-EXPANSION STATES.

SEC. 138. ELIGIBILITY FOR MEDICAID.

SEC. 138. ELIGIBILITY FOR MEDICAID.

SEC. 139. TRANSITION TO MEDICAID.
subsection (a) during the fiscal year, the State shall no longer be treated as a non-expansion State under this section for any subsequent fiscal years.

SEC. 128. ELIGIBILITY REDETERMINATIONS.

(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) is amended by adding at the end the following:

“(J) FREQUENCY OF ELIGIBILITY REDETERMINATIONS.—Beginning on October 1, 2017, and notwithstanding subparagraph (H), in the case of a category whose eligibility for medical assistance under the State plan under this title (or a waiver of such plan) is determined based on the application of modified adjusted gross income under subparagraph (A) and who is so eligible on the basis of clause (i)(VIII), (ii)(XX), or (iii)(XXIII) of subsection (a)(19)(A), at the option of the State, the State plan may provide that the individual’s eligibility shall be redetermined every 6 months (or such shorter number of months as the State may select).

(b) INCREASED ADMINISTRATIVE MATCHING PERCENTAGE.—For each calendar quarter during the period beginning on October 1, 2017, and ending on December 31, 2019, the Federal administrative matching percentage otherwise applicable under section 1903(a) of the Social Security Act (42 U.S.C. 1396a(a)) with respect to State expenditures attributable to activities carried out by the State and approved by the Secretary under this section (relating to eligibility redeterminations made on a 6-month or shorter basis) (as added under subsection (a)) to increase by 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to exercise the option described in subparagraph (J) of such section (relating to eligibility redeterminations required under this section) upon such an individual’s satisfaction of a work requirement (as defined in paragraph (2)).

(2) WORK REQUIREMENT DEFINED.—In this section, the term ‘work requirement’ means, with respect to an individual, the individual’s participation in work activities (as defined in section 407(d)) for such period of time during the fiscal year of such State, and as directed and administered by the State.

(3) REQUIRED EXCEPTIONS.—States administering a work requirement under this subsection may establish such requirements as—

(A) a woman during pregnancy through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) expires;

(B) an individual who is under 19 years of age;

(C) an individual who is the only parent or caretaker of a child with disabilities; or

(D) an individual who is married or a head of household and has not attained 20 years of age and who—

“(1) maintains satisfactory attendance at secondary school or the equivalent; or

“(2) participates in education directly related to employment.”

(b) INCREASED ADMINISTRATIVE MATCHING PERCENTAGE.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following:

“(aa) The Federal matching percentage otherwise applicable under subsection (a) with respect to State administrative expenditures (as defined in paragraph (4)) for such period of time during the fiscal year for which the State receives payment under such subsection shall, in addition to any other increase to such Federal matching percentage, be increased by an amount equal to 5 percentage points with respect to State expenditures attributable to activities carried out by the State (and approved by the Secretary) to implement subsection (oo) of section 1902.

SEC. 131. PROVIDER TAXES.

Section 1903(w)(4)(C) of the Social Security Act (42 U.S.C. 1396b(w)(4)(C)) is amended by adding at the end the following new clause:

“(iii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on June 1, 2017, except—

“(I) for fiscal year 2021, ‘5.8 percent’ shall be substituted for ‘6 percent’ each place it appears;

“(II) for fiscal year 2022, ‘5.6 percent’ shall be substituted for ‘6 percent’ each place it appears;

“(III) for fiscal year 2023, ‘5.4 percent’ shall be substituted for ‘6 percent’ each place it appears;

“(IV) for fiscal year 2024, ‘5.2 percent’ shall be substituted for ‘6 percent’ each place it appears;

“(V) for fiscal year 2025 and each subsequent fiscal year, ‘5 percent’ shall be substituted for ‘6 percent’ each place it appears;

“(vi) for fiscal year 2026, ‘4.8 percent’ shall be substituted for ‘6 percent’ each place it appears; and

“(vii) for fiscal year 2027 and each subsequent fiscal year, ‘4.6 percent’ shall be substituted for ‘6 percent’ each place it appears.”

SEC. 132. PER CAPITA ALLOTMENT FOR MEDICAL ASSISTANCE.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended—

(1) in section 1903 (42 U.S.C. 1396b)—

“(a) APPLICATION OF PER CAPITA CAP ON PAYMENTS FOR MEDICAL ASSISTANCE.

“(1) IN GENERAL.—Beginning October 1, 2017, the Secretary shall—

“(A) apply the term ‘excess aggregate medical assistance payments’ to amounts for per capita base periods required under this section; and

“(B) the Federal average medical assistance matching percentage (as defined in paragraph (2)) for the State for the fiscal year; and

(2) by inserting after such section 1903 the following new section:

“SEC. 1903A. PER CAPITA-BASED PAYMENTS FOR MEDICAL ASSISTANCE.

“(a) APPLICATION OF PER CAPITA CAP ON PAYMENTS FOR MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term ‘excess aggregate medical assistance expenditures’ means, for a State for a fiscal year, the product of—

“(A) the excess aggregate medical assistance expenditures (as defined in paragraph (2)) for the State for the fiscal year; and

“(B) the Federal average medical assistance matching percentage (as defined in paragraph (4)) for the State for the fiscal year.

“(b) FEDERAL AVERAGE MEDICAL ASSISTANCE MATCHING PERCENTAGE.—In this subsection, the term ‘Federal average medical assistance matching percentage’ means, for a State for a fiscal year, the ratio (expressed as a percentage) of—

“(A) the amount of the Federal payments that would be made to the State under section 1903A(a)(1) for medical assistance expenditures for calendar quarters in the fiscal year if paragraph (1) did not apply; and

“(B) the amount of the medical assistance expenditures for the State for the fiscal year.

“(c) PER CAPITA BASE PERIOD.—

“(1) IN GENERAL.—In this section, the term ‘per capita base period’ means, with respect to a period of time during which a State selecting a period under subparagraph (D), not less than 4 consecutive fiscal quarters, selected the per capita base period under this paragraph, a State shall—

“(i) only select a period of 8 (or, in the case of a State selecting a period under subparagraph (D), not less than 4 consecutive fiscal quarters which begins with a fiscal quarter earlier than the first quarter of fiscal year 2014 or ends with a fiscal quarter which follows fiscal year 2017, the State may select a per capita base period that is less than 8 consecutive fiscal quarters, but in no case shall the period selected be less than 4 consecutive fiscal quarters

“(A) the amount of target total medical assistance expenditures (as defined in subsection (c)) for the State and fiscal year.

“(B) EXCESS AGGREGATE MEDICAL ASSISTANCE EXPENDITURES.—In this subsection, the term ‘excess aggregate medical assistance expenditures’ means, for a State for a fiscal year, the product of—

“(A) the excess aggregate medical assistance expenditures (as defined in paragraph (2)) for the State for the fiscal year; and

“(B) the Federal average medical assistance matching percentage (as defined in paragraph (4)) for the State for the fiscal year.

“(c) FEDERAL AVERAGE MEDICAL ASSISTANCE MATCHING PERCENTAGE.—In this subsection, the term ‘Federal average medical assistance matching percentage’ means, for a State for a fiscal year, the ratio (expressed as a percentage) of—

“(A) the amount of the Federal payments that would be made to the State under section 1903A(a)(1) for medical assistance expenditures for calendar quarters in the fiscal year if paragraph (1) did not apply; to

“(B) the amount of the medical assistance expenditures for the State for the fiscal year.

“(d) PER CAPITA BASE PERIOD.—

“(1) IN GENERAL.—In this section, the term ‘per capita base period’ means, with respect to a period of time during which a State selecting a period under subparagraph (D), not less than 4 consecutive fiscal quarters, which provide for such assistance for such category in a subsequent fiscal quarter that is not later than the fourth quarter of fiscal year 2016, the State may select a per capita base period that is less than 8 consecutive fiscal quarters, but in no case shall the period selected be less than 4 consecutive fiscal quarters.

“(2) APPLICATION OF OTHER REQUIREMENTS.—Except for the requirement that a per capita base period be a period of 8 consecutive fiscal quarters, all other requirements of this paragraph shall apply to a per capita base period selected under this subparagraph.

“(e) APPLICATION OF BASE PERIOD ADJUSTMENTS.—The adjustments to amounts for per capita base periods required under sections (b)(5) and (d)(4)(E) shall be applied to amounts for per capita base periods selected under this subparagraph by substituting ‘divided by the ratio that the number of quarters in the base period bears to 4’ for ‘excess aggregate medical assistance expenditures (as defined in paragraph (2)) for the State for the fiscal year; and

“(F) ADJUSTMENT BY THE SECRETARY.—If the Secretary determines that a State took—
actions after the date of enactment of this section (including making retroactive adjustments to supplemental payment data in a manner that affects a fiscal quarter in the per capita base period, pursuant to the regulation of the quantity of the data from the per capita base period used to make determinations under this section, the Secretary may adjust the data as the Secretary deems appropriate.

(b) Adjusted Total Medical Assistance Expenditures.—In this section, the term ‘adjusted total medical assistance expenditures’ means, for a State and fiscal year or per capita base period, the sum of—

(i) the amount of medical assistance services (as defined in paragraph (2)) for the State and fiscal year that is attributable to 1903A enrollees, reduced by the amount of any excluded expenditures (as defined in paragraph (3)) for the State and fiscal year which otherwise include in such medical assistance expenditures; and

(ii) the 1903A base period population percentage (as defined in paragraph (4)) for the State; or

(B) for fiscal year 2019 or a subsequent fiscal year, the sum of—

(i) the amount attributable to 1903A enrollees (as defined in subsection (a)(5)), the product of—

(A) the number of 1903A enrollees for such fiscal year or portion of a fiscal year, as estimated by the Bureau of the Census; and

(B) the applicable annual inflation factor (as defined in paragraph (3)) for fiscal year 2019, and

(ii) the amount attributable to 1903A enrollees (as defined in subsection (a)(5)), the product of—

(A) the number of 1903A enrollees for such fiscal year or portion of a fiscal year, as estimated by the Bureau of the Census; and

(B) the applicable annual inflation factor (as defined in paragraph (3)) for the fiscal year involved; and

(C) the aggregate amount of expenditures under paragraph (3) for the State and fiscal year that is attributable to 1903A enrollees (as defined in subsection (a)(5)), the product of—

(i) the number of 1903A enrollees for such fiscal year or portion of a fiscal year, as estimated by the Bureau of the Census; and

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

(D) the target total medical assistance expenditures for 1903A enrollees in the State for the fiscal year that is attributable to 1903A enrollees (as defined in subsection (a)(5)), the product of—

(i) the target per capita medical assistance expenditures (as defined in paragraph (2)) for the enrollee category, State, and fiscal year; and

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

(E) the product of—

(i) the number of 1903A enrollees for such fiscal year or portion of a fiscal year, as estimated by the Bureau of the Census; and

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

(F) the target per capita medical assistance expenditures (as defined in paragraph (2)) for the enrollee category, State, and fiscal year; and

(G) the number of 1903A enrollees for such fiscal year or portion of a fiscal year, as estimated by the Bureau of the Census; and

(H) the applicable annual inflation factor (as defined in paragraph (3)) for the fiscal year involved; and

3. 1903A Base Period Population Percentage.—In this subsection, the term ‘1903A base period population percentage’ means, for a State, the Secretary’s calculation of the percentage of the 1903A enrollees (as defined in subsection (a)(5)) for the State during the period from January 1, 2016, to December 31, 2019, in areas affected by a public health emergency. In this subsection, the term ‘1903A enrollee’ means an individual who is enrolled in a State’s medical assistance program under title XIX of the Social Security Act, as in effect on the first day of the calendar year in which the fiscal year involved begins.

4. Target Medical Assistance Expenditures.—In this subsection, the term ‘target total medical assistance expenditures’ means, for a State and fiscal year or per capita base period, the sum of—

1. 1903A Base Period Population Percentage.—In this subsection, the term ‘1903A base period population percentage’ means, for a State, the Secretary’s calculation of the percentage of the 1903A enrollees (as defined in subsection (a)(5)) for the State during the period from January 1, 2016, to December 31, 2019, in areas affected by a public health emergency. In this subsection, the term ‘1903A enrollee’ means an individual who is enrolled in a State’s medical assistance program under title XIX of the Social Security Act, as in effect on the first day of the calendar year in which the fiscal year involved begins.

2. Target Per Capita Medical Assistance Expenditures.—In this subsection, the term ‘target per capita medical assistance expenditures’ means, for a 1903A enrollee category and State—

(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 the fiscal year 2020; and

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

(i) the target per capita medical assistance expenditures (under subparagraph (A) or this subparagraph) for the 1903A enrollee category and State for the preceding fiscal year that occurs during such period, minus the amount that shall not exceed the amount determined under subparagraph (B) for the State and year or portion of a year if—

(A) the number of 1903A enrollees during the year or portion of a year to which such amount applies, as estimated by the Bureau of the Census; and

(B) the percentage increase in the consumer price index for all urban consumers (U.S. city average) from September of the previous fiscal year to September of the fiscal year involved; and

(ii) the applicable annual inflation factor (as defined in paragraph (3)) for that succeeding fiscal year.
(ii) Contributions required by a State from a political subdivision for administrative expenses if the State required such contributions from such subdivision without reimbursement from the State as of January 1, 2017.

(5) Adjustments to state expenditures targets to promote program equity across states.

(A) In general.—Beginning with fiscal year 2020, the target per capita medical assistance expenditures for a 1903A enrollee category for a fiscal year, as determined under paragraph (2), shall be adjusted (subject to subparagraph (C)(i)) in accordance with this paragraph.

(B) Calculation of amount by which state medical assistance expenditures for such category for the fiscal year in question shall be increased by a percentage for such category for the fiscal year in question by not less than 25 percent, the State's per capita medical assistance expenditures (as defined in subparagraph (D)) for the State, category, and fiscal year; divided by

(ii) the number of 1903A enrollees for the State, category, and year;

(c) Calculation of provisional target amount for each 1903A enrollee category.—Subject to subsection (g), the following shall apply:

(i) Calculation of base amounts per per capita basic period amount for fiscal year 2019.—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 the period; divided by

(B) The number of 1903A enrollees for the State's per capita base period (as determined under subsection (e)(4)).

(ii) Calculation of per capita medical assistance expenditures for the State for the State's per capita base period equal to—

(A) the amount calculated under subparagraph (A); and

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

(f) Calculation of fy19 provisional target amount for each 1903A enrollee category.—Subject to subsection (g), the following shall apply:

(i) Calculation of base amounts per per capita basic period amount for fiscal year 2019.—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 the period; divided by

(B) The number of 1903A enrollees for the State's per capita base period (as determined under subsection (e)(4)).

(ii) Calculation of per capita medical assistance expenditures for the State for the State's per capita base period equal to—

(A) the amount calculated under subparagraph (A); and

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

(g) Calculation of fy19 fiscal year average per capita medical assistance expenditures per capita for fiscal year 2019 for each 1903A enrollee category.—The Secretary shall calculate (and provide notice to the State not later than January 1, 2020, of the following):

(A) The average per capita medical assistance expenditures for the State for the State's per capita base period (as determined under subparagraph (C)); divided by

(B) The percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for the fiscal year for which fiscal year 2019 is the last fiscal year for which fiscal year 2019 is the last fiscal year for which the State's per capita base period is effective.

(ii) In this paragraph, the term 'non-DSH supplemental and pool payment percentage' means the ratio (expressed as a percentage) of—

(A) the total amount of non-DSH supplemental expenditures and payments described in subparagraph (A)(ii) and adjusted under subparagraph (E) and payments described in subparagraph (A)(ii) and adjusted under subparagraph (E) for the State for the period; to

(B) the average per capita medical assistance expenditures per capita for fiscal year 2019 for each 1903A enrollee category for the State for the period; and

(C) the average per capita medical assistance expenditures per capita for the State for fiscal year 2019 (as calculated under paragraph (E)).

(h) Calculation of fy19 provisional target amount for each 1903A enrollee category.—Subject to subsection (g), the following shall apply:

(i) Calculation of base amounts per per capita basic period amount for fiscal year 2019.—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 the period; divided by

(B) The number of 1903A enrollees for the State's per capita base period (as determined under subsection (e)(4)).

(ii) Calculation of per capita medical assistance expenditures for the State for the State's per capita base period equal to—

(A) the amount calculated under subparagraph (A); and

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

Section 1923.

(b) Provisional fy19 per capita target amount for each 1903A enrollee category.—Subject to subsection (d)(2), 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 section 1923; to

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

Subject to subsection (f)(2), 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 section 1923; to

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

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

(D) the number of 1903A enrollees for the State in fiscal year 2019, as calculated under paragraph (3)(A).
(e) 1903A enrollee; 1903A enrollee category.—Subject to subsection (g), for purposes of this section, the following shall apply:

(1) 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 (ii)) who for such month is in any of the following categories of excluded individuals:

(A) a disabled individual, as defined in section 1915(k)(2), child health assistance under title XXI.

(B) an individual who receives any medical assistance under this title only on the basis of subparagraph (A).

(C) 1905(b) medical assistance for items or services for which payment is made under the third sentence of section 1905(b).

(D) medical assistance for items or services for which payment is made under section 1115, section 1915, or another provision of this title, this section, the Social Security Act, and section 422 of the Public Health Service Act, following categories of excluded individuals:

(i) an individual who—

(1) is enrolled in a State plan under this title or title XXI or under a waiver of such plan.

(ii) are under 21 years of age; and

(iii) have a chronic medical condition or serious injury that—

(A) requires intensive healthcare interventions (such as multiple medications, therapies, or durable medical equipment) and intensive care coordination to optimize health and avoid hospitalizations or emergency department visits; or

(B) meets the criteria for medical complexity under existing risk adjustment methodologies using a recognized, publicly available pediatric grouping system (such as the pediatric complex conditions classification system or the Pediatric Medical Complexity Algorithm) selected by the Secretary in close collaboration with the State agencies responsible for administering State plans for children and the national pediatric, pediatric specialty, and pediatrics specialty experts.

(2) AUDITING OF CMS–64 DATA.—The Secretary shall conduct an audit of the number of individuals and expenditures reported through the CMS–64 report for the State’s per capita base period, fiscal year 2019, and each subsequent fiscal year, which audit may be conducted on a representative sample (as determined by the Secretary).

(3) AUDITING OF STATE SPENDING.—The Inspector General of the Department of Health and Human Services shall conduct an audit (which shall be conducted using random sampling, as determined by the Inspector General or the Secretary) of each State’s spending under this section not less than once every 3 years.

(4) TEMPORARY INCREASE IN FEDERAL MATCHING PERCENTAGE TO SUPPORT IMPROVED DATA REPORTING SYSTEMS FOR FISCAL YEARS 2018 AND 2019.—In the case of any State that selects as its per capita base period the most recent 6 consecutive quarter period for which an audit is necessary to determine the numbers of enrollees within each of such enrollee categories, as the Secretary determines are necessary (including timely guidance published in the Federal Register), and the numbers of enrollees within each of such enrollee categories, as the Secretary determines are necessary (including timely guidance published in the Federal Register), and the numbers of enrollees within each of such enrollee categories, as the Secretary determines are necessary (including timely guidance published in the Federal Register), the Secretary shall modify the CMS–64 report form to require that States submit data to report medical assistance expenditures for qualified inpatient psychiatric hospital services (as defined in section 1905(h)(3)).
increased by 10 percentage points to 100 percent; and
(ii) the Federal matching percentage applied under section 1902(a)(b)(B) shall be increased by 25 percentage points to 100 percent; and
(iii) the Federal matching percentage applied under section 1902(a)(7) shall be increased by 10 percentage points to 60 percent, but only with respect to amounts expended that are attributable to a State’s additional administrative expenditures to implement the data requirements of paragraph (1).

(5) HHS REPORT ON ADOPTION OF T-MSIS DATA.—Not later than January 1, 2025, the Secretary shall submit to Congress a report making recommendations as to whether data from the Transformed Medicaid Statistical Information System would be preferable to CMS–64 report data for purposes of making the determinations necessary under this section.

(b) ENSURING ACCESS TO HOME AND COMMUNITY-BASED SERVICES.—Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

(1) INCENTIVE PAYMENTS FOR HOME AND COMMUNITY-BASED SERVICES.—Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following new subsection:

(c) LIMITATIONS ON PAYMENTS.—

(i) ANNUAL ALLOTMENT.—Subject to clause (ii), for each year of the demonstration project under subsection (i), the Secretary shall allot an amount to each State that is an eligible State for the year under subparagraph (A)(i).

(ii) LIMITATION OF PAYMENTS.—Payment under section 1903(a) shall not be made to an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment that is paid to a single provider or group of providers in an amount that exceeds a percentage which shall be established by the Secretary of the payment otherwise made to the provider.

(iii) LIMITATION ON PAYMENTS TO AMOUNT OF ALLOTMENT.—Payment under section 1903(a) shall not be made to an eligible State for expenditures for a year that are attributable to an HCBS payment adjustment made by the State in the year exceeds the amount allotted to the State for the year under subparagraph (A)(i).

(i) REPORTING AND EVALUATION.—

(A) IN GENERAL.—As a condition of receiving the increased Federal medical assistance percentage described in paragraph (4)(B), each eligible State shall collect and report information, as determined necessary by the Secretary, for the purposes of providing Federal oversight of a State’s compliance with the health and welfare and financial accountability safeguards taken by the Secretary under subsection (c)(2)(A).

(B) FORMS.—By expenditure on eligible States on HCBS payment adjustments shall be separately reported on the CMS–64 Form and in T-MSIS.

(2) DEFINITIONS.—In this subsection:

(A) ELIGIBLE STATE.—The term ‘eligible State’ means a State that—

(i) is one of the 50 States or the District of Columbia;

(ii) has an application approved by the Secretary under subsection (c)(2)(A); and

(iii) submits an application under paragraph (2)(A); and

(iv) is selected by the Secretary to participate in the demonstration project.

(B) HCBS PAYMENT ADJUSTMENT.—The term ‘HCBS payment adjustment’ means a payment adjustment made by the Secretary to an eligible State to the amount of payment otherwise provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i).

(C) APPLICATION.—Before submitting an application under paragraph (2)(A), and

(iv) is selected by the Secretary to participate in the demonstration project.

(D) REPORTING AND EVALUATION.—The term ‘HCBS payment adjustment’ means a payment adjustment made by the Secretary to the amount of payment otherwise provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i).

(3) TERMS OF DEMONSTRATION PROJECT.—The demonstration project shall be conducted for the 4-year period beginning on January 1, 2020, and ending on December 31, 2023.

(d) STATE ALLOTMENTS AND INCREASED FMAP FOR PAYMENT ADJUSTMENTS.—

(i) GENERAL.—The Secretary shall select States to participate in the demonstration project on a competitive basis except that, in making selections under this paragraph, the Secretary shall give priority to any State that is one of the 15 States in the United States with the lowest population density, as determined by the Secretary based on data from the Bureau of the Census.

(ii) LIMITATION ON FEDERAL SPENDING.—The aggregate amount that may be allotted to eligible States under clause (i) for each year of the demonstration project, the Secretary shall allot an amount to each State that is an eligible State for the year.

(iii) LIMITATION ON FEDERAL SPENDING.—

(A) IN GENERAL.—Beginning with fiscal year 2020, any State (as defined in subsection (e)) that has an application approved by the Secretary under subsection (b) may conduct a Medicaid Flexibility Program to provide targeted health assistance to program enrollees.

(B) IN GENERAL.—

(A) IN GENERAL.—To be eligible to conduct a Medicaid Flexibility Program, a State shall submit an application to the Secretary that meets the requirements of this subsection.

(B) CONTENTS OF APPLICATION.—An application under this subsection shall include the following:

(i) A description of the proposed Medicaid Flexibility Program and how the State will satisfy the requirements described in subsection (d).

(ii) The proposed conditions for eligibility of program enrollees.

(iii) The applicable program enrollment category (as defined in subsection (e)(1)).

(iv) A description of the types, amount, duration, and scope of services which will be offered as targeted health assistance under the program, including a description of the proposed package of services which will be provided to program enrollees to whom the State would otherwise be required to make medical assistance available under section 1902(a)(10)(A)(i).

(v) A description of how the State will notify individuals currently enrolled in the State plan for medical assistance under title XIX of the Social Security Act of the State’s title of the transition to such program.

(vi) Statements certifying that the State agrees to—

(A) is one of the 50 States or the District of Columbia;

(B) has an application approved by the Secretary under subsection (c)(2)(A); and

(C) submits an application under paragraph (2)(A); and

(D) is selected by the Secretary to participate in the demonstration project.

(E) A description of the proposed Medicaid Flexibility Program, which shall include—

(i) goals related to quality, access, rate of growth targets, consumer satisfaction, and outcomes;

(ii) a plan for monitoring and evaluating the program to determine whether such goals are being met; and

(iii) a proposed process for the State, in consultation with the Centers for Medicare & Medicaid Services, to take remedial action to make progress on unmet goals.

(F) Such other information as the Secretary may require.

(G) Such other information as the Secretary may require.

(i) Report a process for the State, in consultation with the Centers for Medicare & Medicaid Services, to take remedial action to make progress on unmet goals.

(2) DURATION.—The Medicaid Flexibility Program shall be in effect until such time as the Secretary determines is necessary for monitoring, evaluation, or program integrity purposes, including—

(A) survey data, such as the data from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys;

(B) birth certificate data; and

(C) clinical patient data for quality measurements which may not be present in a claim, such as laboratory data, body mass index, and blood pressure;

(iv) on an annual basis, conduct a report evaluating the program and make such report public to the Secretary;

(v) SUBMISSION OF ANNUAL REPORT.—The proposed conditions for eligibility of program enrollees.

(B) REPORTING AND EVALUATION.—The term ‘HCBS payment adjustment’ means a payment adjustment made by the Secretary to an eligible State to the amount of payment otherwise provided under a waiver under subsection (c) or (d) or a State plan amendment under subsection (i).

(3) STATE NOTICE AND COMMENT PERIOD.—

(A) IN GENERAL.—Before submitting an application under this subsection, a State shall make the application publicly available for a 30 day notice and comment period.

(B) NOTICE AND COMMENT PROCESS.—During the notice and comment period described in paragraph (A), the State shall provide opportunities for a meaningful level of public input, which shall include public hearings on the proposed Medicaid Flexibility Program.
any application to conduct a Medicaid Flexibility Program without making such application publicly available for a 30 day notice and comment period.

(3) THE FEDERAL SUBMISSION.—

(A) IN GENERAL.—A State may submit an application under this subsection to conduct a Medicaid Flexibility Program that would begin in the fiscal year following the date on which the Secretary determined that an application is complete.

(B) DEADLINES.—Each year beginning with 2019, the Secretary shall specify a deadline for submission of an application under this paragraph for a State and year preceding such first fiscal year, in the total block grant amount available to the State for the succeeding fiscal year under paragraph (2) for such year, an amount for each quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the amount of Federal payments made to the State for such fiscal year under paragraph (2). The Secretary shall make such funds available to the State for the succeeding fiscal year if—

(i) the State satisfies the maintenance of effort requirement under paragraph (3)(B); and

(ii) the amount of State expenditures for uncompensated targeted health assistance for program enrollees during the year or portion of a year, to the same proportion of the block grant (reduced, in the case of a State that makes expenditures for targeted health assistance for program enrollees during the year or portion of a year, of the amount by which such expenditures exceeded such amount for the fiscal year preceding such year) under paragraph (2) for such year, an amount for each quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the total amount expended under the program during such quarter as targetted health assistance, and the State is responsible for the balance of the funds to carry out such program.

(ii) the amount of State expenditures for uncompensated targeted health assistance for program enrollees in areas of the State which are subject to a declaration described in section 1903A(b)(6)(A)(i) for the year or portion of a year each year during which a State is conducting a Medicaid Flexibility Program.

(3) FEDERAL PAYMENT AND STATE MAINTENANCE OF EFFORT EXPENDITURES.—For each year during which a State is conducting a Medicaid Flexibility Program, the State shall make expenditures for uncompensated targeted health assistance for program enrollees during the year or portion of a year, to the same proportion of the block grant (reduced, in the case of a State that makes expenditures for targeted health assistance for program enrollees during the year or portion of a year, of the amount by which such expenditures exceeded such amount for the fiscal year preceding such year) under paragraph (2) for such year, an amount for each quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the total amount expended under the program during such quarter as targetted health assistance, and the State is responsible for the balance of the funds to carry out such program.

(4) REDUCTION IN BLOCK GRANT AMOUNT FOR STATES FAILING TO MEET MFP REQUIREMENT.—

(i) IN GENERAL.—In the case of a State conducting a Medicaid Flexibility Program in any year, the Secretary bears the burden of proving that the State made expenditures for uncompensated targeted health assistance for program enrollees during the year or portion of a year to the same proportion of the block grant (reduced, in the case of a State that makes expenditures for targeted health assistance for program enrollees during the year or portion of a year, of the amount by which such expenditures exceeded such amount for the fiscal year preceding such year) under paragraph (2) for such year, an amount for each quarter of such year equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the total amount expended under the program during such quarter as targetted health assistance, and the State is responsible for the balance of the funds to carry out such program.

(ii) DISREGARD OF REDUCTION.—For purposes of determining the amount of a State block grant under paragraph (2), any reduction to a State’s block grant amount in a previous fiscal year shall be disregarded.

(iii) APPLICABLE TO STATES THAT TERMINATE.—If the Secretary determines that a State described in clause (i) that terminates the State Medicaid Flexibility Program under subsection (d)(2)(B) and such termination is effective with the end of the fiscal year in which the State fails to make the required amount of expenditures under subparagraph (B) of subparagraph (B) (i) of paragraph (3)(C), the block grant amount determined for the State in such succeeding fiscal year under clause (i) shall be treated as an overpayment under this title.

(5) DETERMINATION FOR NONCOMPLIANCE.—If the Secretary determines that a State conducting a Medicaid Flexibility Program is not complying with the requirements of this subsection, the Secretary shall reduce the block grant amount determined under subparagraph (B)(ii) of the enhanced FMAP described in the subparagraph (B)(ii) of the block grant amount available to a State for the succeeding fiscal year for a Medicaid Flexibility Program without making such application available to the State for the succeeding fiscal year for such Medicaid Flexibility Program.

(E) ADDITIONAL FEDERAL PAYMENTS DURING PUBLIC HEALTH EMERGENCY.—

(i) IN GENERAL.—In the case of a State and fiscal year or portion of a fiscal year for which the Secretary has excluded expenditures under section 1903A(b)(6), if the State has uncompensated targeted health assistance expenditures for the year or portion of a year, the Secretary may make an additional payment to such State equal to the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) of the amount of such uncompensated targeted health assistance expenditures, except that the amount of such additional payment shall not exceed the amount determined for the State and year or portion of a year under clause (i).

(ii) ADDITIONAL FEDERAL PAYMENT.—The amount determined for a State and fiscal year or portion of a fiscal year under this subparagraph shall not exceed the Federal average medical assistance percentage (as defined in section 1903A(a)(4)) for such year or portion of a year of the amount by which such expenditures exceeded such amount for the fiscal year of equal length to the portion of a fiscal year involved during which no such declaration was in effect.

(III) UNCOMPENSATED TARGETED HEALTH ASSISTANCE.—In this subparagraph, the term ‘uncompensated targeted health assistance’ means—

(A) the amount of State expenditures for uncompensated targeted health assistance for program enrollees in areas affected by a public health emergency for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.

(B) the amount determined was made for the purpose of ensuring that the health care needs of program enrollees in areas affected by a public health emergency are met.
each year thereafter, the Secretary shall de-
terminate for each State, regardless of whether the
State is conducting a Medicaid Flexi-
bility Program or has submitted an applica-
tion for such a program, the amount of the
block grant for the State under para-
graph (2) which would apply for the up-
coming fiscal year if the State were to conduct
such a program for the fiscal year and that such
provisions are otherwise consistent with the
requirements of this section.

(a) General.—A State Medicaid Flexi-
bility Program approved under subsection
(B), which meets the requirements of this section,
shall be conducted for not less than 1 pro-
gram period;

(b) Election to terminate a Medicaid
Flexibility Program unless the State has in
place an appropriate transition plan ap-
proved by the Secretary.

(c) Waivers and state plan amend-
ments.—

1. In general.—In the case of a State
conducting a Medicaid Flexibility Program
that has in effect a waiver or State plan
amendment, such waiver or amendment shall
not apply with respect to the program, tar-
ged health assistance provided by a State
under such a waiver or amendment, or
such program enrollees for each program period
during which the State conducts the pro-
gram

2. Effect of termination.—In the case of a
State conducting a Medicaid Flexibility Program
that is approved under subsection (a), the
Secretary shall apply as if program enrollees were
not 1903A enrollees for each program period
during which the Secretary deems appro-
priate, shall not apply.

3. Definitions.—For purposes of this sec-
tion:

(A) Applicable program enrollee category.—The term ‘applicable program enrol-
role category’ means, with respect to a State Medicaid Flexibility Program for a
program period, the following:

(1) General.—In general, the program enrollee category described in subparagraph
(2) of section 1905(l)(3).

(B) Expansion enrollees.—The 1903A enrol-
role category described in subparagraph
(2) of section 1903A(e)(2).

(C) Nonelderly, nondisabled, nonexpan-
sion adults.—The 1903A enrollee category
described in subparagraph (E) of section
1903A(a)(2).
State program for providing targeted health assistance to program enrollees funded by a block grant under this section.

(3) Program enrollee. The term ‘program enrollee’ means, with respect to a State that is conducting a Medicaid Flexibility Program for a program period, an individual who is a 1903A enrollee (as defined in section 1903A(e)(1)) who is in the applicable program enrollee category specified by the State for the period.

(B) RULE OF CONSTRUCTION. For purposes of section 1903A(e)(3), eligibility and enrollment of an individual under a Medicaid Flexibility Program shall be deemed to be eligible and enrolled under a State plan (or waiver of such plan) under this title.

(4) Program period. The term ‘program period’ means, with respect to a State Medicaid Flexibility Program, a period of 5 consecutive fiscal years that begins with either—

(A) the first fiscal year in which the State conducts the program; or

(B) the next fiscal year in which the State conducts such a program that begins after the end of a previous program period.

(5) Target State. The term ‘Target State’ means one of the 50 States or the District of Columbia.

(6) Targeted Health Assistance. The term ‘targeted health assistance’ means assistance provided to enrollees under a State plan amendment, or under such modified terms and conditions.

SEC. 134. MEDICAID AND CHIP QUALITY PERFORMANCE BONUS PAYMENTS.

Section 1903 of the Social Security Act (42 U.S.C. 1396b), as amended by section 130, is further amended by adding at the end the following new subsection:

(1) QUALITY PERFORMANCE BONUS PAYMENTS. —

(A) INCREASED FEDERAL SHARE. — With respect to each of fiscal years 2023 through 2026, the Secretary of Health and Human Services shall—

(i) establish a Federal matching percentage for purposes of this paragraph for each Target State (as defined in section 1139B), which shall be—

(ii) the amount of the target total medical assistance expenditures for the State and fiscal year determined in section 1903A(b)(1) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E); is less than

(B) the amount of the target total medical assistance expenditures for the State and fiscal year determined in section 1903A(c)(1) without regard to the 1903A enrollee category described in section 1903A(e)(2)(E).

SEC. 135. GRANDFATHERING CERTAIN HCBS WAIERS; PRIORITIZATION OF HCBS WAIERS.

(A) Managed Care Waivers. —

(1) In general. — In the case of a State with a grandfathered managed care waiver, the State may, as its option through a State plan amendment, continue to implement the managed care delivery system that is the subject of such waiver in perpetuity under the terms and conditions of the Social Security Act (or a waiver of such plan) without submitting an application to the Secretary for a new waiver to implement such new managed care delivery system.

(2) MODIFICATIONS. —

(A) In general. — If a State with a grandfathered managed care waiver intends to modify the terms or conditions of such a waiver, the Secretary shall submit to the Secretary an application for approval of a new waiver under such modified terms and conditions.

(B) APPROVAL OF MODIFICATION. —

(i) In general. — An application described in subparagraph (A) is deemed approved unless the Secretary, not later than 90 days after the date on which the application is submitted, submits to the State—

(I) a denial; or

(II) a request for more information regarding the application.

(ii) ADDITIONAL INFORMATION. — If the Secretary requests additional information, the State shall submit the requested information to the Secretary within 90 days after the date on which the Secretary’s request to deny the application or request more information was made.

(C) Grandfathered Managed Care Waiver Defined. — In this section the term ‘grandfathered managed care waiver’ means the provisions of a waiver or an experimental, pilot, or demonstration project that relate to the authority of a State to implement a managed care delivery system under this title, or a State plan under title XIX of the Social Security Act (or under a waiver of such plan under section 1115 of such Act) that—

(A) is approved by the Secretary of Health and Human Services under section 1915(b), 1932, or 1115(a)(1) of the Social Security Act (42 U.S.C. 1396b, 1396u-2, 1115(a)(1)) as of January 1, 2017; and

(B) has been renewed by the Secretary not less than 1 time.

(h) HCBS Waivers. — The Secretary of Health and Human Services shall implement procedures to encourage States to extend or modify waiver terms to allow for home and community-based services under the State plan under title XIX of the Social Security Act if the State determines that such waivers would improve patient access to services.

SEC. 136. COORDINATION WITH STATES.

Title XIX of the Social Security Act is amended by inserting after section 1904 (42 U.S.C. 1396d) the following:

"(c) Coordination with States. —

SEC. 1304A. No proposed rule (as defined in section 551(4) of title 5, United States Code) incorporating in the preamble to the proposed rule or in the application for a new waiver or modification of an existing waiver or grant a proposal for a project that is likely to have a direct effect on the operation or financing of State plans under this title (or waivers of such plans); and

(b) prior to submission of any final proposed rule, plan amendment, waiver request, or proposal for a project that is likely to have a direct effect on the operation or financing of State plans under this title (or waivers of such plans).

(2) Digitally and considers written and oral comments from a bipartisan, nonprofit, professional organization that represents State Medicaid Directors, the Federal Coordinating Office for Long-Term Care Planning, and the Agency for Healthcare Research and Quality under this title, regarding such proposed rule; and

(3) incorporates in the preamble to the proposed rule a summary of comments received in paragraph (2); and

SEC. 137. OPTIONAL ASSISTANCE FOR CERTAIN INPATIENT PSYCHIATRIC SERVICES.

(a) State Option. —

SEC. 1903 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (16)—

(i) by striking ‘‘and, (B)’’ and inserting ‘‘and’’;

(2) in subsection (h), by adding at the end the following:

(3) For purposes of subsection (a)(16)(C), the term ‘qualified inpatient psychiatric
hospital services’ means, with respect to individuals described in such subsection, services described in subparagraph (B) of paragraph (1) that are not otherwise covered under subsection (a)(18)(A) and are furnished—

(a) in an institution (or distinct part thereof) which is a psychiatric hospital (as defined in section 1396d(b)(1)(A)) and (B) with respect to such an individual, for a period not to exceed 30 consecutive days in any month and not to exceed 90 days in any calendar year.

(4) As a condition for a State including qualified inpatient psychiatric hospital services as medical assistance under subsection (a)(18)(C), the State must—

(A) maintain at least the number of licensed beds at psychiatric hospitals owned, operated, or contracted for by the State that were being maintained as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection;

(B) maintain on an annual basis a level of funding expended by the State (and political subdivisions thereof) other than under this title in fiscal years 1987 and 1988 that is equal to the amount for such services in an institution described in paragraph (3)(A), and for active psychiatric care and treatment provided on an outpatient basis, other than the level of such funding for such services and care as of the date of the enactment of this paragraph or, if higher, as of the date the State applies to the Secretary to include medical assistance under such subsection.

(c) EFFECTIVE DATE—The amendments made by this section shall apply to qualified inpatient psychiatric hospital services furnished on or after October 1, 1988.

SEC. 139. MEDICAID OPTION TO PROVIDE CONSUMER-FOCUSED COST-SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

Section 1903A(a)(4) of the Social Security Act (42 U.S.C. 1396a(a)(4)) is amended, in the third sentence, by adding at the end of such sentence the following: “Notwithstanding the provisions of this subsection, the Federal average medical assistance percentage shall be 50 percent with respect to medical assistance for services and individuals described in subsection (a)(18)(C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to qualified inpatient psychiatric hospital services furnished on or after October 1, 1988.

SEC. 139. MEDICARE OPTION TO PROVIDE CONSUMER-FOCUSED COST-SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), is amended by inserting after section 1906A the following new section:—

(a) CONSUMER-FOCUSED COST-SHARING ASSISTANCE FOR LOW-INCOME INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

Subtitle A of title 20 of chapter 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101 et seq.) is amended by adding at the end the following new part:

(b) SPONSOR.—The sponsor of a group health plan is described in this subsection if such sponsor—

(1) is a qualified sponsor and receives certification from the Secretary; and

(2) is organized and maintained in good faith, with a constitution or bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis.

(3) is established as a permanent entity;

(4) is established for a purpose other than providing health benefits to its members, such as an organization established as a bona fide trade association, franchise, or section 7703(s) corporation; and

(5) does not condition membership on the basis of a minimum group size.

(c) DETERMINATION OF MINIMUM ESSENTIAL COVERAGE.—Cost-sharing assistance provided under this section shall be considered to be minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(4) NONAPPLICATION OF OTHER REQUIREMENTS.—Sections 1902(a)(1) (relating to the employee retirement income security act of 1974); and 1916 (relating to cost-sharing for medical assistance), and any other provision of this title which would be directly contrary to the authority under this section shall not apply to the provision of cost-sharing assistance under this section.

SEC. 140. SMALL BUSINESS HEALTH PLANS.

(a) TAX TREATMENT OF SMALL BUSINESS HEALTH PLANS.—A small business health plan (as defined in section 7901 of the Small Business Health Options Program Act of 2010) is a qualified health plan (as defined in section 1301(a)(4) of the Patient Protection and Affordable Care Act) if—

(1) the plan meets the requirements of this section and the provisions of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101 et seq.) and title XXII of the Public Health Service Act (42 U.S.C. 300gg et seq.) and title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91); and (2) the plan—

(B) maintains at least the number of lives maintained by the plan (as defined in section 1301(a)(4)).

(b) RULES.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1101 et seq.) is amended by adding at the end the following new part:

PART 8—RULES GOVERNING SMALL BUSINESS RISK SHARING POOLS

SEC. 801. SMALL BUSINESS HEALTH PLANS.

(a) IN GENERAL.—For purposes of this part, the term ‘small business health plan’ means a fully insured group health plan, offered by a health insurance issuer in the large group market, whose sponsor is described in subsection (b); and

(1) is a qualified sponsor and receives certification from the Secretary; and

(2) is organized and maintained in good faith, with a constitution or bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis.

(3) is established as a permanent entity;

(4) is established for a purpose other than providing health benefits to its members, such as an organization established as a bona fide trade association, franchise, or title 7703(s) corporation; and

(5) does not condition membership on the basis of a minimum group size.

(b) SPONSOR.—The sponsor of a group health plan is described in this subsection if such sponsor—

(1) is a qualified sponsor and receives certification from the Secretary; and

(2) is organized and maintained in good faith, with a constitution or bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis.

(3) is established as a permanent entity;

(4) is established for a purpose other than providing health benefits to its members, such as an organization established as a bona fide trade association, franchise, or section 7703(s) corporation; and

(5) does not condition membership on the basis of a minimum group size.
SEC. 802. FILING FEE AND CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

(a) FILING FEE.—A small business health plan shall pay to the Secretary at the time of filing an application for certification under subsection (b) a filing fee in the amount of $5,000, which shall be available to the Secretary for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

(b) Certification.—

(1) In general.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule a procedure by which the Secretary will—

(A) will certify a qualified sponsor of a small business health plan, upon receipt of an application that includes the information described in paragraph (2);

(B) may provide for continued certification of small business health plans under this part;

(C) shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved fails to comply with the requirements of this part;

(D) shall conduct oversight of certified plan sponsors, including periodic review, and consistent with section 519, applying the requirements of sections 518, 519, and 520; and

(E) will consult with a State with respect to a small business health plan domiciled in such State regarding the Secretary’s authority under this part and other enforcement authority under sections 502 and 504.

(2) Information to be included in application for certification.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

(A) identifying information.

(B) States in which the plan intends to do business.

(C) Bonding requirements.

(D) Plan documents.

(E) Agreements with service providers.

(3) Requirements for certified plan sponsors.—Not later than 6 months after the date of enactment of this part, the Secretary shall prescribe by interim final rule required terms for certified plan sponsors that include requirements regarding—

(A) structure and requirements for boards of trustees;,

(B) notification of material changes; and

(C) notification for voluntary terminations.

(4) Filing notice of certification with states.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed by the plan sponsor with the applicable State authority in each State in which the small business health plan operates.

(5) Expedited and deemed certification.—

(1) In general.—If the Secretary fails to act on a complete application for certification under this section within 90 days of receipt of such complete application, the applying small business health plan sponsor shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

(2) Penalty.—The Secretary may assess a penalty of up to $5,000 in connection with the imposition of any fine by the plan sponsor with the applicable State authority of each State in which the small business health plan operates.

(6) Expired and deemed certified.—

(1) In general.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such complete application, the applying small business health plan sponsor shall be deemed to have completed the certification procedures and the Secretary determines that the applicant for certification of such small business health plan sponsor was willfully or gross negligence incomplete or inaccurate.

SEC. 803. PARTICIPATION AND COVERAGE REQUIREMENTS.

(a) Certification of sponsors and individuals.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

(1) each plan participating employer must be—

(A) a member of the sponsor;

(B) the sponsor; or

(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer who is a participating employer is an individual who is who partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor,

(2) all individuals commencing coverage under the plan after certification under this part must be—

(A) active or retired owners (including self-employed individuals with or without employees), officers, directors, or employees of, or partners in, participating employers; or

(B) the dependents of individuals described in subparagraph (A).

(b) Prohibition of discrimination against employers and employees eligible to participate.—The requirements of this subsection are met with respect to a small business health plan if—

(1) under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan; and

(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate.

SEC. 804. DEFINITIONS; RENEWAL.

(a) Definitions.—

(1) Affiliated member.—The term ‘affiliated member’ means, in connection with a sponsor—

(A) a person who is otherwise eligible to be a member of the sponsor who elects an affiliated status with the sponsor, or

(B) in the case of a sponsor with members which consists of associations, a person who is a member or employee of such an association and elects an affiliated status with the sponsor.

(2) Applicable State authority.—The term ‘applicable State authority’ means the plan sponsor. In the case of a group health plan, such term includes coverage offered to individuals other than in connection with a group health plan.

(3) Franchisor; franchisee.—The terms ‘franchisor’ and ‘franchisee’ have the meanings given such terms for purposes of sections 436 and 436A of, or paragraph (d) of, section 7705 of, the Internal Revenue Code of 1986, including any rules made by the Secretary of Labor regulating the applicability of such provisions.

(b) Plan sponsor.—Section 3(16)(B) of such Act (29 U.S.C. 1001(16)(B)) is amended by adding at the end the following:

(2) such term includes coverage offered to individuals other than in connection with a group health plan.

(c) Savings clause.—Section 782(c) of such Act is amended by inserting ‘or part 8’ after ‘this part’.

(d) Effective date.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 805. ADMINISTRATION OF CERTIFICATION PROGRAM.

(a) In general.—The provisions of this Act shall apply with respect to plans described in section 732(d)(3) on the first day of the plan year.

(b) State exception.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 720(e)(5) of the Public Health Service Act) is regulated by such State.

(c) Participating employer.—The term ‘participating employer’ means, in connection with a small business health plan, any employer, if any individual is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer with or without employees (for any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employer or self-employed individual in relation to the plan.

(7) Section 705 Organization.—The term ‘section 705 organization’ means an organization providing services for a customer pursuant to a contract meeting the conditions of subparagraphs (A), (B), (C), (D), and (E) (but not (F)) of section 7705(e)(2) of the Internal Revenue Code of 1986, including an entity that is a part of a section 705 organization control group. For purposes of this part, any reference to ‘member’ shall include a customer of a section 705 organization except with respect to references to a ‘member’ or ‘members’ in paragraph (1).”.

(c) Preemption Rules.—Section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end the following:

(2) such term includes coverage offered to individuals other than in connection with a group health plan which is certified under part 8.”.

(d) Plan sponsor.—Section 3(16)(B) of such Act (29 U.S.C. 1021(16)(B)) is amended by adding at the end the following:

(3) “Such term includes coverage offered to individuals other than in connection with a group health plan which is certified under part 8.”.

(e) Saver Clause.—Section 732(c) of such Act is amended by inserting ‘or part 8’ after ‘this part’.

(f) Effective date.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.
TITLE II

SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.
Subsection (b) of section 4002 of the Patient Protection and Affordable Care Act (42 U.S.C. 300gg–11) is amended—

(1) in paragraph (3), by striking “each of fiscal years 2018 and 2019” and inserting “fiscal years 2018 through 2026”;

(2) by striking paragraphs (4) through (8).

SEC. 202. SUPPORT FOR STATE RESPONSE TO OPIOID AND SUBSTANCE ABUSE CRISIS.

There is authorized to be appropriated, and is appropriated, to the Secretary of Health and Human Services, out of monies in the Treasury not otherwise obligated—

(1) $1,972,000,000 for each of fiscal years 2018 through 2026, to provide grants to States to support substance use disorder treatment and recovery support services for individuals who have or may have mental or substance use disorders, including counseling, medication assisted treatment, and other substance abuse treatment and recovery services as such Secretary determines appropriate; and

(2) $50,400,000 for each of fiscal years 2018 through 2022, for research on addiction and pain in the context of the substance abuse crisis.

Funds appropriated under this section shall remain available until expended.

SEC. 203. COMMUNITY HEALTH CENTER PROVISION.

Effective as if included in the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10, 129 Stat. 17), paragraph (3) of section 330g(a)(1) of the Public Health Service Act is amended by inserting “,”, and an additional $422,000,000 for fiscal year 2017” after “2017”.

SEC. 204. CHANGE IN PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES.

Section 2701(a)(1)(A)(iii) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)(iii)) is amended by inserting after “consistent with section 2701(c)” the following: “or, for plan years beginning on or after January 1, 2019, 5 to 1 for adults (consistent with section 2707(c)) or such other ratio after January 1, 2019, 5 to 1 for adults (consistent with section 2707(c))” and inserting “in accordance with this subsection;” and

(2) by redesigning such paragraph as paragraph (4); and

(2) by inserting after paragraph (2), the following:

‘‘(3) WAITING PERIODS.—
‘‘(A) IN GENERAL.—With respect to health insurance coverage that is effective on or after January 1, 2019, a health insurance issuer described in subsection (a) that offers such coverage in the individual market shall impose a 6 month waiting period (as defined in section 2706(b)(4) for group health plans) on any individual who enrolls in such coverage and who cannot demonstrate—

(i) in the case of an individual submitting an application during an open enrollment period, 12 months of continuous creditable coverage under the plan begins on the first day of the first month that begins 6 months after the date on which the individual submits an application for health insurance coverage in the individual market on the day before the effective date of the coverage in which the individual is newly enrolling.

(B) INDIVIDUALS ENROLLED IN OTHER COVERAGE.—Such a waiting period shall not apply to an individual who is enrolled in health insurance coverage in the individual market on the day before the effective date of the coverage in which the individual is newly enrolling.

(C) WAITING PERIOD DESCRIBED.—Such a waiting period shall not impose a waiting period with respect to such coverage in the individual market on the day before the effective date of the coverage in which the individual is newly enrolling.

‘‘(4) SUNSET.—(A) in clause (i), by striking “6 months after the date on which the individual submitted an application for health insurance coverage in the individual market on the day before the effective date of the coverage in which the individual is newly enrolling.”

(B) INDIVIDUALS ENROLLED IN OTHER COVERAGE.—Such a waiting period shall not apply to an individual who is enrolled in health insurance coverage in the individual market on the day before the effective date of the coverage in which the individual is newly enrolling.

‘‘(5) MEDICAL LOSS RATIO DETERMINED BY THE STATE.

Section 2701(b) of the Public Health Service Act (42 U.S.C. 300gg–18(b)) is amended by adding at the end the following:

‘‘(A) has the meaning given such term in section 2704(c)(1); and

‘‘(B) the first day of the first month that begins 6 months after the date on which the individual submits an application for health insurance coverage; or

‘‘(I) the first day of the first month that begins 6 months after the date on which the individual submits an application for health insurance coverage; or

‘‘(II) the first day of the next plan year.

(C) CERTIFICATES OF CREDIBLE COVERAGE.—The Secretary shall require health insurance issuers and health care sharing ministries (as defined in section 5000A(d)(2)(B) of the Internal Revenue Code of 1986) to provide certificates of credible coverage and waiting periods, in a manner prescribed by the Secretary, for purposes of verifying that the continuous coverage requirements of subparagraph (A) are met.

‘‘(D) SUBMISSION OF APPLICATION.—For purposes of this paragraph, the term ‘credible coverage’ means

(1) has the meaning given such term in section 2704(c)(1); and

‘‘(E) CONTINUOUS CREDIBLE COVERAGE DEFINED.—For purposes of this paragraph, the term ‘continuous coverage’ means

(1) would qualify for a reduction in premium revenue a health insurance issuer expended by the issuer on non-claims costs to the total amount of premium revenue during a full calendar year, and

(2) the amount of any annual rebate required to be paid to enrollees under such coverage if the ratio of the amount of premium revenue received from the issuer on claims to the total amount of premium revenue exceeds the ratio set by the State under subparagraph (A).’’.

SEC. 205. MEDICAL LOSS RATIO DETERMINED BY THE SECRETARY.

(a) ENROLLMENT WAITING PERIODS.—Section 2702(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(1)) is amended by inserting “, and as described in paragraph (3) before such paragraph shall have no force or effect.

(b) MEDICAL LOSS RATIO DETERMINED BY THE SECRETARY.—Section 2718(b) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(1)) is amended by adding after the period

‘‘(A) set the ratio of the amount of premium revenue a health insurance issuer offering group health insurance coverage may expend on non-claims costs to the total amount of premium revenue; and

(B) determine the amount of any annual rebate required to be paid to enrollees under such coverage if the ratio of the amount of premium revenue received from the issuer on non-claims costs to the total amount of premium revenue exceeds the ratio set by the State under subparagraph (A);’’.

SEC. 206. STABILIZING THE INDIVIDUAL INSURANCE MARKETS.

(a) ENROLLMENT WAITING PERIODS.—Section 2702(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–1(b)(1)) is amended by inserting “, and as described in paragraph (3) before such paragraph shall have no force or effect.

(b) CREDIBLE COVERAGE REQUIREMENT.—Section 2702(b)(2) of the Public Health Serv-
considered in determining whether the State plan increases the Federal deficit.’.’; and
(C) in paragraph (4), by adding at the end the following:
‘‘(D) EXPEDITED PROCESS.—The Secretary shall establish an expedited application and approval process that may be used if the Secretary determines that such expedited process is necessary to respond to an urgent or emergency situation with respect to health insurance coverage within a State.’’;
(2) in subsection (b), in the matter preceding subparagraph (A)—
(i) by striking ‘‘may’’ and inserting ‘‘shall’’; and
(ii) by striking ‘‘only if’’ and inserting ‘‘unless’’;
(3) in paragraph (1), by striking ‘‘plan—’’ and all that follows through the period at the end of subparagraph (D) and inserting ‘‘application is missing a required element under subsection (a)(1) or that the State plan will increase the Federal deficit, not taking into account any amounts received through a grant under subsection (a)(5)(B).’’;
(4) in paragraph (2)—
(i) in the paragraph heading, by inserting ‘‘OR CERTIFY’’ after ‘‘LAW’’;
(ii) in subparagraph (A), by inserting before the semi-colon a certification described in this paragraph is a document, signed by the Governor, and the State insurance commissioner, of the State, that provides for such termination signed by the Governor, and the State insurance commissioner, of the State, that provides
(iii) by adding at the end the following:
‘‘(3) may not be cancelled by the Secretary
(2) may be renewed for unlimited addi-
(1) shall be in effect for a period of 8 years
(4) in subsection (e), by striking ‘‘No waiv-
(2) in subsection (b)—
(1) may not be cancelled by the Secretary
(3) may be renewed for limited addi-
(2) in section 1332, as in effect on the
(1) certifies to the Secretary and the appli-
(2) certifies to the Secretary that such issuer will make available through the Ex-
(3) the conditions of this subsection for a health insurance issuer for a plan year are the same as the conditions that applied before
May 3 of the calendar year preceding the plan year involved—
(1) certifies to the Secretary and the appli-
(2) certifies to the Secretary that such issuer will apply subsection (a) with re-
(3) the provisions described in this sub-
(4) the provisions described in this sub-
(5) the provisions described in this sub-
SEC. 210. FUNDING FOR COST-SHARING PAY-
There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropri-
at for expenditures for cost-sharing reductions authorized by the Patient Protection and Af-
fordable Care Act (including adjustments to any prior period payments) for the period beginning on the date of enact-
ment of this Act and ending on December 31, 2019. Notwithstanding any other provision of this Act, the Secretary, after consultation with the Council for Medicaid and CHIP Operations and for adjustments to any obligations incurred for plan years 2018 and 2019 may be made during plan years 2020 and 2021.
SEC. 211. REPEAL OF COST-SHARING SUBSIDY PROGRAM.
(a) IN GENERAL.—Section 1402 of the Pa-
(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to cost-sharing re-
(c) Non-applicability of section.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 300g–13(a)) shall not apply to health insurance coverage offered off the Exchange by such issuer in the
(d) Non-applicability of section.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 300g–13(c)).
coverage offered off the Exchange in accordance with subsection (a) or to the issuer of such coverage with respect to that coverage.

(i) EFFECT OF WAIVER.—A State that receives for any health insurance coverage offered in accordance with subsection (a) or to make payments to issuer of such coverage shall remain available until the end of the following: “or a plan that includes coverage offered in accordance with subsection (a). Amounts paid to any such State from such an allotment shall be used to offset costs attributable to providing allotments for States in which a health insurance issuer offers coverage in accordance with subsection (a).

(g) FUNDING FOR STATES.—(1) APPROPRIATION.—There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, $2,000,000,000 for the period beginning on January 1, 2020, and ending on December 31, 2026, for the purpose of providing allotments for States in which a health insurance issuer offers coverage in accordance with subsection (a).

(2) PROCEDURE FOR DISTRIBUTION OF FUNDS.—Health insurance issuers shall determine an appropriate procedure for providing and distributing funds under this subsection.

(b) ENSURE AVAILABLE.—Health insurance coverage offered off the Exchange in accordance with subsection (a) shall not be taken into account as a qualified health plan for purposes of calculating the amount of the premium tax credit under section 36B of the Internal Revenue Code of 1986.

SA 271. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to amend the Health Care and Education Reconciliation Act of 2017—

**TITLES I**

**SEC. 101. RECAPTURE EXCESS ADVANCE PAYMENTS PREMIUM TAX CREDIT.**

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

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

**SEC. 102. PREMIUM TAX CREDIT.**

(a) IN GENERAL.—

(1) MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN.—(A) IN GENERAL.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by striking the second sentence of the section heading inserted by section 36B(f)(1)(B)—

(2) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2017.

(b) EFFECTIVE DATE.—The amendment made by this paragraph shall apply to taxable years beginning after December 31, 2019.

**SEC. 103. SMALL BUSINESS TAX CREDIT.**

(a) sunset.—

(1) IN GENERAL.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

(ii) Termination.—No disclosure may be made under this paragraph after December 31, 2019.

(2) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect on January 1, 2020.

(b) ENSURE AVAILABLE.—Health insurance coverage offered off the Exchange in accordance with subsection (a) shall not be taken into account as a qualified health plan for purposes of calculating the amount of the premium tax credit under section 36B of the Internal Revenue Code of 1986.

**(SA 271]**

SEC. 104. INDIVIDUAL MANDATE.

(a) IN GENERAL.—Section 9001(a)(2) of the Internal Revenue Code of 1986 is amended by striking “2.5 percent” and inserting “Zero percent”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2017.

**SEC. 105. EMPLOYER MANDATE.**

(a) IN GENERAL.—

(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting “$0 in the case of months beginning after December 31, 2015” after “$2,000”.

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

**SEC. 106. FEDERAL PAYMENTS TO STATES.**

(a) IN GENERAL.—Notwithstanding section 504(a), 1902(a)(23), 1902(a), 2002, 2005(a)(4), or 2105(a) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396a, 1397a, 1397a(d)(4), 1397a(b)(7), 1397e(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), for the 1-year period beginning on the date of 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 payment to a prohibited entity, whether made directly to the prohibited entity or through a managed care organization under contract with the prohibited entity.

(b) DEFINITIONS.—In this section:

(1) PROHIBITED ENTITY.—The term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinicians.

(2) EFFECTIVE DATE.—The term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinicians.

(3) CLINICIAN.—The term “clinician” means 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) EFFECTIVE DATE.—The term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinicians.

(4) DIRECT SPENDING.—The term “direct spending” has the meaning given to it under subsection 255(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900(c)).

**SEC. 107. MEDICAID.**

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(a) in subsection (a)(10)(A), in each of clauses (i) and (ii), by striking “2014” and inserting “2015”.

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

**SEC. 108. MEDICAID.**

The Social Security Act (42 U.S.C. 301 et seq.) is amended—

(a) in subsection (a)(10)(A), in each of clauses (i) and (ii), by striking “2014” and inserting “2015”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2015.
that follows through the period.

(p) is amended by striking "Such term" and all that follows through the period.

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

(2) in section 1943(a), by inserting "and before January 1, 2020, after "January 1, 2014.";

SEC. 108. REPEAL OF DSH ALLOTMENT REDUCTIONS.
Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended by striking the following new sentence:

"This subsection shall not apply after December 31, 2019.''; and

end the following: ''This subsection shall not apply to taxable years beginning after December 31, 2019.''; and

(6) in section 1943(a), by inserting "and before January 1, 2020, after "January 1, 2014.";

SEC. 109. REPEAL OF THE TAX ON EMPLOYEE HEALTH INSURANCE PREMIUMS AND HEALTH PLAN BENEFITS.

(a) In General.—Chapter 43 of the Internal Revenue Code of 1986 is amended by striking section 3610i.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2019.

(c) SUBSEQUENT EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to taxable years beginning after December 31, 2025, and chapter 43 of the Internal Revenue Code of 1986 is amended to read as such chapter would read if such subsection had not been enacted.

SEC. 110. REPEAL OF TAX ON OVER-THE-COUNTER MEDICATIONS.

(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) ARCHER MSAS.—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.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Subtitle A of the Internal Revenue Code of 1986 is amended by striking section 125.

(d) EFFECTIVE DATES.—(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2019.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2019.

SEC. 111. REPEAL OF TAX ON HEALTH SAVINGS ACCOUNTS.

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

(b) ARCHER MSAS.—Section 223(d)(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 this section shall apply to distributions made after December 31, 2019.

SEC. 112. 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) Repeal Date.—The amendment made by this section shall apply to plan years beginning after December 31, 2017.

SEC. 113. REPEAL OF 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, 2018.''

SEC. 114. REPEAL OF MEDICAL DEVICE EXCISE TAX.

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

"(2) in section 1943(a), by inserting "and before January 1, 2020, after "January 1, 2014.";

SEC. 115. REPEAL OF HEALTH INSURANCE TAX.

Subsection (j) of section 9010 of the Patient Protection and Affordable Care Act is amended by striking", and" at the end of paragraph (1) and all that follows through "2017".

SEC. 116. REPEAL OF ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO A FOREIGN TRADE ZONE.

(a) In General.—Section 1924(f) of the Internal Revenue Code of 1986 is amended by striking "20 percent" and inserting "10 percent".

SEC. 117. REPEAL OF MEDICARE TAX INCREASE.

(a) In General.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking "10 percent" and inserting "7.5 percent".

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

SEC. 118. 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 wages as defined in section 3121(a) received by such individual in respect to employment as defined in section 3121(b)."

(b) SECA.—Subsection (b) of section 1401 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 shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 2.9 percent of the amount of the self-employment income for such taxable year.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2017.

SEC. 119. REPEAL OF MEDICARE TAX INCREASE.

(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 September 30, 2017.

SEC. 120. REPEAL OF NET INVESTMENT 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.

SEC. 121. REMUNERATION.

Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

"(I) TERMINATION.—This paragraph shall not apply to taxable years beginning after December 31, 2018."
plan years 2018 and 2019 may be made through December 31, 2020.

SEC. 205. REPEAL OF COST-SHARING SUBSIDY PROGRAM.
(a) In general.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) 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, 2019.

SA 272. Mr. JOHNSON submitted an amendment intended to be proposed to amendment SA 267 proposed by Mr. MCCONNELL to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017, which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. 2. FINDINGS.

Congress makes the following findings:
(1) Before the passage of the Patient Protection and Affordable Care Act (Public Law 114-148) in 2010, Americans with pre-existing conditions faced unfair barriers to accessing health insurance coverage and health care costs had risen rapidly for decades.
(2) Since 2010, the rate of uninsured Americans has declined to a historic low, with more than 20,000,000 Americans gaining access to health insurance coverage.
(3) Since 2010, America has experienced the slowest growth in the price of health care in over five decades.
(4) Thanks to the Patient Protection and Affordable Care Act (Public Law 114-148), millions can no longer be denied insurance or charged more on the basis of their health status, more Americans than ever have insurance, and the health care they receive is continually improving.
(5) Starting in 2016, independent, non-partisan organizations, including the Congressional Budget Office, have determined that the individual, nongroup insurance markets have stabilized and improved.
(6) The cost-sharing reduction payments in the Patient Protection and Affordable Care Act provide stability in the individual health insurance market, lower insurance premiums by nearly 20 percent, and encourage competition among health insurers. The payment reduce costs for approximately 6,000,000 people with incomes below 250 percent of the poverty line by an average of about $1,100 per person and should be continued to help more Americans.
(7) Risk mitigation programs, such as the reinsurance program for the Medicare Part D prescription drug benefit program, have provided additional stability in health insurance markets, restrained premium growth, and lowered taxpayer costs by helping health insurers predict and bear risk associated with managing health care costs for a population.
(8) From 2014 to 2016, the temporary reinsurance program established under the Affordable Care Act helped stabilize the new insurance marketplaces and reduced insurance premiums in the individual health insurance market by as much as 10 percent.

SA 276. Mr. KAINE (for himself, Mr. CARPER, Mr. COONS, Mrs. SHAHEEN, Mr. CARDIN, Ms. HASSAN, Ms. KLOBUCAR, Ms. STABENOW, Mr. WARNER, Ms. HEITKAMP, and Mr. NELSON) submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

In lieu of the matter proposed to be inserted, insert the following:

ATTACHMENT — HOUSE REPORT NO. 115-38

Published: Thursday, July 27, 2017 at 11:13 AM EDT

Mr. President: The following is the report of the Committee on the Budget in response to a request of the Speaker of the House of Representatives that a report be submitted in the form of an attachment to the Congressional Record:

This week, the Senate will take up one more amendment to undo the American Rescue Plan. As the country works to fight back against the unprecedented economic challenges we face, the Senate has already taken numerous steps to help Americans. The American Rescue Plan included $192 billion in direct aid to states and localities, $72 billion in aid to K-12 and higher education, $20 billion to help升级 public transit, and $24 billion in aid to hospitals and providers. These investments have been vital in helping health care providers remain open and ensuring a stable supply chain. And earlier in the year, the Senate passed a bill to increase spending on the childhood nutrition programs by $1.2 billion. This week, we will consider an amendment to undo a $50 billion increase in government spending that was included in the American Rescue Plan.

The American Rescue Plan, which was signed into law on March 11, provided $1.9 trillion in economic assistance to families, businesses, and health care providers. The American Rescue Plan also includes $1.9 trillion in spending on health care, education, and other programs. These investments have been vital in helping health care providers remain open and ensuring a stable supply chain. And earlier in the year, the Senate passed a bill to increase spending on the childhood nutrition programs by $1.2 billion.

The American Rescue Plan, which was signed into law on March 11, provided $1.9 trillion in economic assistance to families, businesses, and health care providers. The American Rescue Plan also includes $1.9 trillion in spending on health care, education, and other programs. These investments have been vital in helping health care providers remain open and ensuring a stable supply chain. And earlier in the year, the Senate passed a bill to increase spending on the childhood nutrition programs by $1.2 billion.
gonna have a much better health care plan at much less money".

(10) The goal of any health care legislation should be to build on the Affordable Care Act to continue covering and make health care more affordable for Americans. Improving affordability and expanding coverage will also broaden the individual market and stabilize premium and strengthening market stability.

SEC. 3. SENSE OF THE SENATE.

It is the sense of the Senate that, with the reinsurance program under section 4 bringing stability to the individual marketplace for the 2018 plan year, the Senate should work in a bipartisan manner to find solutions to improve the health care system.

SEC. 4. INDIVIDUAL MARKET REINSURANCE PROGRAM.

(a) Establishment of Fund.—

(1) In general.—There is established the "Individual Market Reinsurance Fund" to be administered by the Secretary to provide funding for an individual market stabilization reinsurance program in each State that complies with the requirements of this section.

(2) Funding.—There is appropriated to the Fund, out of any moneys in the Treasury not otherwise appropriated, such sums as are necessary to carry out this section (other than subsection (c)) for each calendar year beginning with the 2018 plan year. The amounts appropriated to the Fund shall remain available without fiscal or calendar year limitation to carry out this section.

(b) Individual Market Reinsurance Program.—

(1) Use of funds.—The Secretary shall use amounts in the Fund to establish a reinsurance program under which the Secretary shall make reinsurance payments to health insurance issuers with respect to high-cost individuals enrolled in qualified health plans offered by such issuers that are not grandfathered health plans or transitional health plans for any plan year beginning with the 2018 plan year. This subsection constitutes budget authority in advance of appropriation Acts and represents the obligation of the Secretary to provide payments from the Fund to issuers for such payments.

(2) Amount of payment.—The payment made to a health insurance issuer under subsection (a) with respect to each high-cost individual enrolled in the individual market shall not exceed 80 percent of the lesser of—

(A) the amount (if any) by which the individual's claims incurred during the plan year exceeds—

(i) in the case of the 2018, 2019, or 2020 plan year, $50,000; or

(ii) in the case of any other plan year, $100,000; or

(B) for plan years described in—

(i) subparagraph (A)(ii), $450,000; and

(ii) subparagraph (A)(i), $400,000.

(3) Indexing.—In the case of plan years beginning after 2018, the dollar amounts that appear in subparagraphs (A) and (B) of paragraph (2) shall each be increased by an amount equal to—

(A) such amount, multiplied by

(i) the adjustment percentage specified under section 1302(c)(4) of the Affordable Care Act, but determined by substituting "2018" for "2013".

(B) the increase in the national health care index under subsection (b)(2).

(A) In general.—Payments under this subsection shall be based on such a method as the Secretary determines. The Secretary may use any payment method under which interim payments of amounts under this subsection are made during a plan year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

(B) Requirement for provision of information.—

(i) Requirement.—Payments under this subsection to a health insurance issuer are conditioned upon the furnishing to the Secretary form and manner specified by the Secretary, of such information as may be required to carry out this subsection.

(ii) Restriction on use of information.—Information disclosed or obtained pursuant to clause (i) is subject to the HIPAA privacy and security law, as defined in section 3009(a) of the Public Health Service Act (42 U.S.C. 300j-19(a)).

(5) Secretary's flexibility for budget neutral revisions to reinsurance payment specifications.—If the Secretary determines appropriate, the Secretary may substitute higher dollar amounts for the dollar amounts specified under subparagraphs (A) and (B) of paragraph (2) (and adjusted under paragraph (3), if applicable) if the Secretary certifies that such substitutions, considered together, neither increase nor decrease the total projected payments under this subsection.

(c) Outreach and Enrollment.—

(1) In general.—During the period that begins on January 1, 2018, and ends on December 31, 2020, the Secretary shall award grants to eligible entities for the following purposes:

(A) Outreach and Enrollment.—To carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of, and encourage enrollment in, qualified health plans.

(B) Assisting Individuals Transition to Qualified Health Plans.—To provide assistance to individuals who are enrolled in health insurance coverage that is not a qualified health plan.

(C) Assisting Enrollment in Public Health Programs.—To facilitate the enrollment of eligible individuals in the Medicare program or in a State Medicaid program, as appropriate.

(D) Raising Awareness of Premium Assistance.—To distribute fair and impartial information concerning enrollment in qualified health plans and the availability of premium assistance tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act, and to assist eligible individuals in applying for such tax credits and cost-sharing reductions.

(E) Eligible entities defined.—

(A) In general.—In this subsection, the term "eligible entity" means—

(i) a State; or

(ii) a nonprofit community-based organization.

(B) Enrollment agents.—Such term includes a licensed independent insurance agent or broker that has an arrangement with a State or nonprofit community-based organization to enroll eligible individuals in qualified health plans.

(C) Exclusions.—Such term does not include an entity that—

(i) is a health insurance issuer; or

(ii) receives any consideration, either directly or indirectly, from any health insurance issuer in connection with the enrollment of any individuals employed or otherwise associated with such entity that are employees of a qualified employer in a qualified health plan.

(D) Priority.—In awarding grants under this subsection, the Secretary shall give priority to awarding grants to States or eligible entities in States that have geographic rat-
of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle E of title XXVIII, add the following new section:

SEC. 2850. ESTABLISHMENT OF A VISITOR SERVICES FACILITY ON THE ARLINGTON RIDGE TRACT.  
(a) Arlington Ridge Tract Defined.—In this section, the term “Arlington Ridge tract” means the parcel of Federal land located in Arlington County, Virginia, known as the “Nevius Tract” and transferred to the Department of the Interior in 1953, that is bounded generally by—

(1) Arlington Boulevard (United States Route 50) to the north;
(2) Jefferson Davis Highway (Virginia Route 110) to the east;
(3) the wall Drive to the south; and
(4) North Meade Street to the west.

(b) Establishment of Visitor Services Facility.—Notwithstanding section 2863(c) of the Oak Ridge Act for Fiscal Year 2002 (Public Law 107–107; 115 Stat. 1332), the Secretary of the Interior may construct a structure for visitor services, to be by this project, on the Arlington Ridge tract in the area of the United States Marine Corps War Memorial.

SA 278. Ms. DUCKWORTH submitted an amendment intended to be proposed by her to the bill H.R. 2810, to authorize appropriations for fiscal year 2018 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe military personnel strengths for such fiscal year, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle J of title VIII, add the following:

SEC. 899D. INCLUSION OF SBIR AND STTR PROGRAMS IN TECHNICAL ASSISTANCE.  
Section 216(b) of title 10, United States Code, is amended—

(1) by striking “issued under” and inserting the following: “issued—

(a)(1) under”;

(2) by striking “and on” and inserting “,” and on”;

(3) by striking “requirements,” and inserting “requirements;”; and

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

“(2) under section 9 of the Small Business Act (15 U.S.C. 638), and on compliance with those requirements.”

SA 279. Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. 200. FEDERAL HEALTH DATABASES; NICS.—No funds made available to the Department of Health and Human Services or any other agency under this Act may be used to examine a Federal health database for the name of an individual to be submitted to the National Instant Criminal Background Check System (commonly known as “NICS”) established pursuant to the Brady Handgun Violence Prevention Act (18 U.S.C. 922 note).

SA 280. Mr. PAUL submitted an amendment intended to be proposed by him to the bill H.R. 1628, to provide for reconciliation pursuant to title II of the concurrent resolution on the budget for fiscal year 2017; which was ordered to lie on the table; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.  
This Act may be cited as the “ObamaCare Repeal Reconciliation Act of 2017”.

TITLE I  
SEC. 101. 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: “(11) Nonapplicability of limitation.—This subparagraph shall not apply to taxable years ending after December 31, 2017, and before January 1, 2020.”.

SEC. 102. PREMIUM TAX CREDIT.  
(a) PREMIUM TAX CREDIT.—

(1) MODIFICATION OF DEFINITION OF QUALIFIED HEALTH PLAN.—

(A) In general.—Section 36B(c)(3)(A) of the Internal Revenue Code of 1986 is amended by striking “issued under” and inserting “issued—

(1) under”;

(2) and on”;

(3) requirements,” and inserting “requirements;”; and

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

“(2) under section 9 of the Small Business Act (15 U.S.C. 638), and on compliance with those requirements.”

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to tax years beginning after December 31, 2017.

SEC. 103. SMALL BUSINESS TAX CREDIT.  
(a) SUNSET.—

(b) PREMIUM TAX CREDIT.—

(1) IN GENERAL.—Section 45R of the Internal Revenue Code of 1986 is amended by adding at the end the following subsection: “(j) SHALL NOT APPLY.—This section shall not apply with respect to amounts paid or incurred in taxable years beginning after December 31, 2017.”.

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply to taxable years beginning after December 31, 2019.

(c) DISALLOWANCE OF SMALL EMPLOYER HEALTH INSURANCE PREMIUM TAX CREDIT FOR PLAN WHICH INCLUDES COVERAGE FOR ABORTION.—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) .

(d) EFFECTIVE DATE.—The amendments made by this subsection shall apply to months beginning after December 31, 2017.

SEC. 104. INDIVIDUAL MANDATE.  
(a) IN GENERAL.—Section 5000A(c) of the Internal Revenue Code of 1986 is amended—

(1) in paragraph (2)(B)(iii), by striking “2.5 percent” and inserting “Zero percent”, and

(2) in paragraph (A) by striking “4,695” in subparagraph (A) and inserting “30”, 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. 105. EMPLOYER MANDATE.  
(a) IN GENERAL.—(1) Paragraph (1) of section 4980H(c) of the Internal Revenue Code of 1986 is amended by inserting “the first month of the applicable years beginning after December 31, 2015” after “$2,000”.

(2) Par. (1) of section 4980H(b) of the Internal Revenue Code of 1986 is amended by inserting “the first month of the applicable years 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. 106. FEDERAL PAYMENTS TO STATES.  
(a) IN GENERAL.—Notwithstanding section 504(a), 1902(a)(23), 1903(a), 2002, 2005(a)(4), 2102(a)(7), or 2106(a)(1) of the Social Security Act (42 U.S.C. 704(a), 1396a(a)(23), 1396b(a), 1397a, 1397d(a)(4), 1397b(a)(7), 1397e(a)(1)), or the terms of any Medicaid waiver in effect on the date of enactment of this Act that is approved under section 1115 of the Social Security Act (42 U.S.C. 1315, 1396n), for the 1-year period beginning on the date of enactment of this Act, no Federal funds provided 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.

(c) DEFINITIONS.—In this section—

(1) PROHIBITED ENTITY.—The term “prohibited entity” means an entity, including its affiliates, subsidiaries, successors, and clinicians.

(2) THAT, as of the date of enactment of this Act—

(a) an organization described in section 501(a) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code;
Revenue Code of 1986 is amended by striking “Such term” and all that follows through the period.

(4) ARCHER MSAs.—Subparagraph (b) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by striking “Such term” and all that follows through the period.

(5) in section 1937(b)(5), by adding at the end the following new sentence: “(j) REPEAL.—This section shall apply to taxable years beginning after December 31, 2016.”

(6) in section 1937(b)(6), by inserting “and the tax imposed by the preceding subsection, there shall be imposed for each taxable year, on the self-employment income of every individual, a tax equal to 2.9 percent of the amount of the self-employment income for such taxable year.”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration received after, and taxable years beginning after, December 31, 2017.

SEC. 119. 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 September 30, 2017.

SEC. 120. REPEAL OF NET INVESTMENT 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 services performed after, and taxable years beginning after, December 31, 2016.

SEC. 121. REMUNERATION.

Paragraph (6) of section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

“(i) TERMINATION.—This paragraph shall not apply to taxable years beginning after December 31, 2016.”

TITLE II

SEC. 201. THE PREVENTION AND PUBLIC HEALTH FUND.

Subsection (b) of section 4902 of the Patient Protection and Affordable Care Act (42 U.S.C. 300u–9(f)) is amended—

(1) in paragraph (3), by striking “each of fiscal years 2018 and 2019” and inserting “fiscal year 2018”; and

(2) by striking paragraphs (4) through (8).

SEC. 202. SUPPORT FOR STATE RESPONSE TO SUBSTANCE ABUSE PUBLIC HEALTH CRISIS AND URGENT MENTAL HEALTH NEEDS.

(a) IN GENERAL.—There are authorized to be appropriated, and are appropriated, out of any money in the Treasury not otherwise obligated, $750,000,000 for each of fiscal years 2018 and 2019, to the Secretary of Health and Human Services (referred to in this section as the “Secretary”) to award grants to States to address the substance abuse public health crisis or to respond to urgent mental health needs within the State. In awarding grants under this section, the Secretary may give preference to States with an incidence or prevalence of substance use disorders that is substantial relative to other States or to States that identify special needs within their communities that are urgent relative to such needs of other States. Funds
appropriated under this subsection shall remain available until expended.

(b) Use of Funds.—Grants awarded to a State under subsection (a) shall be used for one or more of the following public health-related activities:

(1) Improving State prescription drug monitoring programs.

(2) Implementing prevention activities, and evaluating such activities to identify effective strategies to prevent substance abuse.

(3) Training for health care practitioners, such as best practices for prescribing opioids, pain management, recognizing potential cases of substance abuse, referral of patients to treatment programs, and overdose prevention.

(4) Supporting access to health care services provided by Federally certified opioid treatment programs or other appropriate health care providers to treat substance use disorders or mental health needs.

(b) Public health-related activities as the State determines appropriate, related to addressing the substance abuse public health crisis or responding to urgent mental health needs within the State.

SEC. 202. 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. 65), paragraph (1) of section 221(a) of such Act is amended by inserting ‘‘ and an additional $322,000,000 for fiscal year 2017’’ after ‘‘2017.’’

SEC. 204. FUNDING FOR COST-SHARING PAYMENTS.

There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary for payments for cost-sharing reductions authorized by the Patient Protection and Affordable Care Act (including adjustments to any prior obligations for such payments) for the period beginning on the date of enactment of this Act and ending on December 31, 2019. Notwithstanding any other provision of this Act, payments and other actions for adjustments to any obligations incurred for plan years 2018 and 2019 may be made through December 31, 2020.

SEC. 205. REPEAL OF COST-SHARING SUBSIDY PROGRAM.

(a) In General.—Section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) 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, 2019.

AUTHORITY FOR COMMITTEES TO MEET

Mr. ENZI. Mr. President, I have 7 requests for committees to meet during today’s session of the Senate. I have the approval of the Majority and Minority leaders.

Pursuant to Rule XXVI, paragraph 5(a), of the Standing Rules of the Senate, the following committees are authorized to meet during today’s session of the Senate:

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

The Committee on Agriculture, Nutrition, and Forestry is authorized to meet during the session of the Senate on Tuesday, July 25, 2017 at 8:30 am, in 106 Dirksen Senate Office Building, in order to conduct a hearing entitled ‘‘Commodities, Credit, and Crop Insurance: Perspectives on Risk Management Tools and Trends for the 2018 Farm Bill.’’

COMMITTEE ON THE JUDICIARY

The committee of the Judiciary is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 10 a.m., in room SD–226 of the Dirksen Senate Office Building, to conduct a hearing entitled ‘‘Nominations.’’

COMMITTEE ON INTELLIGENCE

The Intelligence Select Committee on Intelligence is authorized to meet during the session of the 115th Congress of the U.S. Senate on Tuesday, July 25, 2017 from 2:30 pm, in room SH–219 of the Senate Hart Office Building to hold a Closed Business Meeting followed by a Closed Member Briefing.

SUBCOMMITTEE ON SEAPOWER

The Subcommittee on Seapower of the Committee on Armed Services is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 2:30 p.m., in open session, to receive testimony on options and considerations for achieving a 355-ship Navy from naval analysts.

SUBCOMMITTEE ON OCEAN, ATMOSPHERE, FISHERIES, AND COAST GUARD

The Committee on Commerce, Science, and Transportation is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 10 AM in room 253 of the Russell Senate Office Building. The Committee will hold Subcommittee Hearings on ‘‘Efforts on Marine Debris in the Oceans and Great Lakes.’’

SUBCOMMITTEE ON CLIMATE AND NUCLEAR SAFETY

The Subcommittee on Clean Air and Nuclear Safety of the Committee on Environment and Public Works is authorized to meet during the session of the Senate on Tuesday, July 25, 2017, at 10 AM, in Room 406 of the Dirksen Senate office building, to conduct a hearing entitled, ‘‘Developing and Deploying Advanced Clean Energy Technologies.’’

SUBCOMMITTEE ON EAST ASIA, THE PACIFIC, AND INTERNATIONAL CYBER SECURITY POLICY

The Committee on Foreign Relations Subcommittee on East Asia, the Pacific, and International Cyber Security Policy is authorized to meet during the session of the Senate on Tuesday, July 25, 2017 at 2:30 p.m., to hold a 1-hour hearing entitled ‘‘Assessing the Maximum Pressure and Engagement Policy toward North Korea.’’

PRIVILEGES OF THE FLOOR

Mr. ENZI. Mr. President, I ask unanimous consent that Paul Vinovich and Greg D’Angelo, from my staff, be given all-access floor passes to the Senate floor and that Robert Creager, Tiffany Mortimore, Sean Ross, and Sam Safari, interns for the Budget Committee, be granted floor privileges during the consideration of H.R. 1628.